Gateshead Council

NHS Newcastle Gateshead Clinical Commissioning Group

Transforming lives together

Children and Young People transitioning between services

Introduction

This guide has been put together in response to lessons learnt and should be used as a guide for our workforce. This document aspires to provide staff with a comprehensive guide to supporting young people in their journey into adulthood.

In order to accomplish this, it covers areas around:

children and young people's health	education	financial support	accommodation

This document applies to children that have Education Health Care Plans (EHCP's), children and young people who are cared for by the local authority, children and young people with Special Education Needs (SEND) as well as issues around Deprivation of Liberty (DOLS), The Mental Capacity Act and Court of Protection applications.

This document provides a framework for staff to use when considering issues for the children and young people they work with, in relation to their care planning. We would recommend that issues around transitions are considered as early as possible.

By following these processes, we believe that we can ensure that our amazing children and young people have the support and assistance they need to live their best lives as young adults, receiving the right support, accommodation and education when they need it. There is also a glossary of terms at the back of this document.

This document will be regularly reviewed – please use this link to access the document (where possible) to ensure up-to-date information.

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Transitions Team Pathway

14 years old

- A dedicated transitions worker (Karen Ruddick) will attend appropriate Year 9 EHCP reviews (when possible) - This is to enable discussions around transitions and to determine if young people who are not open to children's services will require a referral into the transitions team pre-18. This would be the case if they are likely to have eligible care and support needs under the Care Act 2014.
- Attendance at EHCP reviews is prioritised to those young people aged 14 years old, post 16, Cared for young people, out of area placements, and those young people open to a children's social care team. See *this link* for guidance

16 years old or before

- The transitions team should receive a referral for a Cared for young person at 16 years old or before depending on the needs of the young person.

17 years old

- **The transitions team should receive a referral for a Child in Need (CIN) at 17 years old or before depending on the needs of the young person.**
- All internal referrals from Children's services should be done by Children's workers adding the 'Passport into Adulthood' form on Mosaic then running this off the system and sending this to the transitions duty inbox (TransitionTeam@gateshead.gov.uk) in a pdf/word format FAO of Charlotte Smith for it to be actioned/ added to the transitions team waiting list.
- LAC Cared for young people aim to be allocated a transitions worker prior to their 17th birthday (unless the young person is transitioning via the CHC pathway then a transitions worker will be involved in a consultative capacity until 18 years old).
- CIN young people aim to be allocated a transitions worker prior to 17 years old 6 months (unless the young person is transitioning via the CHC pathway then a transitions worker will be involved in a consultative capacity until 18 years old).
- The transitions worker will add themselves as a co-worker to the young person's file and liaise with the children's allocated worker and attending scheduled meetings (CIN/LAC Reviews, Care Team Meetings etc) to begin gathering information to help inform the young person's Adult Assessment.

18 years old

- The transitions worker will become the primary worker and the Transitions Team will become the responsible team. Case management responsibility becomes Adults, unless the young person's care is transferred to the CCG as they become CHC funded

Cared for Children and young people

At 15 year 10 months old

- Pathway plans are started by the young person's social worker and take over from the traditional care plan when a child reaches 15 and 10 months in age. This should start with a comprehensive need's assessment and, this then feeds into the pathway plan.
- The main changes are that this plan is centred on what independence skills the young person needs to work on and this would include practical issues as well as post 16/18 education, training, employment, accommodation, and mental and physical health and well-being issues that may need additional support.
- Where possible the needs assessment and pathway plan should be completed alongside the young person as a joint endeavour.

At 16 years old

- A Personal Advisor (PA) is allocated from The Leaving care team to co-work with the allocated social worker until the young person is 18.
- Introductions take place and a working relationship is built up with the young person.
- The PA's role is to advise of mainstream care leavers accommodation options and to assist the allocated social worker to formulate a post 18 plan with the young person and to advise of their entitlements as a care leaver.
- If the Transitions team are involved, then they become the primary team.
- The PA's role is to advise of the young person's entitlements as a care leaver and ensure they are provided to them.

