HALTON BOROUGH COUNCIL

NHS
Halton Clinical Commissioning Group

# Transition Protocol

For children and young people with disabilities and/or complex needs

## 2017 to 2020

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# Information Sheet

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| **Service area** | Health, Education and Social Care Services |
| **Date effective from** | March 2017 |
| **Responsible officer(s)** | Principal Manager, Transition Team, People Directorate (Adult Social Care)<br>Programme Manager (14-19), People Directorate (Education, Inclusion and Provision)<br>Policy Officer, People Directorate (Adult Social Care) |
| **Date of review(s)** | March 2018 |
| **Status:**<br>• **Mandatory (all named staff must adhere to guidance)**<br>• **Optional (procedures and practice can vary between teams)** | Mandatory |
| **Target audience** | All professionals/agencies in Halton supporting young people with disabilities/complex needs in their transition to adulthood |
| **Date of committee/SMT decision** | Adult Social Care Senior Management Team: 1st March 2017<br>People Directorate Senior Leadership Team: 7th March 2017 |
| **Related document(s)** | As referenced throughout the protocol |
| **Superseded document(s)** | Inter-Agency Transition Agreement 2012 |
| **Equality Impact Assessment completed** | 24th February 2017 |

# Section One: Introduction

**Transition** is a process or period of change. The term can be applied to all young people to describe the stage in their lives when they move from adolescence to adulthood. However, for the purposes of this protocol it refers to children and young people with disabilities and/or complex needs and their journey from children's to adults' health, education and social care services.

It can be a time of excitement and opportunity with young people perhaps leaving school and considering their plans for the future in terms of employment, training or further education. But it can also be a challenging time with feelings of anxiousness particularly for those who rely on support from health and/or social care services.

This protocol sets out Halton's commitment to supporting those young people who may have a need for care and support in adulthood. It describes how the Council will fulfil its duties and responsibilities under current legislation and guidance relating to transition.

In order for transition to be effective, it is vital that a multi-agency approach is taken rather than being restricted to services provided by the Council. It is equally important that young people and their families/carers are fully informed and involved in the process and enabled to have as much choice and control as possible. It is also essential that transition is seen as an evolving process and not a single event.

This protocol is set within the context of the following vision from the Halton Special Educational Needs and/or Disabilities (SEND) Strategy 2016-2020:

> ***"Our vision is for children and young people with SEND to be included in the planning and development of services; to be provided with information to enable them to participate as fully as possible in decisions so that the personalised support they receive helps them to achieve the best possible aspirational outcomes, preparing them effectively for adulthood, allowing them to be as independent, successful and healthy as possible."***

## Scope

This protocol applies to children and young people between the ages of 14 and 25 who have disabilities and/or complex needs, including the following distinct groups:

- Those who have an Education, Health & Care (EHC) Plan (or a Statement of Special Educational Needs);
- Those who are likely to meet the eligibility criteria for adult social care services (in line with the Care Act 2014);
- Those with Continuing Healthcare needs;
- Those with complex needs (e.g. challenging behaviour, learning disabilities, severe autism, acute or chronic medical conditions);
- Those who would benefit from support in planning for adult life but do not have an EHC Plan/SEN (e.g. those with high-functioning autism or social/emotional/mental health difficulties/ill health);
- Carers of young people preparing for adulthood and young carers who are themselves preparing for adulthood.

*This protocol **does not** apply to those young people with mental health conditions, i.e. those being supported by the Council's Mental Health Social Work Teams.*

It is intended that this protocol will provide professionals from all agencies involved in supporting young people through the transition process with information about what should happen and when, who has responsibility and how agencies should work together. It is aimed at professionals from across education, health and social care, including the following services/organisations:

- Halton Borough Council – Children's and Adults' Social Care and Education Services;
- NHS Halton Clinical Commissioning Group;
- Bridgewater Community Healthcare NHS Trust;
- 5 Boroughs Partnership NHS Foundation Trust;
- Schools, colleges and other education providers;
- Other partner agencies, e.g. information and advice providers and advocacy services.

## Aims and outcomes

Against the backdrop of relevant legislation and guidance outlined in subsequent sections, this protocol aims to ensure that in Halton all young people and their families/carers have a positive transition experience.

Success will be evidenced by the following outcomes of good transition:

- Young people making decisions and taking the lead or being supported by people who can advocate for them;
- Young people being supported to plan what they want to do and achieve;
- Young people with care and support needs being able to access the same opportunities as other young people;
- Young people being able to access services that help them;
- Young people being able to try things out and being free to change their mind;
- Young people and their carers telling their story only once;
- Young people and their carers being listened to and fully involved in planning and decision-making;
- Young people and their carers having one key point of contact through the transition process and receiving consistent messages;
- Young people and their carers feeling supported;
- Young people and their carers having access to understandable information;
- Professionals pursuing agreed plans but being flexible to accommodate change as required.

# Section Two: Local processes and procedures

## Transition Team

In order to fulfil the obligations placed on local authorities under the legislation and guidance outlined in Section Three, Halton Borough Council has established a dedicated Transition Team comprising 3.5 full-time equivalent Social Workers and a Principal Manager.

The Team will facilitate a joined-up approach to transition from across education, health and social care with increased and targeted co-ordination and communication from all agencies starting from Year 9 (age 13/14) up to the age of 25 years or until appropriate to transfer into generic adult services.

The Team will work closely with a range of professionals from across a range of education, health and social care services.

Referrals into the Transition Team will usually be made by schools in preparation for involvement with the annual review meeting in year 9. Other referral routes will include the SEND Service, children's early intervention services, Complex Needs Panel, Transition Operational Group and family members. Referrals should usually be directed via the Council's Contact Centre. New and unexpected entries to the system may also occur (e.g. as a result of someone moving into the area or a young person acquiring an enduring injury during the transition phase) and would be highlighted via the monthly Transition Operational Group meetings or via a referral through the Contact Centre (either from a professional or the individual themselves/their family).

