



Hull Childhood to Adulthood Transition Protocol

Approved version - revised Dec 2018

1. **Introduction**
   1. This protocol aims to help Hull Special Educational Need and/or Disability Services (SEND) and other services within the Children, Young People and Families Directorate, work together with families and young people, and adult social services, to help achieve the best possible outcomes for young people as they approach, and live through, their transition from childhood to adulthood[[1]](#footnote-1)
   2. The protocol aims to bring clarity to the purpose and roles of the diverse range of organisations and agencies that need to work together in the interest of young people and their families[[2]](#footnote-2)
   3. This protocol has been co-produced with contributions from parents, and comments from young people[[3]](#footnote-3)
   4. All young people and their representatives should be able to access advocacy which is appropriate to their needs[[4]](#footnote-4)
2. **Scope**
   1. This Transition Protocol applies to all young people from age 13 upwards who are formally recognised as having Special Educational Needs, whether or not they have an Education, Health and Care Plan (EHCP). Note, however, that where an EHCP exists, procedures are more detailed due to the requirements of the Code of Practice and the number of agencies likely to be involved. All national guidelines have been followed in developing this protocol[[5]](#footnote-5)
3. **The role and commitments of different agencies for young people with Education, Health and Care Plans (EHCPs)** 
   1. All agencies involved will put plans in place so that there is a ‘Transition’s Champion’ in the organisation. This champion will be available to provide information and advice to young people, parents and staff about the transitions processes and pathways. They will also point from which system issues and concerns about transitions can be resolved through either the Operational Group or the Strategic Transitions Group[[6]](#footnote-6)
   2. The Transitions Champion role will be to:

* Support the dissemination and growth of best practice for everyone involved in transition from children’s to adult services in the adults workforce
* To support and advise team/service area colleagues on transition matters
  + 1. Specifically the Transition Champion will:
* Act as a resource and a point of contact for colleagues who require support and guidance on transition issues
* Cascade/disseminate transition information received to colleagues within their teams
* Support staff in identifying those in need of protection and assist in their understanding of the action they need to take
* Maintain up to date knowledge of transition issues including the referral processes to be followed internally within the organisation and when raising concerns with partner agencies
* Meet regularly with other transition champions in children and young people’s service area and with partner agencies
* Encourage colleagues to recognise and be aware of trends and themes within their area so these can be fed back to the Transitions Strategic Group
* Make sure transition practice complies with the legislation, policies and guidance of their organisation

1. **The Named Worker in the transition planning process for individual young people and their families**
   1. All young people who require integrated support from more than one practitioner should experience a seamless[[7]](#footnote-7) and effective service in which one practitioner takes the lead to ensure that services are coordinated, coherent and achieving intended outcomes
   2. The Named Worker should act as the single point of contact for all professionals providing services to a young person including coordinating the actions agreed at Transition Planning meetings and Annual Reviews. Named Workers are responsible for their own service’s input; they are not responsible for the actions of other practitioners or services
   3. The Named Worker will be expected to co- ordinate the provision of services to the young person (and to the family, where this will support the young person)
   4. Young people (and their family where relevant) who will be consulted on who their Named Worker is. Where possible, the worker should be known to the young person and their family, hence the importance of introduction meetings. Named Workers and their managers will have to be mindful of size of caseloads when taking on this role. Bearing in mind that it is important that the young person and their family are consulted over the choice of the Named worker; this consultation will be undertaken by the Special Educational Needs Coordinator (SENCO)[[8]](#footnote-8)
   5. In the majority of cases where a young person has an Education, Health and Care Plan for special educational needs, a Connexions Senior Participation advisor will take the Named Worker role from year 9 onwards. However, this is the way the Named Worker role changes:

* Pre-transition, where an Initial or Core Assessment is being carried out under the framework for the Assessment of Children in Need and their Families (2000), the responsible Social Worker shall be the Named worker during the assessment period
* Where a young person is subject to a Child Protection Plan, or where the young person is Looked After or where adoption is the plan for the young person; the named Social Worker is responsible for acting as the Named Worker
* Where the young person is a care leaver and is an “eligible child” under the Children (Leaving Care) Act 2000, they will have a named Social Worker who will assume the role of Personal Adviser and will, therefore, be the Named Worker.
* Where the young person has a learning disability or mental health needs and a Care Programme Approach is being followed; the Care Coordinator will be the Named Worker from Humber Foundation Trust
* Where young people are subject to community orders or sentences, the Youth Offending Team will allocate a Supervising Officer who would normally be expected be the Named Worker

1. **Schools and EHCPs**
   1. The SEND Coordinator (SENDCO) , or designated person is responsible for:
      1. Ensuring that young people and their parents are fully informed about the Education, Health and Care Plan (EHCP) process at each stage
      2. Organising Annual Reviews of EHCPs
      3. Ensuring that the Annual Review report is drawn up and sent to the Special Educational Needs and Disability (SEND) Team and all involved in the process, using paperwork supplied by the SEND team
      4. Inviting all relevant partners to Annual Review meetings at least 2 weeks before the term begins (the meetings should take place at an appropriate time to ensure attendance by all relevant parties).
      5. The SEND Code of Practice states that the Local Authority must be invited to all meetings
      6. The SEND Team must be invited to all Annual Reviews, as the Local Authority’s representative
   2. Year 9
      1. The SENCO (or designated person) invites all relevant agencies to the Annual Review meeting. SENDCOs should check with the young person / family who they would like to invite. As a minimum, schools must invite:

* The young person
* The young person’s parent / carer
* The relevant teacher
* The Local Authority SEND Team
* Connexions Senior Participation Advisor
* Health Services where involved
* Local Authority Social Care where involved
* Other Educational services as appropriate e.g. Integrated Physical and Sensory Service (IPASS)
  + 1. In addition to a review of progress and support the review should begin to focus on preparation for adulthood and other transition issues. This process is begun by the SENCO (or designated person) referring the young person to the Transitions Operational Management Group (TOMAG)[[9]](#footnote-9)
    2. The school will send a copy of the documentation to all who were invited, the chair of TOMAG[[10]](#footnote-10), and the Local Authority SEND Team at Children, Family and Adult Services, Brunswick House, Strand Close, Hull HU2 9DB within 2 weeks of the review meeting
  1. Year 10
     1. The preferred post 16 option / provision should be identified at this stage if possible and noted on the Annual Review report. This is especially important if a place in a maintained school 6th form is likely to be required to allow time for consultation, allocation and the amendment of Education, Health and Care Plans by 31st March of Year 11
  2. Year 11
     1. It is important that the Annual Review is used to inform applications to post

16 provision and other processes such as the SEN transport application. For this reason it is desirable that a year 11 review, dealing with transition issues takes place early in the autumn term. Alternatively, the year 10 review, if it has taken place in the summer term, may be the key planning forum for post 16 options as a year 11 summer term review will be too late

* + 1. As per Year 10, but in addition:
* Connexions Senior Participation Adviser to provide help with applications to college / training / employment as appropriate
* Named Worker to explain to family that social worker involvement is necessary if a person-centred assessment will be required
* Adult Social Care should attend as part of the handover process where this applies. Note that if Adult Social Care have not have been involved in the earlier reviews it is essential that they are given sufficient notice (a minimum of 6 weeks), otherwise they cannot guarantee attendance. A request for attendance should be made via the TOMAG chair
  1. Year 12 and beyond
     1. As per Year 9, the planning for transition to Adult Social Care (where appropriate) should begin when the young person reaches 14. If this process has not already begun, the following needs to happen with some urgency:
* Meetings with the young person, their family, carer or representative, Children and Young People’s (CYP) worker and a worker from Adult Social Care
* Completion of referral forms to Transitions Operational Management Group (TOMG) by CYP representative[[11]](#footnote-11)
* A person-centred assessment completed where appropriate by a social worker or social work support officer
* A focus on EHCP outcomes linked to the transition to adulthood for the young person
* EHCP will cease if the young person does not attend an education provision. The EHCP could also cease if the Local Authority deem that the young person no longer needs it I.e. following a review the education outcomes detailed in the plan have been achieved and no longer need additional education support
* Case responsibility will to transfer to Adult Social Care when the Young Person is 18, but there is no guarantee that adult social care will continue established packages of care and support unless the notification requirements of this protocol have been adhered to
  + 1. Where young people are educated otherwise than at a school, college or training provider the procedures are generally the same as described above, however it is the Local Authority that has responsibility for organising and chairing the reviews. The Local Authority also has the responsibility for providing the necessary support to young people placed at specialist out of area colleges, for example during the school holidays and when they return to Hull on completion of the course