SEND

From 14 years old

- (Year 9) onwards, Preparation for Adulthood should be embedded in the Education, Health and Care Plan to ensure that employability, independent living, being in good health and having social opportunities & experiences are planned for and supported.
- Every effort should be made to combine EHCP reviews with other statutory reviews such as CIN, LAC.
- There should be an annual review of the young person's EHCP, which they should be encouraged to attend, to ensure this is brought up to date and to establish SMART outcomes for the year ahead.

At 18 years old

- (after Year 13) when compulsory school age expires learners should be progressing away from supported educational provision and into further mainstream learning, employment or training whichever is preferred and attainable for the individual.

From 18 years old +

- if the young person is not making progress in their educational achievements, then it is very likely that the EHCP will not continue.
- EHCPs cannot be maintained unless the young person is attending an Ofsted registered educational placement or a training provider.

MCA/DoLS (Mental Capacity Act/Deprivation of Liberty)

At 15 years old 9 months

- A formal mental capacity assessment should be undertaken to include residence and/or tenancy, care, finances and contact (if applicable).
- If a child is in foster care/residential care/own tenancy/accessing respite - A Court of Protection (COP) application should be submitted if they are deemed to lack capacity and meet the acid test (*Is the person subject to continuous supervision and control? And Is the person free to leave*?). The care plan should clearly outline the arrangements at each placement.

At 17 years old

- A COP review will be required once instructed by the Court of Protection. Legal Services will notify the allocated worker when this is due.

At 18 years old

- The adult social worker will submit the adults care and support plan with a COP24 witness statement to the Court of Protection. **Adult Services will become responsible**.

Initial COP Application (Court of Protection)

Initial COP application requires the following to be completed:-

- ☐ **MCA 1** – contact and finances should be done in separate MCAs from residence/tenancy/respite/contact and care.
- ☐ **MCA 2** - contact and finances should be done in separate MCAs from residence/tenancy/respite/contact and care.
- ☐ **Confirmation of Diagnosis** – Available via Legal Services (GP must provide information).
- ☐ **COP 3** – Available via www.gov.uk/government/collections/court-of-protection-forms
- ☐ **COPDOL10** – Available via www.gov.uk/government/collections/court-of-protection-forms
- ☐ **Care Plan** – dated within 3 months.
- ☐ **COP24** – This should be completed by the young person's Rule 1.2 representative (only if someone is acting in this role i.e. parent/family member). Available via www.gov.uk/government/collections/court-of-protection-forms

A copy of the most recent capacity note can be found here

Please note: Individual workers should liaise/consult with legal services regarding the COP documentation required.

COP Review

A COP review will need to be submitted to legal services **2 months prior to the expiry date** of the existing court order.

The following will be required: -

- ☐ **Review of Decision (COP 3)** – Available via Legal Services.
- ☐ **Review of Decision (Confirmation of Diagnosis)** – Available via Legal Services.
- ☐ **Review of Decision (MCA 2)** – Available via Legal Services.
- ☐ **COPDOL11** - Available via www.gov.uk/government/collections/court-of-protection-forms
- ☐ **Care Plan** – dated within 3 months.

Please note: Individual workers should liaise/consult with legal services regarding the COP documentation required.

Finances (Cared for Children and Young People)

At 15 years 9 months old – 16 years old

- A young person should have a bank account in their own name.
- If a foster carer has previously been an appointee for the child/young person for the purposes of payment of DLA (Disability Living Allowance) whilst they were under the age of 16, the foster carer should now contact DWP and provide a bank account in the name of the young person for PIP to be paid directly into.
- If we have concerns around a young person's capacity to manage their own finances, their social worker should be assessing their capacity at 15 years old 9 months to determine, if and/or what arrangements needs to be put in place to support with financial management of their monies. Any imposed limitations on the ability to manage finances must be taken within the principles of the Mental Capacity Act.

Prior to 18 years old (17 years 6 months)

- A young person should be referred to the Financial Protection Team for Appointeeship (if appropriate) i.e., young people in foster care/residential care.
- The Financial Protection Team can be contacted directly on CR Financial Protection Team FinancialProtectionTeam@Gateshead.Gov.UK (workers should save this form so that they can use it for any other future applications they may have) for their referral paperwork.
- An MCA 1 around finances will be required as evidence. It takes on average 6 months to process the referral and Appointeeship to be in place so a referral should be made in a timely manner to allow this to be in place for the young person's 18th birthday.
- The financial protection Team will complete the benefits applications but there will need to be joint working on the completion of ESA/PIP/Work capability forms for DWP – the appointee team will not have day to day involvement or details on someone's disability so they will invariably need input from the workers who know that detail and to ensure a successful claim.