*See Appendix 1 for the CareFirst Transition Recording Process.*

## Transition timetable

As per the Children & Families Act 2014 (see Section Three for more information), every EHC Plan review from year 9 onwards must have a focus on preparing for adulthood. Transition planning for those young people with SEND takes place as part of the statutory annual review process, which is arranged by both mainstream and special schools and is monitored by the Council's SEND Service.

For those young people at a point of transition, who currently have a Statement of Special Educational Needs, the function of the review meeting will be:

- To discuss progress made by the young person;
- To look at the different options available and discuss the plan for transition;
- To transfer the Statement of Special Educational Needs to an Education, Health and Care Plan.

For those young people who already have an Education, Health and Care Plan, the function of the review meeting will be:

- To discuss progress made by the young person;
- To look at the different options available and discuss the plan for transition;
- To review the Education, Health and Care Plan and the outcomes.

**All reviews are to be conducted in a person centred manner.** Currently, Halton Speak Out is commissioned by the Council to provide a facilitation role in person centred reviews for those with a learning disability and/or complex needs; their involvement should be arranged by professionals as appropriate.

*See Appendix 2 for a flow chart of the Annual Transition Review Process.*

## *Year 9*

Year 9 (age 13/14) marks the start of the formal transition to adulthood process and at this point the Transition Team will become involved in planning for the transition to adult services.

The review meeting is called by school and the following must be in attendance:

- The young person and their family/carers or chosen representative;
- School staff;
- A member of the Transition Team (Transition Social Worker);
- SEND Team representative;
- Health professionals as relevant (e.g. school nurse and any therapists involved);
- Careers advisor (provided through school), if relevant;
- Person centred facilitator, if relevant.

In advance of the year 9 review, school will support the young person to complete the **'My Transition Plan'** document (see Appendix 3), which will be discussed during the review meeting and added to and updated as appropriate afterwards. The Transition Social Worker will support school staff with this process. The purpose of My Transition Plan is to capture the young person's aims and aspirations for the future, the options that may be available to them as they move towards adulthood and the care and support they may require.

To assist with transition planning, young people and their families should be referred to the Preparing for Adulthood section of Halton's Local Offer, which provides information, support and advice across education, health and social care covering ages 0-25 years. In addition, the Care and Support for You Portal provides information, advice and signposting with regards to adult social care services (age 18+).

My Transition Plan sits alongside the Education, Health and Care (EHC) Plan and the Health Action Plan, which is initiated by the school nurse at year 9, as necessary. Some young people may also have an 'All About Me' book, which is produced by schools from year 7 onwards (schools are responsible for maintaining this). Each of these documents will be considered within the review and updated by the relevant professional as appropriate following the meeting. The Transition Social Worker, supported by the relevant school, takes responsibility for the My Transition Plan. The SEND Service has responsibility for the EHC Plan. Health staff in attendance at the review will give consideration to whether the young person needs any therapeutic involvement or if any further referrals need to be made.

## *Year 10 to Year 14*

An annual review takes place each year and the process is the same as year 9; schools will arrange the review meeting and ensure that all relevant professionals are invited to attend along with the young person and their family/carers (see full list under year 9). The young person's My Transition Plan, EHC Plan and other documents will be reviewed and updated as appropriate.

There are some additional considerations in **year 11** and **year 14**, as at these times it is possible that the young person may change education provider or finish education. Schools have a statutory responsibility to ensure that young people have access to careers education, information, advice and guidance from year 9 onwards. In years 10 to 14 it is focussed on firming up the options when leaving statutory education. There should be taster sessions offered from the educational setting that the young person is looking to attend post-16 and these will be explored and confirmed by the current setting.

If leaving school or college (year 11/14), the young person's final School Health Review (to incorporate the Health Action Plan) should be completed by the school nurse or paediatrician and a copy given to the young person/their family and shared with their GP (if consent given). It should also be made available to adult services to inform future health needs.

Annual reviews, with involvement from the Transition Team and review/update of My Transition Plan, will continue to take place post-16 whether the young person remains within the same school or moves to another post-16 education provider. Schools/colleges will arrange review meetings and invite all relevant people as per the list provider under year 9.

***Financial considerations***

When a young person reaches age 16, their financial position may change in a number of ways depending on individual circumstances:

- If Personal Independence Payment (PIP, formerly known as Disability Living Allowance or DLA) is being claimed on a young person's behalf, they will be able to claim it in their own right from age 16;
- Some young people may be able to access Employment and Support Allowance and/or Income Support.

The Transition Team, school or other professional (as appropriate) should make a referral to the Welfare Rights Service in order to ensure that the young person is in receipt of the correct benefits.

It may also be necessary for a referral to be made to Welfare Rights as the young person approaches age 18 given the possible changes in income at this time and the fact that they may be required to make a financial contribution to the services they receive from adult social care.

***Referrals for those with learning disabilities***

Young people with a learning disability may be eligible for services from the Council's Adult Learning Disability Nursing Team from age 18 (in line with the eligibility criteria at Appendix 4). For those with more complex needs, the ALD Nursing Team may begin their involvement from age 17. The Transition Social Worker should make a referral at the appropriate time; the LD Nurses will then complete an eligibility assessment, Health Action Plan or an alternative piece of work, if required.

The Adult Community Learning Disability Nurse will liaise with child health and paediatric therapy services to establish if there are ongoing interventions that are likely to need to be transferred to adult health services' nursing and therapists. Where necessary, referrals will be made to the appropriate adult health service provider so that any joint working and phased transfer of ongoing intervention required can be facilitated.

Referrals may also be made to the 5 Boroughs Partnership (5BP) Halton Community Learning Disability Team, in line with the eligibility guidance outlined at Appendix 5. The Transition Social Worker should make a referral at the appropriate time.