1. **Connexions** 
   1. Connexions offers an impartial client-centred careers information and guidance service. The staff are trained to offer confidential advice and practical help relating to a wide range of issues including Special Educational Needs and/or disabilities (SEND)
   2. The Connexions service will:

* Allocate a named Connexions Senior Participation Adviser to work with each young person from age 13 upwards (including those who are home educated, or off-school role) and provide advice and guidance on post 16 options 9and who will normally act as the named worker for most young people).
* Carry out a pre-review or post review discussion with the young person at year 9 and attend each review from then onwards
* Draw up a written report summarising their discussions with the young person, what the young person’s future aspirations are and what action needs to take place in order fulfil those aspirations.

1. **Hull City Council Special Educational Needs and Disabilities (SEND) Team** 
   1. The Team’s core responsibility is to issue and maintain Education Health and Care Plans for young people aged 0-25 who have been assessed as requiring it, following statutory guidance laid down in the SEND Code of Practice issued 2015
   2. Hull City Council Special Educational Needs and Disabilities (SEND) Team will:

* Process the Annual Review, consider any requests for amendments to the Education, Health and Care Plan and confirm their decision to the parent / carer / young person and school
* Monitor whether or not Annual Reviews have been held and provide reports on completion rates for the Annual Performance Assessment

1. **Local Authority Children and Families Disability Team, and Children’s Social Work teams (ILAC and Localities)** 
   1. The disability team offers support to children and families who are significantly affected by disability. Services are targeted in a way that promotes family life, individual needs and the rights of the child. The team works collaboratively with key partner agencies in health and education to reduce disadvantage and promote care and support. The team accesses a range of provision from both local authority and the private sector, which enables them to provide a flexible response to individual family needs
   2. The Local Authority Children and Families Disability Team will undertake the following:

* If the child / young person has an allocated Social Worker from the Children and Families Disability Team, when invited, they will provide a report for, and attend, all EHCP reviews
* If a young person is receiving commissioned services, and it is likely that statutory services will be needed for the young person post 18, the child’s social worker will inform the Transitions Operational Management Group (TOMG) at age 14, so adult social care commissioner can begin planning suitable accommodation and care and support arrangements on an individual basis.
* The referral to adult services for the age 14 review must be made at least 6 weeks prior to that review
* If a child or young person is ‘Looked After’ their social worker will (if appropriate) maintain links with the child/young person’s family
* Make sure that Looked After young people over the age of 14 have a pathway plan which has been established via an assessment
* Looked After children/ young people will be given extra support to think about their options regarding their living arrangements, continuing their education and employment as they make their transition into adulthood
* Support the training made available by Adult services and to embed new sustainable practices in the Children’s social work teams
* Monitor and respond to training issues as they arise, and maintain commitment to reducing the ‘cliff edge’ experience in relation to service provision by young people and families as they approach adulthood[[12]](#footnote-12)
  1. The mechanism for informing adult social care commissioners is via the TOMG. The case will be presented to the TOMG in a manner prescribed by the Chair of that group, and the suggestions and recommendations of that group will be acted upon by the Children’s social worker
  2. If a young person at age 14 is receiving a care and support package that includes health funded provision, a referral must be made to the Complex Care Group AND the TOMG
  3. If a young person is looked after in one of the Local Authority’s children’s homes or an externally commissioned children’s home placement, and appropriate move-on provision has not been identified by the young person’s 16th birthday, an immediate Children’s transition meeting should be held to make decisions about whether or not the young person is able to remain in the placement and agree timescales for suitable move-on. If adult social services funding will be needed at age 18, immediate referral to the Adults Panel must be made (i.e. at age 16), so that appropriate transition planning can take place. **NB: this should be done at 14 if at all possible**
  4. In summary: It is important to note that for every young person who will require adult social care support at age 18, in any form, the following notifications apply:
* The Health Complex Care Panel age 14 if there are likely to be health care needs
* TOMG at age 14, especially if their social care needs are ‘complex’[[13]](#footnote-13)
  1. Failure to follow these notifications at the correct time will mean funding commitments made by Children’s services from age 18 may not be maintained. Decisions on this issue will be made by the Director of Adult Social services on a case-by-case basis
  2. Where a young person has been in receipt of direct payments funded by Children’s Social Care, the payments will be considered as part of the young person’s transitions plan. This transitions plan will include the way in which payments via a direct payment may or may not change

1. **The Leaving Care Team**

* The leaving care team will follow the statutory guidance in appendix 9.
* Young people who are subject leaving care arrangements will, in the large part, have an EHCP. Where this is the case the processes early in this protocol (sections 5, 6 and 7) will apply.
* Where for some reason, perhaps due to an out of area placement, or because there is no SEND involvement, a young person may not be able to following the pathway described in sections 5, 6 and 7. In this case, as soon as the leaving care team becomes aware of the likelihood of an ongoing service from adult social care, a referral will be made, by the relevant leaving care worker, to the adult’s transitions panel.
* The adult’s panel and the leaving care team will jointly decide (following a statutory assessment of need by the adults social care worker), to develop a bespoke care and support with young person and the Leaving Care Team.
* The formal transitions process will then begin from this moment with collaborative working across the two departments as required, until age 25.

1. **Special Educational Needs Information, Advice and Support Service (SENDIASS) provided by KIDS**
   1. SENDIASS is a free impartial and confidential service. They can offer support and advice to parents/carers in Hull who have a child aged 0-25 years with a special educational need and/or disability. Support can also be provided directly to young people themselves if required
   2. SENDIASS will help to explain to young people and families engaged in transitions:

* The SEND process including assessment and provision
* Parents/carers and young people’s roles and rights
* Professional reports
* Educational options and choices
* The roles of other agencies
* Personal budgets and the local offer
* Support to help parents/carers and young people make appropriate and informed choices
  1. Support can be provided via telephone advice, home visits, meetings in schools and with other agencies. Help is also available with letters, referrals to other agencies and support when things go wrong such as appeals and complaints
  2. KIDS also provide a specialist advocacy service for young people up to 19 years old who are living in residential setting or care settings including foster placements. KIDS also provide a young person SENDIASS practitioner for young people up to the age of 25
  3. Contact details for these services is:
* KIDS, 182 Chanterlands Avenue, HULL HU5 4DJ tel: 01482 467540 email: [enquiries.yorkshire@kids.org.uk](mailto:enquiries.yorkshire@kids.org.uk)

1. **Hull Youth Justice Service**
   1. Youth Offending Teams (YOTs) are responsible for the supervision of children and young people aged below 18 years who are sentenced by a court, in line with the Youth Justice Board’s (YJB0 National Standards for Youth Justice Services and YJB Case Management Guidance
   2. YOTs are required to follow the minimum standards identified in this protocol and adopt a local system to manage the transition of young people from youth justice service into the adult services using this guidance
   3. The YOT will:

