Children's Social Care

And

Transitions (Physical and Learning Disabilities) Service

Transition Tracking Protocol

(Young People Aged 14 - 25 Years Old With SEND)

Created: February 2022

Contents

1. The Purpose Of The Transition Tracking Group:

- The purpose of the Transition Tracking Group is to ensure we are starting transition arrangements in good time (from Year 9) and that we are working collaboratively with parents, children and young people to produce and deliver good outcomes for young people as they move towards adulthood.
- The Group will be multidisciplinary and have input from other teams and professionals as required (e.g. Special Educational Needs, National Health Service and the Clinical Commissioning Group, Shared Lives).
- Senior/service managers will administer the Group both in Children, Special Educational Needs, Children with Disabilities and Adult Social Care. It will meet monthly to review the needs of young people from year 9 onwards, ensuring that their needs and aspirations are linked to independence.

This protocol applies to:

- Social workers and managers within the Children with Disabilities Team.
- Staff within Adults with Learning Disabilities Team.
- Social workers and managers in the Leaving Care Teams working with children with disabilities.
- Social workers and managers in other Adult Services Team working with disabled young people
- Workers in the Special Educational Needs and Disability service
- Health staff – e.g. therapy services, nursing and mental health

2. Good Practice In Transition to Adulthood Work:

There are six established key prerequisites for successful transition planning:

There is a commitment

Good transition work is the responsibility of all teams and does not fall solely on the Transition Team. Children and young people with disabilities and complex needs are given priority in transition planning by professionals in Children Social Care, Education and Health Services. Transition planning starts from 14 years onwards ensures that the needs of young people are linked with the preparation for adulthood outcomes according to the (Preparation for Adulthood protocol). Early transition helps to ensure that services will be provided earlier to children and young people in order to prevent a cliff edge when young people turn 18 years.

Young People and Families are fully involved in the process

Young people and their families are fully engaged in transition planning from year 9.

Children and young people are involved in their annual education review/EHCP, children in need meetings and also in the decision making of the support they require. Young people and their families are also involved in strategic planning for transition.

Effective Strategic Planning and Commissioning

The planning and commissioning of Adult Social Services are informed by an analysis of transition needs of the cohort of young people from 14 onwards receiving support from Children's Service and who will require services in Adult Health and Social Care. This will assist with forecasting expenditure and financial planning. In addition the range and quality of services commissioned and outcomes for young people are systematically monitored as outlined in the Preparation for Adulthood Standards.

There is a multi-agency approach with good protocol systems and processes

All relevant services to support the young person transition are actively engaged and begin providing support that focuses on transition planning to the young person and their family from 14 years onwards. This work involves a multi-agency team of professionals such as commissioning teams, housing, schools, colleges and other services working collaboratively to achieve good outcomes.

There is a co-ordinated person-centred planning process

Person-centred planning methods and processes are used to create integrated transition plans. Direct payments are promoted. The focus is on achieving outcomes, improving and supporting independence, and providing normal life opportunities.

Regular review of the transition plan

There is regular follow-up to see that the plan for transition remains appropriate and is delivering good outcomes.

3. Transition Planning Arrangements:

How cases will be referred to the Transition Team from Children with Disabilities:

- From the age of 17 – 17 ½, a referral will be made to the Transition Service / Adult Social Care with the parent's consent or the young persons. They will review the referral and decide whether the young person is likely to be Care Act eligible based on the presenting information.
- Case responsibility remains with the social worker in children's social care. However, a Transition Social Worker will aim to start attending the annual education review/Education Health Care Plan (ECHP) from year 11 (16 years old) if they are not able to attend copies of the EHCP review to be forwarded onto the Transition Team.
- Referrals to the Transition team will be made via email croydonadultsupport@croydon.gov.uk to the Croydon Adult Support Team. Referrals to include key clinical information & contact details of key professionals, the service users NHS number, contact details, date of birth and current care package. Applications to be made for Joint Funding or Continuing Health Care funding if the service user is eligible.

Care Experienced Young People:

- "Children Looked After and Care experienced young people are supported in our CLA Service and 16+ Young people service. As corporate parents, we are committed to ensuring our children and young people receive the right help and support as they approach and turn 18 years old, especially those with additional needs. All Eligible, Relevant and Former Relevant children and young people will be supported by a social worker and/or a Personal Advisor who will update their pathway plan with them at least every 6 months or when significant changes take place and continue to remain in contact with them while supported and cared for by the CLA and 16+ YP services. When additional needs are identified, the CLA and 16+ services will consult and refer to the transition service when the Care Act criteria is likely to be met.
- Children and young people with additional needs can be referred to the Transition Service for a Care Act assessment in line with the "Transferring a Young Person from Children's Social Care to the Transitions Service Pathway" from 17 – 17 ½ years old. It is vital that assessments are completed and any necessary support is in place before our children reach 18 (where possible) or within a reasonable timescale to ensure a safe and effective transition, with the correct ongoing support in place.
- Referrals to the Transition team will be made via email croydonadultsupport@croydon.gov.uk to the Croydon Adult Support Team. Referrals to include key clinical information & contact details of key professionals, the service users NHS number, contact details, date of birth and current care package. Applications are to be made for Joint Funding or Continuing Health Care funding if the service user is eligible.