***Equipment considerations***

For those young people who use specialist and adaptive equipment to enhance their function, independence or quality of life, child health services will review that equipment in preparation for early adulthood. This is crucial, as some specialist equipment that was funded for their needs as children is not subsequently funded in adult life.

## *Age 18-25*

Some young people with special educational needs remain at a statutory school until they are age 19. As part of the review of their Education, Health and Care Plan, the outcomes under Preparing for Adulthood will be reviewed and if it is considered that they have not yet been achieved and further education is required to meet those outcomes, the young person may transition into a further educational placement. Links will also be made with other services such as Day Services and/or the Community Bridge Building Team to identify opportunities to build independence, maintain and improve health and access employment opportunities, if possible. The most appropriate provision should be identified according to the individual needs of the young person.

All adults in receipt of a service from an adult social care team will have a minimum of an annual review to determine continued eligibility for a service.

If young people aged 18 or over have not been included in the transition process as described above for any reason and professionals/parents/young people feel they may meet the criteria for adults' services, they can refer them for an assessment through the Council's Contact Centre. If the outcome of the assessment is that someone is eligible for services from adult social care, they will be met by the appropriate adult social care team.

### *Out of borough schools*

A number of young people attend schools outside the borough; the procedure outlined above applies in the same way with involvement in annual reviews from the Transition Team and monitoring via the SEND Service.

## Assessment

In line with the Care Act, a **transition assessment** will be conducted for young people with care and support needs if they are likely to have needs when they reach age 18. Adult carers of young people preparing for adulthood and young carers who are themselves preparing for adulthood are also entitled to a transition assessment.

The assessment should be carried out when it is of **significant benefit** to the individual, which will differ according to personal circumstances; there is no set time when the assessment should be done and it can be done before the age of 18.

The assessment is separate to the My Transition Plan and looks at levels of need and eligibility for services but, as with transition planning, the assessment must be person-centred and outcome-focussed. It must also be strengths-based and focus on what the individual can do and achieve.

Assessment will be in line with the Care Act and completed as per the adults process through completion of the Supported Assessment Questionnaire (SAQ). Following assessment, application may be made to fund services.

Eligibility for community care services within adult social care will be in accordance with Care Act assessment and eligibility criteria. For more information, consult the Halton Borough Council Adults Assessment and Eligibility Policy and Carers Assessment and Eligibility Policy, which are available on the Intranet (links are provided to the current version of each policy, which are due for review in April 2017; therefore, please ensure that you consult the most up-to-date version).

Adults who are assessed as eligible for services will also have a financial assessment to determine whether the person will need to make a financial contribution to the services they will receive. This assessment will be in accordance with Halton's Charging for Residential Care Services Policy and Fairer Charging for Non-Residential Services Policy (links are provided to the current 2016/17 versions of the policies; please ensure that you consult the most up-to-date versions via the Council's Intranet. Please note that these policies are to be combined into one overall Charging Policy in 2017/18).

Continuing Healthcare assessments will be conducted in accordance with the National Framework outlined in Appendix 6.

## Funding

Throughout the transition process, funding applications will need to be submitted to the relevant funding panel according the age of the young person (i.e. under 18 or 18+).

If the young person has complex health needs, consideration should be given to Continuing Healthcare (CHC) funding, which will be in line with the National Framework outlined in Appendix

6. The Transition Social Worker should make a referral to the Adult Continuing Healthcare Team (see Appendix 5).

Decisions on funding of education will be aligned to the Education, Health and Care Plans.

## Personal Budgets / Personal Health Budgets

As per the SEND Code of Practice, young people and parents of children who have EHC plans have the right to request a Personal Budget, which may contain elements of education, social care and health funding. A Personal Budget is an amount of money identified by the local authority to deliver provision set out in an Education Health and Care Plan where the parent or young person is involved in securing that provision.

More information is available via the Local Offer using the links below (copy and paste them into your browser):

- Halton Guidance on Personal Budgets for Children with Special Educational Needs and Disability – (September 2014): https://localoffer.haltonchildrenstrust.co.uk/wp-content/uploads/2014/08/Personal-Budgets-.pdf
- Children's & Young People's (0-25) Personalisation & Personal Budgets Policy (*including Personal Health Budgets and Direct Payments*) Special Educational Needs and Disability (SEND): https://localoffer.haltonchildrenstrust.co.uk/wp-content/uploads/2016/06/Personal-budgets-Policy-2016.pdf

Information relating to Personal Budgets for adults is available via the following link:

http://www3.halton.gov.uk/Pages/adultsocialcare/Budgets.aspx

*"Personal Budgets are an allocation of funding given to users after an assessment which should be sufficient to meet their assessed needs. Users can either take their personal budget as a direct payment, or – while still choosing how their care needs are met and by whom – leave councils with the responsibility to commission the services. Or they can take have some combination of the two."*

Also, the adults Personal Budgets Policy can be found on the Council's Intranet:

- Personal Budgets – Social Care & Health (for Direct Payments) Policy, Procedure & Practice

## Safeguarding

Safeguarding is everyone's business. If there are any concerns that a young person is at risk of harm or abuse, a report should be made to Child Safeguarding if the person is under the age of 18 or Adult Safeguarding if they are aged 18 plus. More information on how to report a safeguarding concern is available via the following links:

- Halton Safeguarding Children Board Procedures Manual December 2016
- Safeguarding Adults in Halton Inter-Agency Policy, Procedures and Good Practice Guidance 2015-2018

## Operational and strategic oversight

There are a number of meeting groups that focus on transition of young people into adult life.

Operationally, transition is managed through the Transition Operational Group, which meets on a monthly basis to track progress of individuals going through transition in order to identify and plan for the needs of young people who are likely to meet the eligibility criteria for adults' social care/health services. The group facilitates referrals and multi-agency involvement and also helps to highlight any new/unexpected entries to the system in a timely manner.