* Ensure that all young people have access to education, training or employment
* Refer to relevant services, for example, social care to secure appropriate resources/ interventions
* Attend meetings to share information about risks and needs and plan for transitions
* Consult and work with the young person and their family/carer to inform them of the transition process to adult services and keep them informed at each stage
* Make sure that young people have a transition plan as soon as the need is identified and no later than when the young person reaches 17 years and 6 months
* Access to resources to enable them to work with parents of young people with SEN to help manage their behaviour
* Undertake specialist training in the use of visual tool to work with young people with SEN
* Positively interact with young people to increase the completion of requirements placed upon them by the courts
* Make sure that Practitioners acting as Appropriate Adult in police interviews will use appropriate language at all times relevant to needs and development
* Make sure that Practitioners will adhere to the SEND Code of Practice through the use of assessment and intervention tools which enable the participation of any young people detained in custody
* Make sure that young people sentenced to custody or remand are assessed to identify any needs and that this information is shared with the custodial case manager
* Make sure that when transferring cases to the National Probation Service or the Community Rehabilitation Company that all relevant information about their needs is shared
* Make sure that where young people detained in custody have a EHC plan, this is shared with the custodial establishment and forms part of the young person’s sentence plan

1. **Adult Social Care** 
   1. Adult Social Care is a term that covers the wide range of activities relating to people aged 18 and over. Hull City Council’s Adult Social Care services department has separated its specialist learning disability and mental health social work teams, passing them to Humber Foundation Trust (HFT) through a Section 75 agreement with the Clinical Commissioning Group (CCG)[[14]](#footnote-14). Therefore, this section of the protocol only deals with non-specialist ‘locality team’ social work. For specialist learning disability services please see the section below on HFT
   2. Adult social care has recently introduced a wide ranging new operating model, which focuses on:

* Early intervention and prevention particularly supporting the information and advice offer to citizens[[15]](#footnote-15)
* Developing a more efficient goals and actions-based Active Recovery tier
* Delivering strengths-based social work
* Developing the legal literacy of its workforce
  + 1. Adult social care has also introduced two new innovations
* A new Brokerage Service
* A new Dynamic Purchasing System (DPS)
  + 1. The brokerage service aims to undertake two tasks:

1. Complete care and support plans with people who have capacity, or non-complex cases
2. Use the DPS to find a ‘partner provider’ who can work with the family and young person, and social workers as necessary, to develop a transitions plan, which takes into account any 247 grids completed.
   * 1. The brokerage service needs to be accessed during the 16th year once, the eligibility determination has been made and transition goals identified
     2. The DPS is a tool that the Brokerage service uses to identify partner providers. A pen picture is used to share details of an individual’s needs and providers then express and interest. A number of providers may then be engaged with (depending upon the level of interest), and more detailed plans developed with the social care workers and family – young person.
     3. The DPS system works well when it is accessed early (age 16) for transitions cases. The DPS can be used any number of times until a suitable provider is finalised.
   1. In this context adult social care will:

* Manage a 2-weekly Transitions Panel where all requests for an adult’s social worker will be considered and timely decisions about allocations made. Presentations to this panel are expected for any young person 6 months prior to their 14th birthday, and no later than the young person’s 16th birthday[[16]](#footnote-16)
* On receipt of a referral for a case at age 14, TOMAG will facilitate a joint Adult and Children’s Transitions planning / review meeting with the family and young person. It will do this in cooperation with the Transitions panel. This transitions planning meeting will take place during the young person’s 14th year
* At the joint age 14 planning meeting with the young person, family carers, children’s social worker and adult social worker or support officer, the family and young person will be introduced to the Mental Capacity Act 2005 and the Care Act 2014, and their implications for young people and families.
* Specifically, the emphasis of the Care Act on independence, wellbeing and the three-stage eligibility assessment for adult social services will be discussed, as well as the best Interest decision making process for people who lack capacity to take specific decisions. The family and young person will be introduced to a care and support planning tool which supports, through a process of gradual change, the growth of independence and wellbeing[[17]](#footnote-17). Full training and support will be provided to all staff involved.
* If a young person has health and social care needs at age 14, a referral must also be made by the Children’s social worker to the Complex Health Care Group (which oversees the coordination of health and social care provision for young people with complex health and social care needs)
* Chair the strategic transitions steering group[[18]](#footnote-18)
* Support compilation and maintenance of the transitions list for consideration by TOMG
* Make sure that the work of TOMG (which oversees the progress of all Transitions cases) is joined up with the Adults Panel (which allocates ‘Transitions cases’ to social workers in Adult Social Services), and links into the Health Complex Case Panel.
* Offer legal literacy training, and training on this protocol, to Children and Young People’s social workers, young people and families so that all social work staff across both directorates are better able to meet legal obligations[[19]](#footnote-19)
* Promote use of and access to Connect to Support and the Local Offer
* Promote use of and access to the Social Prescribing service
* Promote use of the Carers Information Support Service (CISS)
* Enable access to independent Care Act or ‘process’ advocacy (ICAA) and or specialist Independent Mental Capacity Advocacy (IMCA) or Independent Mental Health Advocacy (IMHA) as suitable[[20]](#footnote-20)
* Make sure that, for a young person who is referred to TOMG at age 14, that a statutory assessment is completed within 6 months of the young person being 16
* Therefore, in summary, the output of the joint meeting at age 14 will be[[21]](#footnote-21):
  + An outline of the legislative changes as a young person ages
  + Supported access to information about transitions on Connect to Support
  + Information about the Social Prescribing Service, the Carers Information Support Service, and the Independent Care Act Advocacy provision
  + Training and support to use the 247 grid to plan for greater independence and wellbeing in adulthood
  + An agreed date for an age 16 review, at which the formal social care assessment will be undertaken and formal allocation of an adult’s social worker
* In summary, at the age 16:
  + The Adults Panel will:
    - Make sure a social care worker completes a statutory assessment within 6 months; this includes any referrals to HTFT (see below).
    - Update the tracker document with details regarding the assessment and resulting eligibility determination
    - Make sure that a referral is made for any eligible young person to brokerage and close working is maintained between social worker and brokerage
    - Make sure that the Dynamic Purchasing System (DPS) is used during the 16th year once the statutory assessment demonstrates eligibility
    - Make sure that 247 grids are used by the identified provider (obtained through the DPS) in developing the care and support plan
    - Oversee the successful transition at age 18.
* The Brokerage service will:
  + Prioritise transitions cases sent through to them for young people in transition from Children’s services via the Adults Panel.
  + Work with the adults and children’s social workers to facilitate an early use of the DPS at age 16.
  + Use any available 247 grids to procure a partners provider by use of the DPS.

1. **Humber Teaching Foundation Trust (HTFT) Adult Community Learning Disability Team** 
   1. HFT provides a very broad range of community services (including therapies), community and inpatient mental health services, learning disability services, healthy lifestyle support and addictions services to people living in Hull and the East Riding of Yorkshire.
   2. HFT provides specialist services for children including physiotherapy, speech and language therapy and support for children and young people and their families who are experiencing emotional or mental health difficulties[[22]](#footnote-22).
   3. HFT also offers specialist services, such as forensic support and support for offenders with their health[[23]](#footnote-23)
   4. HFT will:

* Respect the young person as an individual who is able with support to make choices about the care and support they need
* Support the young person and those who care for them to get the information, advice they need, and where appropriate any necessary advocacy
* Assess for eligible needs in year 11 and where appropriate co-produce person centred care and support plans with realistic outcomes.
* Provide services and support where appropriate or signpost them to the right kind of help
* Manage the young person’s and their representatives’ expectations of what help they may receive from adult services
* Have a champion in all areas of adult social care which deal with transition (see appendix 11 for an outline of how the community learning disability team works with Hull City Council social work teams in an integrated way)
* Learn from what works well when supporting a young person through Transition
* Attend the most appropriate meetings to support their transition from children’s to adult services.
* Consider all referrals made by the adults panel to them within 2 weeks and provide written feedback to the panel chair on the outcome
* Complete any necessary statutory assessments within 6 months of an accepted RAM referral
* Provide an appeals process should the decision on acceptance be disputed
* Accept referrals from the Adults Panel or TOMG for young people age 14 and over, providing written responses to the Adults Panel or TOMG to all referrals made
* Accept referrals from the Health Complex Care Group for young people age 14 and over, providing written responses to the Health Complex Care Group to all referrals made
* Participate on both the TOMAG and Health Complex Care Group as a core member, providing both adults and children’s representation in each case.