Accommodation

At 14 years old+

- A young person should be supported to complete a 'My Home Form' if the local authority is aware that there will be an accommodation need post 18 for those young people who are likely to or do have eligible needs under the Care Act 2014 (i.e. currently placed in residential care/hospital)
- This will help to plan, build, and procure for future provision.
- The allocated children's worker should facilitate discussions with the young person around their future accommodation needs/wishes i.e. would they like to live with friends in shared accommodation with support, in a family setting (shared lives), live on their own with support from a staff team etc.
- The form should be completed in consultation with people who know the child well, this should include their parents/carers, school and any other professionals supporting the child and their family. This task is often best completed in a care team meeting so that it contains the views of all the people who know the child well.
- The 'My Home Form' should be sent to ascadmin@gateshead.gov.uk and Joanne Waters should be cc'd into this email so it can be processed. Initial discussions around referrals with Joanne Waters (Accommodation and Support Lead, Commissioning) are welcomed.

Between 16 – 18 years old

- The allocated worker should liaise directly with Joanne Waters around suitable accommodation options if the YP needs to move prior to 18 years old.

At 18 years old

- Accommodation needs will be visited/re-visited by adult services and accommodation support provided.
- The allocated transitions worker will liaise with the Accommodation and Support Group around suitable accommodation options and complete all relevant tasks associated with this.

The Growing Healthy Gateshead 0-19 Healthy Child Programme

The Growing Healthy Gateshead 0-19 service is an integrated service for families, expectant mothers, children and young people that offers interventions from the pre-natal stage up to the age of 19.

The Harrogate and District NHS Foundation Trust (HDFT) leads on the delivery of this service, with a focus on working across services and organisational boundaries to improve public health outcomes.
See: https://www.hdft.nhs.uk/services/childrens-services/growing-healthy-gateshead/

5-19 School Nursing Team

The school nursing team work with children, young people and families to empower and enable them to make informed decisions about health, and to support them in transitioning safely and happily into adult life. The 5-19 Service works in community settings to deliver universal and targeted interventions designed to meet public health outcomes. They ensure the emotional and physical health and wellbeing of families, children, and young people across Gateshead. The team includes School Nurses, School Staff Nurse, Screeners, and an emotional and wellbeing resilience nurse.

The School Nursing team provides a service to all children and young people of school age, and their families, whether they are attending school. They offer advice and information and assess health needs

on children entering school and on transfer to secondary schools. They are the first point of contact for schools when there are concerns about a child's health and wellbeing.

They are also responsible for:

- Measuring and weighing children in reception and year 6 as part of the National Child Measurement Programme.
- Providing enuresis (involuntary urination) advice and support.
- Providing emotional health and wellbeing support.
- Supporting children and families with additional health needs or disability.
- Parenting and behavioural problems.
- Risk taking behaviour including drugs and alcohol.
- Stopping smoking.
- Relationships, sexual health & pregnancy.
- Promoting healthy lifestyles in schools and communities through health education.
- Support for children and Young People who are Looked After.
- Safeguarding of children and Young People.

School Nursing Team work closely with Health Visitors so that children and families with complex health and social care needs are identified early. They support the development and implementation of health management plans to promote the child's health and wellbeing, school attendance, education and attainment.

Health/Transitions Group

This group meets *quarterly* and includes professionals for a wide range of health services, adult social care services and children's services.

From 17 years old

- The Health/Local Authority Transitions Group has been formed to ensure that Transitions within health care services for those who are 17 ½ yrs. old are seamless.
- A young person can be brought to the group by the designated children's team manager at 17 years old for discussion if appropriate (i.e. young people with complex needs/ LD screening).