Also at an operational level there is the Preparing for Adulthood Group and the SEND Commissioning Group; the three operational groups work together to feed through recommendations to the SEND Strategic Partnership, the Children's Trust and the All-Age Disability Partnership Meeting in order to effect changes at a strategic level.

Strategic and decision-making responsibility with regards to the Transition Team/matters arising from the Transition Operational Group sits with the Adults' Senior Management Team (SMT), which meets on a weekly basis.

# Section Three: Legislation and guidance

Together, the **Children & Families Act 2014** and the **Care Act 2014** provide a single, comprehensive legislative framework for the transition from children's to adults' services for those with care and support needs.

It is important to note that the Children & Families Act introduced a system of support from birth to 25 years and the Care Act is concerned with those aged 18 or over; therefore, there is a group of young people aged 18-25 who are entitled to support through both pieces of legislation.

The duties from both acts are placed on local authorities, not children's and adults' services separately; therefore, joint working is vital to ensuring smooth transition. Both acts have a shared focus on person-centred and outcome-focussed approaches that involve young people and their carers, recognising that transition is a process experienced as a family rather than an individual. It is also essential that transition is indeed seen as a process evolving gradually from ages 14 to 25, as opposed to a 'cliff-edge' at age 18.

It is also important to note that, with regards to safeguarding, although the Children & Families Act gives rights to young people from the end of compulsory school age, child safeguarding law still applies up to the age of 18. Similarly, the Care Act guidance states that if someone is 18 or over but still receiving children's services and a safeguarding issue is raised, the matter should be dealt with through adult safeguarding but with involvement of children's safeguarding and other organisations as appropriate (e.g. NHS, police).

Displayed below is summary information on the legislation and associated guidance plus links to the full information. There is also a range of good practice and guidance resources provided which will be of assistance to professionals in supporting effective transition from children's to adults' services.

## Children & Families Act 2014 & SEND Code of Practice

**Legislation:**

http://www.legislation.gov.uk/ukpga/2014/6/contents/enacted

Part 3 of the **Children & Families Act** relates to children and young people with special educational needs or disabilities (SEND); it creates a comprehensive 0 to 25 years SEND system with the aim of joining up education, health and care (through EHC Plans) so that services support the best outcomes for children and young people.

**Associated guidance:**

https://www.gov.uk/government/publications/send-code-of-practice-0-to-25

The **SEND Code of Practice** provides statutory guidance on duties, policies and procedures relating to Part 3 of the Children & Families Act 2014. It relates to the SEND system for children and young people aged 0 to 25 years. Chapter 8 of the Code of Practice is concerned with 'Preparing for adulthood from the earliest years.'

***Key points (consult the legislation/guidance in full for further information):***

- Local authorities must publish a 'Local Offer', which should include advice/information on preparing for adulthood;
- Help should be offered at the earliest possible point – good transition planning starts before age 14 and should include raising aspirations and supporting children to make decisions;

- Young people aged 16 or over have the right to make decisions and requests – professionals must ensure they are prepared and that the implications of the Mental Capacity Act 2005 are considered. Parents should still be involved in decision-making, particularly if the young person is aged under 18;
- Education, Health & Care (EHC) Plans (which replace Statements and Learning Difficulty Assessments) must be person-centred and outcome-focussed. Every EHC plan review from Year 9 onwards must have a focus on preparing for adulthood, which includes support to prepare for higher education/employment, independent living, maintaining good health and participating in society;
- Local authorities may continue EHC plans until the end of the academic year during which the young person turns 25;
- There is a right to request a personal budget as part of the EHC process;
- Carers have the right to an assessment and support (similar to the entitlements offered through the Care Act);
- Schools/colleges should raise the career aspirations of SEN students and provide careers guidance;
- All professionals should support young people with SEN to develop the skills, experience and qualifications they need for employment (e.g. arrange work-based learning opportunities);
- All young people with SEN should be supported to make the transition to life after school/college, whether or not they have an EHC plan;
- To prepare the young person for good health in adulthood, support must be provided for their transition to adult health services. Professionals should work with the young person to develop a transition plan, which identifies a lead care co-ordinator (the young person should know who this is and how to contact them). Clinical Commissioning Groups (CCGs) must co-operate with local authorities in supporting transition to adult services and must jointly commission services that will meet EHC plan outcomes. In supporting transition from Child and Adolescent Mental Health Services (CAMHS) to adult mental health services, CCGs and local authorities should refer to 'The Mental Health Action Plan, Closing the Gap: Priorities for essential change in mental health' (Department of Health, 2014);
- With regards to transition to adult social care, young people with SEN turning 18, or their carers, may become eligible for adult care services, regardless of whether they have an EHC plan or whether they have been receiving care under section 17 of the Children Act 1989. Under the Care Act (see next section), local authorities must carry out a transition assessment where there is significant benefit to a young person/their carer in doing so and they are likely to have needs for care and support from age 18. The transition assessment should be undertaken as part of one of the annual statutory reviews of the EHC Plan and this must be at the right time for the individual (i.e. when it would be of 'significant benefit' – there is no set age);
- Services should work in an integrated manner – co-ordinated, multi-agency support is required if young people are to achieve good life outcomes;
- Under no circumstances should young people find themselves without care and support as they go through transition.

## Care Act 2014 & Care & Support Statutory Guidance

**Legislation:**

http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

The **Care Act** creates a new modern framework for care and support legislation with the central principle of wellbeing. Sections 58-66 of Part 1 of the Care Act deal with 'Transition for children to adult care and support, etc.'

**Associated guidance:**

https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

Chapter 16 of the **Care & Support Statutory Guidance** covers 'Transition to adult care and support' (guidance on sections 58-66 of the Care Act).