1. **The Continuing Healthcare Team (CHC)** 
   1. Continuing Health Care funding is provided to people with a long term, primary health need. It is not available to people who have a short term, acute health problem or to people whose needs relate mainly to social care
   2. As healthcare is free at the point of delivery, eligibility means that people able to access this funding will not be required to make a contribution to the cost of their care and support
   3. If someone is in the closing stages of life with a rapidly deteriorating condition, a clinician can complete a fast track referral which means that funding can be given immediately with no further assessment taking place. If this is not the case, then a multidisciplinary team (MDT) of people from across health and social care will meet with the person and their family to carry out an assessment
   4. The Continuing Healthcare Team will[[24]](#footnote-24):

* Complete an assessment after any treatment or therapy for the condition has been completed. The assessment will be recorded on the decision support tool (DST)
* A primary health need will be established by looking at someone’s needs across 12 domains – behaviour, cognition, psychological and emotional needs, communication, mobility, nutrition, continence, skin, breathing, medication, altered states of consciousness and other significant needs. If someone has a severe level of need in two or more of these domains, then that is enough to establish eligibility. If they do not, then the MDT will look at the nature of someone’s needs, the intensity, complexity and unpredictability of these needs
* The MDT will make a recommendation to a panel of people from Continuing Health Care, the CCG and the local authority. The panel will look at how the assessment was carried out, whether the level of need has been accurately identified within the domain findings and whether the recommendation reflects the level of need identified. If eligibility is not established and the person or their representative disagrees with this, they can lodge an appeal within 6 months and the evidence will be reconsidered. If eligibility is established, reviews will be carried out after three months and then annually to make sure the person’s needs have not changed. If someone does not have a primary health need, but still has health related needs, other forms of NHS support or funding may be available

1. **Integrated Commissioning**
   1. The Integrated (Hull Clinical Commissioning Group (CCG) and Hull City Council (HCC)) Commissioning Service is responsible for market shaping and the commissioning of care and support providers. There is recognition of the importance of communicating to the market the potential requirement for specialist services for children in transition to adult services
   2. The Integrated Commissioning Service commits to using the transitions list to inform providers of the likely need for care and support services in the future. This will require integrated working with public health, CCG and wider health and social care colleagues to understand the demographic requirements within the City. This medium to long term planning will enable sufficient, high quality providers to enter the market in the City

**Appendix 1**

**Background**

In 2015-16 a number of children, family carers and Adult Service professionals held a series of workshops to look at what was working well, and what needed to improve in regard to the transition process from childhood to adulthood. The key themes that came out of this work were:

* A need to improve the understanding of the transitions process between Children’s Services and Adult Services in the Council
* Needed improvement about when the Adult Services statutory assessment needs to start
* Greater clarity of the roles and responsibilities of the different professionals involved, e.g. Adults and Children’s social workers, School SEN teachers, Learning Disability teams, Leaving Care teams and Continuing Heath Care and Primary Health Care services
* Better communication between all professionals, young adults and their parents/carers
* Systematic training needed on the transition system and processes for everyone
* A need was identified for Transition Champions within Adult Services
* There was an identified priority to support families and young people more through the transition period even if formal services were not available.

In 2016 two groups were established; a Strategic Transitions Group, tasked by the SEND Board to review the transition system and processes. Central to the work of this group has been listening to and learning from the voice of young people and families[[25]](#footnote-25)

The second group was an Operational Transitions Group, which has the role of collating a comprehensive list of young people who are, or may be, transitioning into adult services over the next few years, and subsequently coordinating a suitable sector-wide response. (Terms of reference for this group are also in appendix 5)

Specific objectives this protocol aims to achieve

1. Central to the implementation of this protocol is the fullest possible participation of the young person and their parents in the transition process. The Government has endorsed Person Centred Planning as a means for achieving this objective.
2. The young person and their family is prepared for the significant change of moving into adulthood, and has the right information and advice to make informed choices about the care and support they need
3. The young person and the family carers understand the role social care, the different legal context for children’s and adult services assessments, the notion of eligible needs for adults, the relevant charging policies, and importance of maximising voluntary, community and informal supports in pursuit of maximising independence as an adult
4. That there is an early conversation (from age 13) between children’s services and the young person and their family about developing the goals the young person wants to achieve in adulthood, and the early intervention, prevention activities and preparations that need to be considered
5. A co-produced care and support plan is devised in childhood that that takes into account the need to maximise independence as an adult
6. That all partners involved in the care/ support plan are clear about their roles and responsibilities and agree realistic timescales for their interventions
7. That there is regular consultation with the young person and the family about the progress of their transition
8. That feedback about transition is used to learn lessons and improve the quality of future transitions.

**Appendix 2**

**Current Climate**

The commitments of the various organisations are made in a challenging context. Austerity has meant reductions in resources available for both Children’s and Adult services and our partners, such that previous transition arrangements cannot and are not being sustained. This means we have to collaborate ever more closely with each other, and work in much more person and family centred ways to stream-line our activity and make the most of the resources we are collectively able to muster.

Austerity, however, is not our only challenge. We have an increasing population in Hull, and an increasing ‘transitions demographic’. Technological advances mean more people living with complex conditions into adulthood. Expectations of the statutory sector are rising – people quite rightly expect better services, more person-centred responses, and higher standards of care and support. Yet what the statutory sector can offer is increasingly constrained. The longstanding ‘deal’ between the young person and their family and the state is changing.

In this challenging context, we (the statutory sector), need to be clear about what is expected of families and young people themselves. This means providing and supporting better access to information, advice and early support so that young people and families are helped to understand what they can expect of the statutory sector, how the voluntary sector can help, and what they need to do for themselves. This protocol aims to achieve this.

**Key concepts and principles used in developing the protocol**

*Advocacy*

An understanding that people should be able to make their own decisions and control their lives; however there may be times when young people and their representatives need some support and the use of advocates needs to be considered.

*Coproduction*

Co-production means professionals and citizens sharing power to design, plan and deliver support together. It's about recognising that everyone has an important contribution to make to improve quality of life for people and communities[[26]](#footnote-26).

The need to develop transition arrangements alongside families and young people has never been more necessary. Austerity means the demands that are being placed on family carers as well as the statutory sector are greater than ever[[27]](#footnote-27). Supporting people in a caring role, helping young people develop their independence and fulfilling our statutory duties means we all have to work together. Imposing systems and processes into this complex environment will neither be affordable or effective.

*Co-ordinated strategic approach*

All people agencies involved in the transitions process have been consulted in the preparation of this protocol, which also takes account of, and builds upon, the SEN Code of Practice, as well as the relevant legislation detailed above. The strategic collaboration shown through the Strategic Transitions Group will continue, as the group will oversee delivery of the agreed protocol.

*Choice and control for young people and families*

People achieve greater health and wellbeing when they are more involved in the decisions and process that affect them. Designing care and support around their needs and circumstances of young people and families prevents crises in people’s lives that lead to unplanned hospital and institutional care, and reduces the overall use of formal services[[28]](#footnote-28).

*Focus on independence and responsibility*

In this protocol we prioritise the notions of independence and responsibility, however, what we mean by independence and how we use the term responsibility needs to be carefully stated. This is because the terms can be used in a variety of ways by different people. In this protocol, when we use the terms independence and responsibility we mean these things:

* Encouraging a young person to do as much as they can for themselves
* Keeping or improving physical and cognitive function so that a young person can fulfil the tasks of independent living
* Improving or maintaining social connections, and individuals making decisions about their own care as far as possible
* A young person learning to take responsibility for themselves and their actions
* An organisation delivering actions that meet their legal duties and obligations

*Person centred planning*

Person centred planning is a process of life planning for individuals, based around the principles of inclusion and the social model of disability. Person centred planning tools are alive and active, always ensuring the focus person is central and in control. They are flexible, setting no limits to the person’s wants, needs and dreams for their life.

In person centred planning, the process, as well as the product, is owned and controlled by the person (and sometimes their closest family and friends). The review should create a comprehensive portrait of who the person is and what they want to do with their life and brings together all of the people who are important to the person including family, friends, neighbours, support workers and other professionals involved in their lives. The resulting plan of support is totally individual.