At 17 ½ years old+

- The Transitions worker will complete a transitions care plan (group document) to refer a young person for discussion at the Health/Transitions Group) if they have health needs post 18.
- The group will then decide if a referral to the Community Learning Disability team is required or signpost where appropriate.
- The care of the young person remains the responsibility of CYPS until the person is 18yrs old, therefore any crisis support required whilst the young person is in transition, will be supported by CYPS services and their outreach team.
- The allocated social worker/s for the young person will be contacted following the meeting with feedback regarding the discussion had and any actions which have been agreed or are required.

Children's Continuing Care

A continuing care package will be required when a child or young person has needs arising from disability, accident or illness that cannot be met by existing universal or specialist services alone.

Diagnosis of a disease or condition is not in itself a determinant of a need for continuing care. A child or young person may have a rare condition which is difficult to diagnose but will still have support needs.

There should be no differentiation based on whether the health need is physical, neurological, or psychological.

The continuing care process should be (and be seen to be) fair, consistent, transparent, culturally sensitive, and non-discriminatory. Some children and young people (up to their 18th birthday) may have very complex health needs. These may be the result of congenital conditions, long-term or life-limiting or life-threatening conditions, disability, or the after-effects of serious illness or injury.

These needs may be so complex, that they cannot be met by the services which are routinely available from GP practices, hospitals or in the community commissioned by clinical commissioning groups (CCGs) or NHS England. A package of additional health support may be needed. This additional package of care has come to be known as continuing care.

- If a child has an unmet health need, the allocated social worker will complete a CCG referral and submit along with consent form (must be signed/completed by parents/carers), the Child in Need Assessment, EHCP and any other relevant documentation.
- Once a referral is received a pre assessment checklist is complete by a Nurse Assessor. If a decision is made to progress to full assessment a Decision Support Tool (DST) meeting will be arranged within 6 weeks. The Decision Support Tool meeting is where all the information from the completed assessments is gathered and allows for discussion regarding support services that may be required.
- Once a proposed Health and Social Care Plan is created, the allocated social worker takes the proposed plan to either High Care Needs Panel (If package cost is over £20,000) or Children with Disabilities Team Resource Panel (If package cost is below £20,000). Once internal authorisation is agreed, the plan is heard at CCG panel and signed off by the Health Director.
- Reviews are completed at 3 months and a minimum of six monthly thereafter. From age 14+ preparation for adulthood discussions will begin.

At 14 years

- the young person should be brought to the attention of the CCG as likely needing an assessment for NHS Continuing Healthcare.
- All children who are age 14 years plus are highlighted and discussed at the children's continuing care panel meeting which is represent by the CCG, social care and education.
- This is held on a monthly basis.

From the age of 14 years..

- all Children's Continuing Care annual reviews to be aligned with EHCP review.

At 17..

- CCC team to ensure that the social worker has submitted a checklist to the CHC team.
- All children who are aged 17 years are discussed at the Children's Continuing Care meeting which is held monthly.
- Packages of care for these children are discussed and the funding agreed in principle.

At 18 years..

- full transition to adult NHS Continuing Healthcare or to universal and specialist health services should have been made

See: CCC Flowchart

Children's Continuing Care and the CHC team will meet up monthly to identify young people from the age of 14 who are potentially eligible for NHS Continuing Healthcare. Support plans will be discussed which will include the levels of support the young person requires and the associated costs for this support. This will ensure that the transition from Children's Continuing care to NHS Continuing Care is as smooth as possible.

NHS Continuing Health Care

There are significant differences between children and young people's continuing care and NHS Continuing Healthcare for adults. Although a child or young person may be in receipt of a package of continuing care, they may not be eligible for NHS Continuing Healthcare or NHS-funded Nursing Care once they turn 18.

If a child is receiving CCG funding, the case will be reviewed regularly within CCG panel and transition planning tracked and discussed.

Any child who has complex health needs and is likely to meet CHC criteria at 18 years old will be highlighted and case discussions can begin with CHC manager at the earliest opportunity to ensure smooth transition planning which may include care planning prior to a child reaching 18 years old. This is particularly relevant for Cared for Children and Young People and complex CIN cases.