***Key points (consult the legislation/guidance in full for further information):***

- The Care Act introduces an entitlement to a **transition assessment** for the following groups if they are likely to have needs once they or the person they care for turns 18 in order to help them plan for transition:
    - Young people under the age of 18 with care and support needs who are approaching transition to adulthood;
    - Young carers under the age of 18 who are themselves preparing for adulthood; and
    - Adult carers of young people who are preparing for adulthood;
- Local authorities have powers to ensure continuity so that for those receiving children's services, they do not abruptly end when the young person turns 18 but must continue until adults' service have a plan in place;
- The transition assessment must be carried out **when there is significant benefit** to the young person or carer in doing so; the most appropriate timing of the assessment will be different for everyone and will depend on circumstances such as upcoming exams, entering college/work, moving out of the family home, planned medical treatment and so on;
- Transition assessments themselves can help with preventing, reducing or delaying the development of care and support needs;
- The transition assessment must be person-centred and outcome-focussed and guided by the principle of wellbeing. It should support the young person and their family to plan for the future by providing them with information about what they can expect. It should consider current needs and likely needs as an adult, including which are likely to be eligible needs;
- The provisions in the Care Act do not relate only to those young people who are already known to the local authority (i.e. those receiving children's services) but also anyone who is likely to have adult care and support needs once they reach age 18 – local authorities need to consider how they will identify such people;
- Successful transition depends on the young person, their carers/family and professionals working together and local authorities have a legal responsibility to ensure effective internal and external co-operation to ensure transition is smooth. Equally, partners of the local authority have a reciprocal duty of co-operation. There is evidence of the value of having a 'named worker' or 'lead professional' to co-ordinate transition and assessment planning across all agencies and local authorities should consider formalising this.

## Mental Capacity Act 2005

**Legislation:**

http://www.legislation.gov.uk/ukpga/2005/9/contents

The **Mental Capacity Act (MCA)** applies to people aged 16 and over who may lack the mental capacity to make decisions about their care /treatment/ support.

**Associated guidance:**

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

The MCA is supported by practical guidance in the form of the **Code of Practice.**

***Key points (consult the legislation/guidance in full for further information):***

- A person lacks capacity if they are unable to make a particular decision or take a particular action for themselves at the time the decision or action needs to be taken;
- There should always be a presumption of capacity; all adults (aged 16 or over) should be considered to have the capacity to make a decision themselves unless an assessment proves otherwise. In addition, it may be that they have capacity to make some decisions but not others;
- People should be given help and support to make their own decisions or participate in decision-making;
- Any decision or action taken on behalf of someone who lacks capacity must be in their best interests.

Part 3 of the Children & Families Act outlines that the right to make requests and decisions applies directly to disabled young people and those with SEN over compulsory school age (the end of the academic year in which they turn 16) rather than to their parents. The Preparing for Adulthood factsheet (see link in the following PfA section) includes more information on how young people can be prepared and supported to make decisions themselves and/or take part in decision making.

## NICE guidance

***NICE Guideline (NG43) 'Transition from children's to adults' services for young people using health or social care services'***

https://www.nice.org.uk/guidance/ng43

This guideline covers the period before, during and after a young person moves from children's to adults' services. It aims to help young people and their carers have a better experience of transition by improving the way it's planned and carried out. It covers both health and social care.

The overarching principles are as follows:

- Young people and their carers should be involved in transition service design, delivery and evaluation;
- Transition support should be developmentally appropriate, strengths-based and person-centred;
- Health and social care service managers in children's and adults' services should work in an integrated manner to ensure that young people experience a smooth transition;
- Service managers in both adults' and children's services across health, social care and education should identify and plan for young people with transition support needs;

- Safeguarding information should be shared as appropriate by all agencies in line with local policy;
- It should be confirmed that the young person has a GP (and consideration should be given to a named GP).

### *NICE Quality Standard (QS140) 'Transition from children's to adults' services'*

https://www.nice.org.uk/guidance/qs140

This standard is based on guideline NG43 and sets out the following quality statements:

- Statement 1: Young people who will move from children's to adults' services start planning their transition with health and social care practitioners by school year 9 (aged 13 to 14 years), or immediately if they enter children's services after school year 9.
- Statement 2: Young people who will move from children's to adults' services have an annual meeting to review transition planning
- Statement 3: Young people who are moving from children's to adults' services have a named worker to coordinate care and support before, during and after transfer.
- Statement 4: Young people who will move from children's to adults' services meet a practitioner from each adults' service they will move to before they transfer.
- Statement 5: Young people who have moved from children's to adults' services but do not attend their first meeting or appointment are contacted by adults' services and given further opportunities to engage.

## Good practice resources

### *Preparing for Adulthood (PfA)*

http://www.preparingforadulthood.org.uk/

The national Preparing for Adulthood (PfA) programme is funded by the Department for Education (DfE) as part of the delivery support for the SEND reforms. PfA's vision is that young people with SEND should have equal life chances as they move into adulthood, which should include paid employment and higher education, housing options and independent living, good health, friends, relationships, community inclusion and choice and control over their lives and support.

There are five key messages from PfA:

- Develop a shared vision of improving life chances with young people, families and all key partners;
- Raise aspirations for a fulfilling adult life by sharing clear information about what has already worked for others;
- Develop a personalised approach to all aspects of support using person-centred practices, personal budgets and building strong communities;
- Develop post-16 options and support that lead to employment, independent living, good health, friends, relationships and community inclusion; and
- Develop outcome-focussed multi-agency commissioning strategies that are informed by the voice of young people and families.

These messages are essential to improving life chances in the four outcome areas – employment, independent living, community inclusion and health.