SEND:

- Any requests for joint funding of educational placements need to be made to Adult Social Care for a decision prior to commitment to the young person and their families.
- Referrals to the Transition Service will be made via email croydonadultsupport@croydon.gov.uk to the Croydon Adult Support Team. Referrals to include key clinical information & contact details of key professionals, the service users NHS number, contact details, date of birth and current care package. Applications to be made for Joint Funding or Continuing Health Care funding if the service user is eligible.

Shared Lives:

- Shared Lives is an adult placement scheme that can offer a model of support for young people 18 plus that is more person-centred and cost-effective than supported living or residential care. An early referral is required to make the matching process most effective. Referrals for Shared Lives need to be made at the age of 17.5 years; by calling the Shared Lives Duty Team on **ext 63516** or emailing the team Sharedlivesteam@croydon.gov.uk to organise a suitable time to discuss the referral.

Assessments to be completed:

- Mental Capacity Assessments are decision specific and will be undertaken when required and by the appropriate Social workers as relevant to the decision that is to be made.
- Where a mental capacity assessment & best interest meetings are required for under 18's this should be undertaken by the lead team, be this SEND, CWD or leaving care. The Transition Service will need to undertake any Mental Capacity assessment & best interest meetings relevant for post 18 work.
- The Transition Social Worker needs to complete the Care Act Assessment, Financial Assessment, and where the young person meets the threshold to get panel funding approval for packages to be funded by Adult Services ahead of the young person's 18th birthday.

Frequency of Transition Tracking meetings:

- Transition tracking meetings will be convened on a monthly basis. Social workers will present their cases that have been identified with managers from children's and adult services to ensure that there is close monitoring of individuals going through the transition process and that there is a tracking mechanism concerning the progress made.

Funding arrangements:

- Children Social Care, have a responsibility to apply for Continuing Care Funding before the child is 18 when the child is eligible.
- The Social Worker in Transitions will present young adults' needs to relevant Adult Social Care panels requesting for funding before the young person's 18th birthday.

4. Transition Planning Timeline

Age	Process	Who	Decision
14	Young Person reviewed by Tracking Group	CWD and Transitions Managers	Social worker in the CWD Team presents the child's needs to the Transition Tracking Group.
16	Consideration about mental capacity assessments –	Allocated Social Worker in CWD /	Consideration to be made about mental capacity assessments in relation to various aspects of daily living (decision specific).
17	Referral for Shared Lives	Allocated Social Worker in CWD and Transition	Social worker in Leaving Care, CWD and the Transition Social Worker jointly work together. Joint visits will be completed, & where possible attending CIN reviews or child looked after reviews
17.5	Care Act assessment	Allocated Transition Social Worker	Care Act Assessment is commenced by the Transitions Social Worker
17.5	Adult Social Care Panel	Allocated Transition Social Worker	Agreement in principle to fund new or existing Children's Services/Health Care Packages post 18.
17 ¾ - 18	Support planning	Allocated Transition Social Worker	A review is completed after six weeks following commence of the care package in Adult Social Care. In circumstances where there is no need for ongoing social work the Young person can be reviewed on an annual basis. Supported employment options will be explored. Packages of support via Adult Social Care including Personal Budgets and Direct Payments will be reviewed every year. Health Care Plans will be reviewed every year. Annual Health Checks for adults with Learning Disabilities available via most GP surgeries. Employment services continue
18	Financial Assessment (Adult Social Care	Allocated Transition Social Worker	If a young person is going to receive services from Adult Social Care after they turn 18 they are required to complete a financial assessment to establish the level of client contribution towards the cost of their care.
25	Transfer Young Person to the 25 – 65 Disabilities Service	Allocated Transition Social Worker	Social workers to work closely work with the SEN case officer. Social workers to review the Care Act Assessment annually, attend the Education Health Care Assessment review. Packages of support via Adult Social Care including Personal Budgets and Direct Payments will be reviewed every year. Health Care Plans will be reviewed every year. Annual Health Checks for adults with Learning Disabilities available via most GP surgeries. Employment services continue