At 14 years old

- Year 9 EHCP meeting is combined with Child in Need (CIN) Review where possible.
- At the CIN Review (14 years old) consideration should be given to whether the young person may be eligible for CHC when an adult.
- The Continuing Healthcare Checklist is the best tool to use to consider potential CHC eligibility. If it is considered that the child may be eligible then the relevant CCG should be notified.
- The allocated children's worker informs the Team Manager and Business Support, and a letter is generated to the CCG to inform them of this.
- The Transitions Team can be contacted for general information and advice regarding the completion of checklists if appropriate.

Between 16 and 17 years old

- at the Review (CiN/LAC) the CHC Checklist should be completed, gathering views and information from all relevant parties involved in the young person's care.
- If the checklist determines the young person is eligible for a CHC assessment a copy should be sent to the relevant CCG

As soon as practically possible after the young person's 17th birthday the CCG should arrange an MDT to determine eligibility in principle

At 17 years old

- A screening for CHC should be undertaken and submitted when a child reaches 17 years 5 months using the adult screening tool (CHC checklist), and an agreement in principle that the young person has a primary health need and is therefore likely to need Continuing Healthcare.
- The allocated children's worker should complete the CHC checklist tool and submit this to ngccg.continuinghealthcare@nhs.net.
- A transitions worker will still be allocated and remain involved pending CHC decisions.
- The transitions worker will attend the DST meeting along with the allocated children's worker.
- The transitions worker should take the lead from an adult social care perspective as this is an 'adults process'.
- The children's worker will attend and provide information on the child's needs.
- The transitions worker will be jointly responsible with the nurse assessor for scoring the different domains as part of the DST.
- If the decision is made that the young person becomes CHC funded, a case manager from the CCG should be allocated as the Care Coordinator following this agreement.
- The transitions worker will remain involved for advice and information purposes only.
- The outcome of the DST meeting needs to be communicated to all members of the care team, the financial protection team and recorded clearly on the young person's file.
- The financial protection team will not be responsible for the management of a person's finances who is open to the CHC Service (Pamela Richardson and Neil Blue are in discussion with the DWP about guidance around who can make applications for young people who meet the CHC criteria).

- Within 14 days of the Panel decision of the DST/MDT meeting, a care planning meeting is to be held with young person, family, CWDT/LAC social worker, Transitions worker, commissioning and CHC Case Manager where a plan post 18 is devised and costings worked out.
- The Child's current plan is used as a starting point of planning and Adult provisions discussed. The devised plan is then to be heard at the next scheduled CCG panel where funding should be approved for adult provision.

- Where it is disputed that the outcome of a CHC/MDT is not a Primary Healthcare Need then the transitions worker should initially discuss this with their own supervisor, then complete a "rational" with the reasons why they think the person does have a Primary Healthcare Needs then forward this to CWL ASC Admin (CWL ASC Admin ASCAdmin@Gateshead.Gov.UK).

- If requesting shared funding consideration, then the transitions worker should discuss this with their own supervisor if they are not clear what elements are health needs. The transitions worker should complete shared funding form (please do not put levels of the DST) however it should be evidenced what you think are health needs.

- The worker must identify in terms of hours what the health needs are (e.g., morning visit for 1 hour to assist dress/breakfast/medication (health need 15 mins for medication) x 7 days = 1hr 45 mins = (multiply by 1.75 x £16.52 hourly rate) = £28.91 x (52 weeks) = £1503.32). This needs to be completed within 2 weeks from the panel date.