There are a range of resources on the PfA website, including the following useful factsheets:

- The links between the Children and Families Act 2014 and the Care Act 2014
- The Mental Capacity Act 2005 and Supported Decision Making

### *Social Care Institute for Excellence (SCIE)*

http://www.scie.org.uk/care-act-2014/transition-from-childhood-to-adulthood/

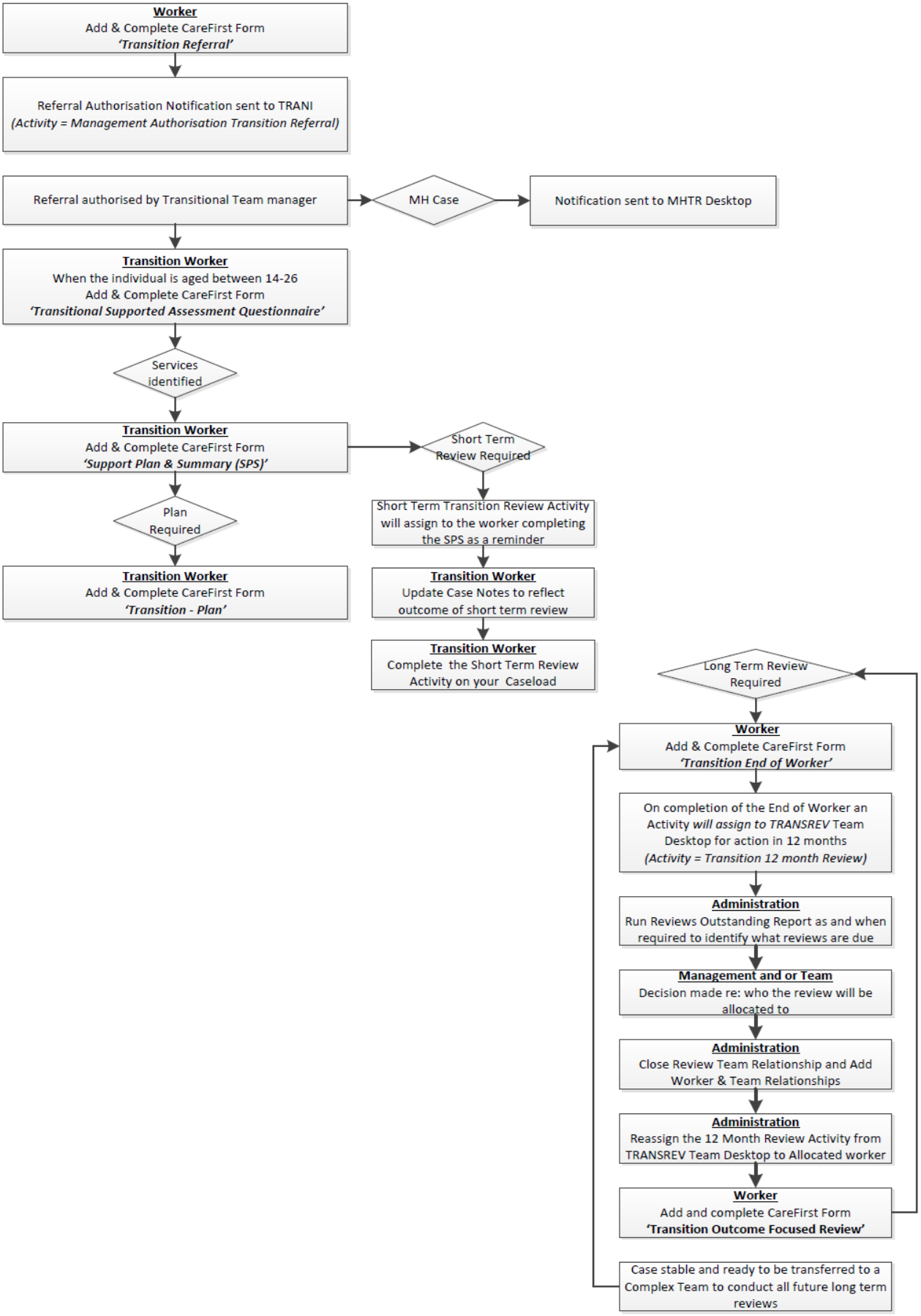
SCIE has developed a range of resources to help local authority staff, social workers, young people and carers to plan for the transition to adult care services.

### *Skills for Care*

http://www.skillsforcare.org.uk/Standards-legislation/Care-Act/Learning-materials/Transition-to-adulthood.aspx

Skills for Care has developed a range of learning and development materials to help with the changes brought about by the Care Act 2014, including a specific set of materials on 'transition to adulthood.'

# Appendix 1: Transition CareFirst Recording Process



# Appendix 2: Transition Annual Review Process

**Preparation for the Transition Review Meeting**

The following is to take place at least two weeks before the meeting:

- Young person supported by school to complete 'My Transition Plan'
- School to invite relevant people in consultation with the young person/their family, including representatives from; the Council's Transition Team, health services (CAMHS, Therapists), school nurse (for those on CHC)
- School staff to ensure that the young person/their family are fully prepared in advance of the meeting
- School staff to ensure that all required information (relating to their experience and aspirations plus any previous education/health/social care reviews) is gathered and distributed to those invited to the meeting

**Annual Transition Review Meetings:**

| Year 9 (age 13-14) | Year 10 (age 14-15) | Year 11* (age 15-16) | Year 12 (age 16-17) | Year 13 (age 17-18) | Year 14 (age 18-19) |
|---|---|---|---|---|---|

**Consider what assessments and services are required to support adulthood:**

- Support with budgets and resources
- Access to leisure and social activities
- Work experience, training, supported employment
- Housing, supported housing, housing advice, adaptations
- Transport, including independent travel training (how will the young person physically get to places?)
- Assistance with personal care and independent living skills
- Short breaks
- Referral to welfare rights (at age 16 for support claiming own benefits)

*At this point (year 11) there needs to be a full assessment of social care needs to determine the appropriate package of support into adulthood – work may need to take place with commissioners to ensure appropriate services are available

**At the Transition Review Meeting:**

School to facilitate/chair the meeting and ensure completion and sharing of the review

'My Transition Plan' to be reviewed and updated as necessary by Transition Social Worker

**A named worker for transition to be agreed at the meeting; this person will act as the contact point for the young person and their family for the forthcoming year**