Person centred planning replaces more traditional styles of assessment and planning which are based on a medical model approach to people's needs.

*Clear commitments that can be monitored*

There is an expectation that the commitments made by organisations and agencies in this protocol are commitments that will be monitored. Furthermore, the expectation is that that the organisations and agencies making commitments in this protocol will prioritise any necessary actions to comply with their commitments.

*Sector wide pathways*

The purpose of the protocol is to being activities and practice together across young people’s journeys through the health and social care system, and to support families to understand that journey and what it means to them. To work across all partners in more effective and efficient ways, wherever an individual’s pathway begins and ends.

*Sector wide commitment*

Whilst it is the Local Authority that is taking the lead, the partners to this protocol understand and accept that a successful transition between childhood and adulthood requires high-level leadership commitment from all partners in the Health and Social Care sector. In recognition of this, signatories to the protocol accept the need for joint action and participation to make transitions work for every young person in Hull.

**Appendix 3**

**What young people and parents are saying about their experience of Transition?**

The feedback from a young people’s participation group was significant in understanding their experience of transition from children’s to adult services.

Young people’s understanding of the process were summed up in comments such as “change”, “going from school to college which is hard, bigger, more people” and “being treated like a grown up”.

When it comes to experience of going through transition, the comments of young people were really telling:

*“I was a Looked after Child. I’d had lots of moves already so it wasn’t much different when I transferred to adult social care. My social worker changed and as I’m now an adult they don’t spend as much time [with me]. Children’s Social Care asks how you’re doing – if you need them they’re there on the phone (not always). Now I have no named social worker so if I call I might speak to anyone. Its better in one way that I can speak to whoever is there, but on the other hand nor everyone knows a lot about you. I met my adult social worker a couple of times but didn’t see her again. I still see my children’s social worker. I know her and trust her although she can’t do anything except pass on messages.”*

*“I have a social worker. I’m 16 and we haven’t talked about adult social care.”*

*“I lost my PAs who I got through direct payments when I was 17. My workers have to stop seeing me.”*

Young people highlighted 2 key things which were important to them when going through transition,

* That people listen to them and act on what they say
* That they receive support from one trusted person

In 2017, working with the Strategic Transitions group, the Kids’ Parent Forum carried out a further survey with parents of young people who were going through or had gone through transition. The general conclusion was that whilst some transitions work smoothly, there are times when things go wrong, leaving the young person and family with a poor experience. Critical to this was the view of parents and young people that they had little information about, and understanding of the transition process. The following comments reflected the findings:

*“From all the data collected I believe that much has to be done with the transition process. Better training about the transition to adulthood needs to be given to any professionals that have contact with young people from the age of 13”*

*“Parent/carers feel in the dark about the whole process of transition”*

*“People I have spoken to have had young people leave school/college with nothing in place, some going as far as October with no placement which is hard on the young person as well as the parent/carers”.*

This highlights how crucial up to date information and advice are to helping young people and parents make the right decisions about their future.

**Appendix 4**

**National Standards**

In December 2016 the National Institute of Clinical Excellence (NICE) produced quality standards which covers all young people (aged up to 25) using children’s health and social care services who are due to make the transition to adults’ services[[29]](#footnote-29).

These are the standards, along with the key legislation (Care Act 2014, Mental Capacity Act 2005 and Children and Families Act 2014, see appendix 7 for more information), that all statutory agencies have to meet and which inform this protocol throughout.

**Appendix 5******

**Appendix 6**

**Legal Framework**

The Care Act 2014

The Care Act 2014 came into effect from 1st April 2015. The Act changes many aspects of how support is arranged, and aims to give greater control and influence to those in need of support. Among the most significant developments are:

• A new set of criteria that makes it clearer when local authorities across the country have to provide support to people

• A change to the way in which local authorities complete assessments with those in need of support - people in need of support will be encouraged to think about what outcomes they want to achieve in their lives - these outcomes can be anything, big or small, which enable people to feel a greater sense of physical or emotional well-being

• New rights for carers which put them on the same footing as the people they care for. All carers are being entitled to an assessment. If a carer is eligible for support for particular needs, they have a legal right to receive support for those needs, just like the people they care for

• A greater emphasis on protecting the most vulnerable people in our society from abuse and neglect

• A greater emphasis on prevention - local authorities and other providers of support encourage and assist people to lead healthy lives which will reduce the chances of them needing more support in the future

• A greater emphasis on local authorities providing clear information and advice which help the public to make informed choices on their support arrangements, and enable them to stay in control of their lives

• A greater emphasis on existing Personal Budgets which give people the power to spend allocated money on tailored care that suits their individual needs as part of their support plan

• A greater emphasis on those most in need being given access to someone to speak up on their behalf when they are dealing with social care professionals

• Greater regulation for those who provide professional care and support, and tougher penalties for those who do not provide care and support of a high enough standard

• Changes to when and how people will be asked to contribute towards the cost of support which has been arranged in conjunction with their local authority

Specifically in regard to young people and families in transition, the Care Act 2014 says that if a child, young carer or an adult caring for a child is likely to have needs when they, or the child they care for, turns 18, the local authority must assess them if it considers there is ‘significant benefit’ to the individual in doing so. This is regardless of whether the child or individual currently receives any services

An adult carer within the context of the Care Act provisions relating to the transition to adult services is ‘an adult (including one who is a parent of the child) who provides or intends to provide care for the child’ (Care Act 2014, clause 60(7)).

An adult carer in this situation may also be a parent carer as defined in the Children Act 1989 (section 17ZD (2), as inserted by section 97 of the Children and Families Act 2014): ‘“parent carer” means a person aged 18 or over who provides or intends to provide care for a disabled child for whom the person has parental responsibility’.

An adult is not defined as a carer if they provide services through voluntary work or under the provision of a contract.

Children and families legislation

Under the Children and Families Act 2014, Local Authorities have a range of duties relevant to transition. The following provides an overview:

• To support and involve the child and their parent, or the young person, in carrying out their functions and to have regard to their views, wishes and feelings. This includes their aspirations for adult life.

• To offer advice and information directly to young people. This includes information and advice which supports children and young people to prepare for adult life

• Together with health services, to make joint commissioning arrangements about the education, health and care provision of children and young people to secure positive adult outcomes for young people with SEN.

• To keep education and care provision under review including the duty to consult young people directly. And to consult schools, colleges and other post-16 providers

• To co-operate with FE colleges, sixth form colleges, 16-19 academies and independent specialist colleges approved under section 41 of the Children and Families Act 2014.

• To include in the Local Offer provision which will help children and young people prepare for adulthood and independent living, to consult children and young people directly about the Local Offer and to publish those comments

• To consider the need for EHC needs assessments, prepare EHC plans where needed, and maintain and review them, including the duty to ensure that all reviews of EHC plans from year 9 (age 13-14) onwards include a focus on preparing for adulthood and, for 19-25 year olds, to have regard to whether educational or training outcomes specified in the EHC plan have been achieved.

Preparation for adulthood is a key element of the reforms that cuts across all of these themes.

The Mental Capacity Act 2005

The third piece of legislation framing this protocol is the Mental Capacity Act 2005

Mental capacity is the ability to make decisions. This could be fairly small decisions such as what we eat or the clothes we wear, or could be much bigger decisions, for example where we live and who we live with. Capacity is based on a single decision at a single time, so some people may have fluctuating capacity, meaning they can make a decision one day and not the next depending on their wellbeing.

The Mental Capacity Act 2005 sets out what should happen when people are unable to make one or more decisions for them. It clarifies the roles that different people play in decision-making, including family carers, and establishes a Court of Protection which acts as the ultimate arbiter about mental capacity issues.

The parents of a young person who is unable to make a decision are likely to be involved in:

• Supporting them to make a decision

• Supporting during an assessment of their mental capacity

• Making a decision or acting on their behalf

• Being consulted when someone else makes a decision or acts on behalf of

their young person

• Challenging a decision made on a relative’s behalf.