# Appendix 3: My Transition Plan

Halton My Transition Plan FINAL.docx

# Appendix 4: HBC ALD Nursing Team Eligibility Criteria

**The formal criteria for a diagnosis of 'learning disability' are: significant impairments of both intellectual and adaptive/social functioning, which have been acquired before adulthood (Valuing People, 2001; British Psychological Society, 2001; American Psychiatric Association, 1994; American Association on Mental Retardation, 1992; World Health Organisation, 1992).**

| **Indicators that the person *may* have a learning disability** | **Indicators that the person *may not* have a learning disability** |
|---|---|
| • Evidence of delays in reaching developmental milestones e.g. walking/talking.<br>• Previous statements indicating cognitive functioning in the learning disability range (e.g. IQ scores less than 70). ***The onus is on the referrer to locate and send copies of these*.**<br>• Attended special school or attended mainstream school with extra support.<br>• Unable to read, write or tell time, or this is limited.<br>• Requires significant support from others for day to day living e.g. home living, use of community facilities, budgeting, personal care.<br>• Unable to work in paid employment without support.<br>• Previously known to learning disability services.<br>• Educational reports refer to 'severe learning difficulties' (often equivalent to mild or moderate learning disability). | • Reached developmental milestones at appropriate time.<br>• No statement, evidence of qualifications e.g. GCSES.<br>• Has a driving licence.<br>• Attended mainstream school and did not struggle.<br>• Able to read/write well and can tell time using analogue clock.<br>• Able to function independently in most areas of day to day living.<br>• Evidence of working successfully in paid employment without support.<br>• Indicators evident, but these can be explained by other factors e.g. mental health difficulties, physical disabilities, drug/alcohol problems, head injury as an adult.<br>• Educational reports refer to 'mild learning difficulty' (less severe than learning disability). |

# Appendix 5: Eligibility Guidance for 5BP Learning Disability Services

NHS
5 Boroughs Partnership
NHS Foundation Trust
in Halton

## Transition Guidance
## Eligibility guidance for learning disability services

**For interventions offered by professions in the team, referrals can be made directly. The following information is aimed as a guide when considering whether the LD team is the correct service for someone. It is aimed to support services to consider who could potentially benefit from LD services however; formal eligibility screening will be conducted by the team if the person is not already known to the service. Eligibility screening will also look at whether the person would be able to access mainstream services and what the need is for input from the team.**

Definition of a Learning Disability (Health criteria – World Health Organisation, 1992)

There are three factors for determining the criteria: all *three* must be met in order for a person to be considered to have a learning disability:

1. *Significant impairment of intellectual functioning* - A significantly reduced ability to understand new or complex information, or to learn new skills, defined as an IQ of less than 70.
2. *Significant impairment of adaptive/social functioning* - A reduced ability to cope independently.
3. *Age of onset before adulthood* – Significant impairments of the above two criteria must have been acquired before 18 years of age.

| **Factors which MAY indicate that someone does NOT have a learning disability** | **Factors which MAY indicate someone DOES have a learning disability** |
|---|---|
| • Successfully attended mainstream education without support<br>• Gained qualifications (GCSE's)<br>• Recorded IQ above 70<br>• No delays to development of speech or other milestones<br>• Typical development until an accident or head injury post 18 years<br>• Able to manage on work placements with minimal support, particularly those that involve complex skills e.g. use of tills<br>• Able to access the community without support<br>• Able to budget finances to an age appropriate level<br>• Has driving licence or would be capable of completing theory and practical | • Recorded IQ less than 70 before 18 years (N.B there must also be evidence of problems with independent living)<br>• Record of delayed development/ difficulties with social functioning and daily living before 18 years<br>• Requires significant assistance to carry out tasks of daily living (eating/drinking, keeping self- clean, warm and clothed)<br>• Requires significant assistance social/community adaptation (e.g. social problem solving/reasoning) NB need for assistance may be subtle<br>• Evidence of difficulties in a number of areas of function, not explainable by another 'label' e.g. mental health, acquired brain injury, anxiety<br>• Attended special school, or mainstream school with **high levels** of support<br>• Unable to read and write<br>• Unable to tell the time or locate events in time accurately |

This table should be used as guidance; it is not exhaustive and other factors may be considered when determining eligibility for learning disability services.

Further support can be sought from Halton Community Learning Disability Team.
Address: Bridges Learning Centre, Crow Wood Lane, Widnes, WA8 3LZ. Tel: 0151 495 5302

# Appendix 6: National Framework for Children and Young People's Continuing Care and Adult NHS Continuing Healthcare

The "National Framework for Children and Young People's Continuing Care" published by the Department of Health in 2016 sets out a process for assessment and agreement of eligibility for Continuing Care.

Continuing Care for children and young people is needed where a child or young person (under 18) has complex needs which cannot be met from the health services routinely commissioned by NHS Halton Clinical Commissioning Group (HCCG) or NHS England. It has been defined in recent regulations as:

> '*a package of care which is arranged and funded by a relevant body for a person aged 17 or under to meet needs which have arisen as a result of disability, accident or illness*.'

The care needed may be resource intensive, and long-term, with a significant element of nursing care. It may be provided in a number of settings and may involve more than one provider.

Children's Continuing Care differs from adult NHS Continuing Healthcare which applies to anyone from 18 years of age who needs to be considered for a health funded package of care that will be arranged and funded solely by the NHS. Children and Young people's Continuing Care should be part of a wider package of care, agreed and delivered in collaboration between health, education and social care. The arrangements for children with special educational needs or disability (SEND) in particular provide a framework for outcomes-focused joint assessments involving different partners across education, health and care, and many children and young people who need Continuing Care will have special educational needs or disability. A decision on whether or not Continuing Care is needed must be informed by a clinical understanding of a child or young person's condition and an understanding of the way in which their needs affect their lives and those of their family. The emphasis should be on understanding the outcomes which would make the biggest difference to the child or young person and their family, and how health services can support delivery of those aims.