There are also certain decisions that the Mental Capacity Act says can never be made on behalf of someone else, whatever their age, usually because they are about intimate personal relationships. These include:

• consenting to marriage

• consenting to sexual relationships

• voting in elections

Although the Act does not allow anyone to make a decision about these matters on behalf of someone who lacks capacity to make such a decision for themselves, this does not prevent action being taken to protect a vulnerable person from abuse or exploitation.

This protocol aims to support best practice that complies with the Care Act, Children and Families and the Mental Capacity Act, amongst everyone involved in transitions from Childhood into adulthood.

**Appendix 7**

**The legal context – key issues**

The Children and Families Act, the Care Act and the Mental Capacity Act work together to provide an overarching legal framework for the statutory bodies to manage a young person’s transition. There are a number of points about this legislative framework that can be usefully drawn out as key elements that inform this protocol.

The first is the impact of the Mental Capacity Act, and it combines with the emphasis in the Care Act on wellbeing and independence. The Mental Capacity Act means that when a child reaches 16 there is a presumption of capacity to make decisions, and the need for a mental capacity assessment if this is in doubt. A best interest decision making process must be followed if the assessment indicates a young person does not have capacity. These decision making processes may at times contrast with the parents expectations, as they have been, quite suitably, taking parental responsibility for their child over many years; but now have to begin to cede some of that responsibility to others and the young person themselves.

The second is a feature of the Care Act and the Children and Families Act which make the Council responsible for developing early intervention and prevention activities that are able to prevent, reduce, and delay the need for formal services. It also places a duty of the council to engage in activities that support the wellbeing of young people and families. This is the case even when the needs of the young person and the carer may not meet statutory eligibility criteria which mediate access to public funds[[30]](#footnote-30). The issue this creates is that it is often difficult to help and support to young people and families who are not eligible for public funds, beyond providing information, advice and guidance.

Examples of groups young people who often have a need for early help and preventative care and support, but who may not always be eligible for public funding are young people:

* With degenerative conditions
* Whose needs have been largely met by their educational institution, but who, once they leave, will require their needs to be met in some other way (e.g. those with autism)
* Detained in the youth justice system who will move to adult custodial services
* Who are carers, whose parents have needs below the local authority’s eligibility threshold but who may nevertheless require advice or support to fulfil their potential, for example, a child with deaf parents who is undertaking communication support
* Receiving child and adolescent mental health services (CAMHS) who may also require care and support as adults even if they did not receive children’s services from their local authority

In all these instances the statutory sector must build professional practice around the individual even if they are not eligible for public funding. A person centred approach, where the young person, or their family carer, is in control of their move from childhood to adulthood, even if there is no recourse to public funds is essential. Equally essential, is that the Council supports the development of ‘low-level’ prevention and early help services that young people can access.

**Appendix 8**

**Prevention and early help during transitions**

The provision of prevention and early help to young people and families in Hull begins with an early personalised conversation with the young person and the family. The early conversation must:

* Be strengths-based, by which we mean it identifies the skills, abilities and knowledge that both the young person and the family have at their disposal, that can be developed in the coming years to increase opportunities and facilitate the growth of wellbeing and independence.
* Focus on relationships that the young person has and how these will be maintained and grown in their transition to adulthood
* Supports increased access to and use of ‘universal services’ such as culture and leisure services, and encompasses the changes to access to health care that arise when a young person becomes an adult at 18.

The second element of early help and prevention that is offered (aged 18) by adult services is a short-term intervention from our Active Recovery team. This team specialises in agreeing short-term (achievable in 6 weeks) goals with people, in this case a young adult, and delivering 6 weeks of support to achieve them. This is intended to ‘get people back on their fee’ or upskilled in a particular aspect of their life. This could include such things as travel training or independent living skills – cooking cleaning etc. However, a key element of this protocol is the partnership between Children and families Services and the Public Health and Adult Social Care Services.

The conversations with family and young people and facilitated conversations between young person and family carers needs to begin in Childhood, age 13. Children and Young People’s social workers will be having these conversations and putting in place activities that prepare young people for adulthood much earlier than is currently the case. See the commitments section for Children’s and Adult’s services. It is also true to say that parents are expected to inform and lead much of this preparation work. In this way, the transitions arrangements are as much about parenting styles and changes to relationships within the family as they are about the role of the statutory sector. These are commitments parents and family carers need to be conscious of, see section 5.

The final element of the prevention and early intervention offer for young people and families in transition is:

* Access for young people and families to high quality information and advice
* Access to independent ‘Care Act Advocacy’
* Support to access the voluntary and community sector

Information and advice is delivered via Connect to Support[[31]](#footnote-31) as is access to independent advocacy. Support to access the voluntary and community sector via the Council and Clinical Commissioning Group’s (CCG) Social Prescribing Service ‘Connect Well’.

Connect to Support is a ‘citizen facing’ web site that has information and advice and a Hull communities database that will help local young people and families get the help and advice they need, and to find out about and access community and voluntary sector services.

Connect to Support also enables adults who need help to understand the systems and processes they are engaging with to access independent advocacy[[32]](#footnote-32). Adult social workers can refer people using Connect to support for this ‘process’ advocacy support. This can happen at age 16 when people receive an adult’s social worker[[33]](#footnote-33).

The Social Prescribing service enables adults who need help to access appropriate voluntary and community sector provision to get support to find out about and then to access that voluntary and community sector provision. This is available for young people at age 16 as part of a transitions plan agreed with an adults social worker[[34]](#footnote-34).

**Appendix 9**

**Care Leavers who require additional specialist support** *(The Children Act 1989 guidance and regulations(Volume 3 planning transitions to adulthood for care leavers)*

15.1 Disabled young people will face many of the same experiences and challenges as other care leavers. However, the transition to adulthood for disabled young people who are looked after may be particularly challenging. They will often experience different professional languages, styles, expectations and cultures as they make the transition from support by children’s services to support from adult health and social care services. Disabled young people also have needs relating to their health, social care and education, and these may vary widely depending on the nature of their conditions.

15.2 The definitions in the 1989 Act and legislation governing provision for disabled adults often differ and have differing thresholds for eligibility for services.

15.3 **Care leavers with complex needs, including those with disabilities, may transfer direct to adult services and the pathway plan will need to ensure that this transition is seamless and supported12.** Local authority responsibilities towards disabled care leavers are the same as for all other care leavers13. Because of their additional needs, some young people may draw on a number of services, receive support from several professionals and have multiple plans14. The local authority must ensure that these processes are streamlined as much as possible and roles and responsibilities discussed with the young person and their carer(s).

**Person centred planning**

15.4 Each disabled young person will have their own individual aspirations, hopes, needs and wants. Whilst different services will have their own eligibility and access criteria, they must work together to adopt a holistic approach based on assessment of individual needs informed by each young person’s wishes and feelings.

15.5 Person centred planning will ensure that planning for disabled young people to make the transition to adulthood is focused on what is important to the young person for the future and what needs to be in place to ensure that they receive the support to achieve their goals. The young person must be kept at the centre with family members, carers and friends being partners in supporting the young person to achieve their potential. A shared commitment should be established to ensure that the young person’s views are listened to and ways are found to remove any organisational barriers that might limit personal development and choices. Young disabled people leaving care should not simply be placed in pre-existing services and expected to adjust. Services should, in particular, be responsive to the needs and preferences of a disabled young person in relation to such issues as housing, social networks and isolation, education, employment and leisure.

12 *Statutory guidance on promoting the health and wellbeing of looked after children* (2009) https://www.gov.uk/government/publications/promoting-the-health-and-wellbeing-of-looked-after-children

13 *Future Positive* (2006) provides a comprehensive resource guide for people from all agencies working with disabled care leavers: https://www.gov.uk/government/publications/future-positive-a-resource-guide-for-people-working-with-disabled-care-leavers

14 *National Framework for NHS Continuing Healthcare* (November 2012 (Revised)) https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care

15.6 PAs and others working with disabled care leavers should be given training to ensure that they are equipped to communicate effectively with them, including those with high communication needs. Trained advocates should also be available to ensure that young people’s views are heard and taken into account.

**Joint protocols**

15.7 For transition to become a positive experience for young people and their families, it is necessary for all agencies to work together and understand each other’s roles, responsibilities, professional frame of reference and legal duties within the transition process. To ensure that this happens for disabled care leavers it is essential that specific protocols and agreements are drawn up in each local authority area, with the participation of all agencies. This will include children’s and adult social care, children’s and adult health, education, housing, youth offending, information, advice and guidance services, supported employment services and leisure services.

15.8 Strategic planning approaches will need to be reflected at an operational level through protocols. These should identify the timing and mechanisms by which key professionals come together with young people to help to identify their needs and to plan individualised support packages. In order to avoid duplication, wherever possible, protocols will need to identify how the pathway planning process relates to other frameworks for planning the transition to adulthood for young disabled care leavers, such as those for special educational needs.

15.9 Young people generally transfer from child to adult health services at 16, from child to adult social care services at 18, from school-based education to further education between 16 and 19, and to higher education from 18. However, there may be exceptions to these general arrangements. Child and Adolescent Mental Health Services usually provide services up to age 18, and young people with a statement of special educational needs may not transfer to support from adult social care services until the end of school year 13, at age 19. Joint protocols must reflect the fact that age-related policies of different agencies do not fit easily with the realities of the transition process for young people leaving care, and should allow for a flexible approach which recognises the corporate responsibility towards them. Where it is likely that a care leaver will require continuing support from adult services, it will be good practice to make a formal referral as early as possible from age 16, so that eligibility for this support is established in time for their 18th birthday. Protocols should clarify roles and funding responsibilities of different agencies. The use of pooled budgets across agencies may help remove some of the barriers arising from potential differences in eligibility criteria of different services provided under different legislation.

15.10 Tracking systems based on the transition arrangements associated with a young person’s statement of special educational needs should be in place to ensure that social care, health, education and other relevant agencies are aware of who are the potential users of adult services from age 14 upwards.

**Young people living out of area**

15.11 **Where disabled young people in care have been placed out of the responsible authority’s area, the care authority and education authority retain responsibility for the child.** The Primary Care Trust (PCT) where the young person is registered with a General Practitioner (GP) will be responsible for day to day health needs, but the PCT for the originating care authority will retain responsibility for commissioning any secondary health services. This is set out in Department of Health guidance, *Who Pays? Establishing the Responsible Commissioner* (2007)15.

15.12 As care leavers living out of area turn 18, responsibility for provision of services may change. The responsible local authority will need to ensure that continued leaving care support is provided under the provision in the 1989 Act requiring responsible authorities to continue to support care leavers. However, any adult social care provision will be the responsibility of the local authority where the child is ordinarily resident within the meaning of the National Assistance Act 1948. Where the young person’s disability was the primary reason for their placement outside the area of the responsible authority, the same authority may remain responsible for the provision of adult social care services even if the young person remains living in another area. Depending on the circumstances of the individual, there may be situations in which the young person’s ordinary residence will have become the local authority in which they were placed and where they have been living and settled for some years16. This will primarily be affected by the young person’s ‘mental capacity’ to make a choice regarding the area in which they live.

15.13 Relevant agencies providing health and adult social care services should have been involved in transition planning in the years leading up to the young person’s 18th birthday in order to ensure a smooth transition.

**Adult social care provision**

15.14 Eligibility for adult social care provision is governed by the Department of Health Guidance on *Eligibility Criteria for Adult Social Care* (2010)17. Local authorities may provide community care services to individual adults with needs arising from physical, sensory, learning or cognitive disabilities and impairments, or from mental health difficulties. Increasingly, support is self- directed and delivered through personal budgets, following self-assessment and person-centred support planning. Young people moving into adulthood and the people close to them need high quality, accessible information about personalisation from the age of 14 so that their planning can be within the context of knowing the resources that will be available for their support.

15 *Who Pays? Establishing the Responsible Commissioner* (2007): http://webarchive.nationalarchives.gov.uk/20130107105354/http:/dh.gov.uk/prod\_consum\_dh/groups/dh\_digitalassets/@dh/@en/documents/digitalasset/dh\_126387.pdf

16 For information about the determination of “ordinary residence” refer to: https://www.gov.uk/government/collections/ordinary-residence-pages#ordinary-residence-guidance

17 *Prioritising need in the context of Putting People First: a whole system approach to eligibility for social care - guidance on eligibility criteria for adult social care* (2010): http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod\_consum\_dh/groups/dh\_digitalassets/@dh/@en/@ps/documents/digitalasset/dh\_113155.pdf

15.15 *Eligibility Criteria for Adult Social Care* requires local authorities to have in place arrangements to identify individuals who may need a variety of services as they move from youth to adulthood. When undertaking assessments and re- assessments, local authorities are required to ensure that marked changes in the type, level and source of support should be managed very carefully as these are usually not in the best interests of people using services.

15.16 Adult social care services have policies regarding charging arrangements and in applying these local authorities should take account of their corporate parenting responsibilities towards care leavers. Care leavers who transfer to adult social care services should be made aware of any charging policy and the impact on any financial support or arrangements.

15.17 Where **disabled young people meet the eligibility criteria for adult placement schemes, the possibility of their former foster carers becoming their adult placement carers should be considered, so that both the young person and foster carers transfer to an adult social care service. The responsible local authority will need to ensure that they continue to provide support in accordance with the requirements of the Children (Leaving Care) Act 2000.** The responsible local authority will also need to ensure that they provide support in accordance with the Carers and Disabled Children Act 2000 and Carers (Equal Opportunities) Act 2004 combined policy guidance18. The guidance requires councils to inform carers of their right to an assessment which takes into account their outside interests (work, study, leisure) and provide services to them directly and/or support carers by providing them with a direct payment to enable them to purchase carers' services for themselves.

15.18 Where it is likely that a young person leaving care will need services into adulthood, an adult services worker should contribute to pathway planning from age 16 onwards, and the change of lead worker from one service to the other should be determined within the planning process taking account of the young person’s wishes and assessed needs.

15.19 Where disabled and vulnerable care leavers transfer to, and become the responsibility of, Adult Care Services, local authorities’ leaving care teams and PAs should ensure that young people do not lose out on any leaving care entitlements. Care leavers should not be disadvantaged financially by transferring to a different service. Pathway plans and transition plans should be used to evidence young people’s financial abilities and to provide a financial framework that sets out the allowances and benefits young people are entitled to, and who will assist them to manage these allowances and benefits.

**Appendix 10**

**Governance and the role of young people and families**

The commitments made in this protocol will be transferred into an action plan and risk register, the implementation and management of which will be overseen by the Strategic Transitions Group. Detailed operational aspects of the protocol will be sorted out in the Operational Transitions group.

The Strategic Transitions group will report on progress regularly to the SEND Board and Adults Services Directorate Management team.

Progress issues or escalation issues will be escalated as necessary by the Chair of the Strategic Group.

The terms of reference for both the Strategic Group and the Operational Group are in appendix 5.

**The role of young people and families**

Coproduction, as discussed earlier in this protocol is essential for this protocol to be successful. Participation of family carers on the Strategic Transitions group is an essential part of this co-production approach. There are two roles for family carers and young people.

The first is their role should they chose to participate in formal capacity on the strategic Transitions Group, and the second is their role as young people and family carers experiencing, living and working though the transitions process with the various organisations in this protocol.

**The formal role of young people and family carers at the transitions strategic group**

The formal role of young people and family carers at the transitions strategic group to ensure that the views of patients, carers and families are taken into consideration during relevant discussions

Young people and family carer representatives who serve on the group is expected to contribute to the decision making process.

Young people and family carer representatives are valued members of the group and have the full support of the Chair, who will be happy to meet with any young person and family carer to help inform them about the role and remit of the Group.