HCCG is responsible for leading the process of identifying the Continuing Care needs of a child or young person in Halton; Continuing Care needs should be identified, and the package of care agreed, as part of a holistic assessment of the child or young person's needs. The subsequent decision about provision of care is made in collaboration with the child or young person's health professionals, social care professionals, education professionals and the child/young person and their family.

***Transition***

As far as possible, the aim of providing continuing care should be to support the move from dependence to independence, with children and young people being enabled to manage their condition themselves with a full understanding of the implications of their condition.

Every child or young person with a package of Continuing Care who is approaching adulthood should have an Education, Health and Care (EHC) Plan which reflects an active transition process to adult or universal services or to a more appropriate specialised or NHS Continuing Care pathway.

Once a young person reaches the age of 18, they are no longer eligible for Continuing Care for children, but may be eligible for NHS Continuing Healthcare, which is subject to legislation and specific guidance. It is important that young people and their families are helped to understand this and its implications right from the start of transition planning.

The Children's Complex Care Nurse should attend Halton's transition planning meeting, and share information regarding Children with Continuing Care needs with Adults Services, with parental consent.

It is best practice that future entitlement to adult NHS Continuing Healthcare should be clarified as early as possible in the transition planning process, especially if the young person's needs are likely to remain at a similar level until adulthood.

- At **14** years of age, the young person will be brought to the attention of adult Continuing Care services.
- At **16** years of age, children receiving Continuing Care will be referred to adult services and all screening for NHS Continuing Healthcare will be undertaken using the adult screening tool.
- At **17** years of age, an agreement in principle for adult NHS Continuing Healthcare should have been made so that, wherever applicable, effective packages of care can be commissioned in time for the individual's 18th birthday (or later, if it is agreed that it is more appropriate for responsibility to be transferred then).
- At **18** years of age, full transition to adult NHS Continuing Healthcare or to universal and specialist services should have been made, except in instances where this is not appropriate.

If a young person who receives children's Continuing Care has been determined NHS Halton CCG as not being eligible for a package of adult NHS Continuing Healthcare in respect of when they reach the age of 18, they should be advised of their non-eligibility and of their right to request an independent review, on the same basis as NHS Continuing Healthcare eligibility decisions regarding adults. HCCG should continue to participate in the transition process, in order to ensure an appropriate transfer of responsibilities, including consideration of whether they should be commissioning, funding or providing services towards a joint package of care (for example, to deliver an EHC Plan).

Children and young people eligible for Continuing Care who have a personal health budget may not be eligible for NHS Continuing Healthcare when they reach 18. Although these young people will cease to have a "right to have" a personal health budget, HCCGs can continue to offer services via a personal health budget on a discretionary basis, to support the transition to adult services. Transition should be planned and agreed with the young person and their family or carers in good time to avoid any disruption or delay to implementing a package of care.

Even if a young person is not entitled to adult NHS Continuing Healthcare, they may have certain health needs that are the responsibility of the NHS. In such circumstances, HCCGs should continue to play a full role in transition planning for the young person, and should ensure that appropriate arrangements are in place for services that meet these needs to be commissioned or provided. The focus should always be on the individual's desired outcomes and the support needed to achieve these.

A key aim is to ensure that a consistent package of support is provided during the years before and after the transition to adulthood. The nature of the package may change because the young person's needs or circumstances change. However, it should not change simply because of the move from children's to adult services or because of a change in the organisation with commissioning or funding responsibilities. Where change is necessary, it should be carried out in a planned manner, in full consultation with the young person. No services or funding should be unilaterally withdrawn unless a full joint health and social care assessment has been carried out and alternative funding arrangements have been put in place.

The legal responsibilities for child and adult services overlap in certain circumstances. In developing individual transition plans, partners should be clear where such overlaps occur, and the plans should clearly set out who will take responsibility and why.

It should be noted that regulations state that, in certain circumstances, when a young person in receipt of children's Continuing Care reaches adulthood, the care arrangements should be treated as having been made under the adult Continuing Care provisions. Guidance on the regulations sets out that young people approaching their 18th birthday will require a reassessment of their

health and social care needs as part of their transition planning and that, wherever possible, these young people should continue to receive their healthcare on an unchanged basis until they have been reassessed.

The Children's Complex Care Nurse, the LA Lead and the Complex Needs Panel should monitor and actively participate in the reviews of those recipients of Continuing Care who are approaching adulthood.

The regulations and guidance for NHS Continuing Healthcare can be found at: https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care

# Glossary

| Term | Definition |
|---|---|
| **CAMHS** | Child and Adolescent Mental Health Services |
| **CCG** | Clinical Commissioning Group |
| **CHC** | Continuing Healthcare |
| **EHC Plan** | Education, Health & Care Plan |
| **Local Offer** | Published by all local authorities to detail in one place the services available in the area for children and young people up to age 25 with SEND. |
| **NICE** | National Institute for Health and Care Excellence |
| **Outcomes** | Refers to what someone would like to achieve or happen (e.g. being able to go out and about); individuals have the right to say which outcomes are important to them and be supported to achieve them. |
| **Person centred reviews** | Puts the person at the heart of the review and explores what is happening from the person's perspective and from other people's perspectives. |
| **Personal Budget** | Money that is allocated by local authorities from adult social to pay for assessed care and support needs. The authority can arrange services or the money can be taken as a direct payment and the individual can arrange their own services. |
| **Personal Health Budget** | As above but relates to health care/services and the money is provided by the NHS. |
| **SCIE** | Social Care Institute for Excellence |
| **SEN** | Special Educational Needs |
| **SEN Statement** | Being replaced by EHC Plans |
| **SEND** | Special Educational Needs and Disability |
| **Strengths based assessment** | An assessment focusing on a person's strengths and what they are able to do, not what they can't do. |