The specific role of the family carer representatives and young people on the Transitions Strategic Group is to:

* Contribute to relevant meetings in a constructive manner, offering ideas and opinions which reflect the voice of young people, patients, carers and their families, but not individual cases which may be confidential or personal
* Where appropriate and applicable, young people and family carers should seek views and feedback from other carer groups / young people.
* Keep abreast of local and national news and developments with regards to social health care policy and particularly transitions issues and consider the impact of this on the activities of the group
* Seek to attend training when offered, if considered useful and applicable
* Work on projects which have been identified as an area of focus by the group when agreed by the Chair. This may sometimes require collaborative working with other group members and at other times working autonomously
* Provide a commitment to the group, attending as many meetings as they are able, and acting as a representative of the group when required
* Family carer representatives or young person should not agree to take on projects, which they feel are outside of their remit, beyond their skill or knowledge level, or would require a time commitment which they are unable to keep

If family carers have any queries relating to their role and responsibilities, they should contact the Strategic Transitions Group Chair

**Appendix 11**

**Social work team at CTLD within Humber Foundation Trust**

**Key**

Red box where cases sit

Blue box how cases move about

**Black Box** RAM ref required in all cases

**Long Term Support Teams**

Long Team support teams associate working with CTLD cases to support new model at HCC. Emphasis on **Prevention** (looking for community options) **Targeted** (short term intervention) and **Specialist** (back to Town End Court (TEC) for support) TEC will provide a consultancy approach with teams around LD supporting new model at HCC-ref through RAM

Identified needs can’t be met with mainstream services, Referral to TEC through RAM process to qualify support within LD integrated team

**Transitions cases** managed through CTLD process

**Transforming care** cases out of area CCG & TEC ref through RAM

3 month support from CTLD/transition support or TCP management

RAM Ref Transitions , CTLD team involved in the process associate work form age 16

RAM Ref Transforming Care, CTLD will support the throughput of TCP cases

TEC CTLD/ offer of three months (may be longer depending on case profile)intensive support to stabilise identify and qualify a package of support, then three months holding with teams East/West to respond quickly and pick up if there is a need for further intensive support /reviewed with teams East/West 6 weeks after support has been initiated/different timescale provisions for TCP and Transitions cases

CTLD Team endorsed discussions/packages for JWF/Brokerage

CTLD/JWF & Brokerage input to support identified care packages and support care and support needs which have been endorsed through team at CTLD/JWF & Brokerage. Risk sits with JWF until a package is agreed, delays and deferments should not prevent meeting needs and consideration about risk mitigation should take priority

Settled cases back to teams Long Term Support, 3 month associate working to support from CLD

1. See appendix 1 for further background information [↑](#footnote-ref-1)
2. See appendix 2 for a description of the current ‘climate’ in social care and the key concepts and principles used in developing this protocol [↑](#footnote-ref-2)
3. See appendix 3 for the comments young people and families have made about their experience of transition [↑](#footnote-ref-3)
4. Independent Mental Capacity Advocates can be accessed via the Adults Safeguarding Team and Independent Care Act advocates can be accessed by an Adult’s Social Worker through Connect to Support. [↑](#footnote-ref-4)
5. See appendix 4 for details of the National Institute of Clinical Excellence (NICE) Guidelines [↑](#footnote-ref-5)
6. See appendix 5 for relevant Terms of Reference [↑](#footnote-ref-6)
7. By seamless, we mean that there will not be a stop-start process – where young people are discharged from any particular children’s service and then have to wait to be re-referred into adult services which may have waiting lists. [↑](#footnote-ref-7)
8. Some of the young people with significant emotional health and behavioural needs (SEMH) who don’t have EHCPs (see 2.1) do not have a SENCO as some are not in school settings due the complexity of their needs. So the relevant person undertaking this consultation will need to vary, in this situation. [↑](#footnote-ref-8)
9. The relevant referral from will be circulated as part of training on this Transitions Protocol which will be available to all relevant staff [↑](#footnote-ref-9)
10. Lee Tether (Transition Manager): [lee.tether@hullcc.gov.uk](mailto:lee.tether@hullcc.gov.uk) [↑](#footnote-ref-10)
11. To be clear this should have been done at year (age 14), but if this has not been done prior to year 12, it should be done now. [↑](#footnote-ref-11)
12. The ‘cliff-edge’ refers to the experience of families and young people when the reality of life as a disabled adult does not meet the expectations of a disabled child and or family. This experience differs both in terms of applicable legislation and changing expectations of independence and responsibility (see appendix 6, 7, and 8 for more background information). When transitions arrangements are not planned well enough and sufficiently in advance, the experience of crossing this boundary between childhood and adulthood can feel abrupt and disjointed. [↑](#footnote-ref-12)
13. By ‘complex’ we mean: there are disputed mental capacity issues, likely future accommodation issues, likely involvement of the Court of Protection for any reason, packages of care that are likely to cost more than £430 per week, problematic offending and / or substance misuse, behaviour that challenges. [↑](#footnote-ref-13)
14. The HFT service meets the needs of people aged over 18 with symptoms or a diagnosis of mental illness and or a learning disability and who are:-

    • Registered with a Hull GP or reside in Hull and are not registered with any GP

    • Aged over 18 years [↑](#footnote-ref-14)
15. See appendix 8 for more information about prevention and early intervention [↑](#footnote-ref-15)
16. To be clear, Adult social care will not be held accountable for agreeing funding arrangements when there has not been a referral to the transitions panel until after the young person’s 16th birthday [↑](#footnote-ref-16)
17. This care and support planning process involves the use of a ‘247 grid’, see: <https://www.247grid.com> [↑](#footnote-ref-17)
18. See appendix 10 for details of how the strategic Group works with young people and families [↑](#footnote-ref-18)
19. See appendix 7 for key legislative differences [↑](#footnote-ref-19)
20. ICAA is accessible via Adult Social Workers and support officers working for Hull City Council using Connect to support. The IMCA and IMHA advocates can be sourced visa Hull City Council’s Multi-agency Adults Safeguarding Hub [↑](#footnote-ref-20)
21. From an adult’s services perspective [↑](#footnote-ref-21)
22. The transition process from children to adults will mean a smooth referred into various therapy services, including occupational therapy, physio, speech and language services, especially for people with profound multiple learning disabilities. [↑](#footnote-ref-22)
23. It should be noted that HFT support patients from the wider Yorkshire and Humber area and from further afield [↑](#footnote-ref-23)
24. A set of flow charts are available on request from [alison.morley@hcc.gov.uk](mailto:alison.morley@hcc.gov.uk) [↑](#footnote-ref-24)
25. See appendix 3 and 9 for more information [↑](#footnote-ref-25)
26. Think Local Act Personal accessed 10-9-17: <https://www.thinklocalactpersonal.org.uk/co-production-in-commissioning-tool/co-production/In-more-detail> [↑](#footnote-ref-26)
27. ‘Carers’ now have rights under the Care Act and any plan made with a carer needs to take into account the impact of their caring role on their wellbeing [↑](#footnote-ref-27)
28. Think Local Act Personal, Getting Serious about Personalisation. TLAP September 2014 [↑](#footnote-ref-28)
29. NICE Guidance is not duplicated in this document, it is freely available here: <https://www.nice.org.uk/guidance/ng43> [↑](#footnote-ref-29)
30. See: <https://www.legislation.gov.uk/ukdsi/2014/9780111124185> for further details of the criteria for Adult Social care in the Care Act 2014 [↑](#footnote-ref-30)
31. <https://hull.connecttosupport.org/s4s/WhereILive/Council?pageId=3226&lockLA=True> [↑](#footnote-ref-31)
32. This is advocacy aimed at helping young people and families to understand the health and social care systems and the processes they are engaging with. It is not about advocacy for people who cannot consent to processes or to receiving advocacy. For this specialist Independent Mental Capacity Advocacy (IMCA) or Independent Mental Health Advocacy (IMHA) are needed [↑](#footnote-ref-32)
33. See commitments in section 3 for adult social care [↑](#footnote-ref-33)
34. See commitments in section 3 for adult social care [↑](#footnote-ref-34)