At 18 years old

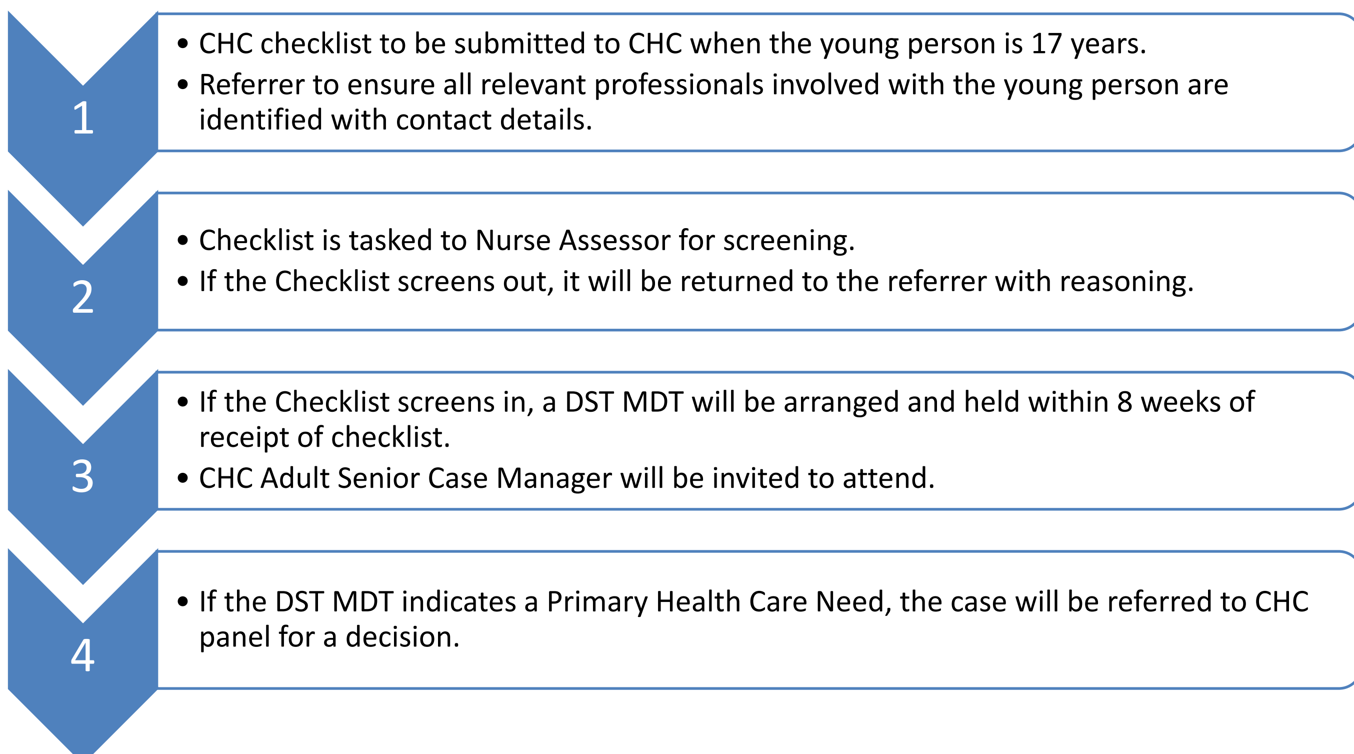
- A full transition to adult Continuing Healthcare or to universal and specialist health services should have been made, except in instances where this is not appropriate.
- If the young person becomes CHC funded, they will not be open to the Transitions Team or Adult Social Care post 18.
- The CCG should become the responsible case manager and funding authority and will receive a case handover from the allocated children's social worker who will close the case at the child's 18th birthday but can be contacted for advice for a period following case handover.

Transition protocol for young people moving from Children Services to NHS Continuing Healthcare

Newcastle Gateshead Continuing Healthcare Team aim to achieve the best outcomes for young people transitioning into our service. The purpose of this protocol is to ensure a safe and effective transfer from Children's Services to Continuing Healthcare for young people currently in receipt of services through Children's Social Care and/or Children's Continuing Care.

We will strive to ensure we are well informed and well prepared to meet the needs of young people. CHC monthly attendance at Gateshead and Newcastle's Children's Continuing Care Panel will ensure young people from the age of 14 who are potentially eligible for adult NHS Continuing Healthcare, are identified and transition plans identified, including the agreement of high levels of support and related costs being commissioned in time to ensure a seamless transition into CHC.

Process for transfer to the CHC Case Management Team



See: CHC and Transition Team Process and Procedure

Case Management and Local Authority responsibilities during transition

Following Panel decision, the allocated CHC Case Manager will contact the Local Authority allocated worker to agree a plan of introduction to the young person and their care givers.

The Local Authority allocated worker will provide information about the young person such as:

- Agreed Educational Plans
- Current Care and Support Plan
- Accommodation needs including Housing Applications / Adaptations / OT / Physio
- Safeguarding Concerns
- Behaviour Support Plans
- Health Treatment Plans
- Financial Planning including Benefit Applications / Appointeeship
- Legal Documentation including MCA, DoLS/LPS, Care Orders, MHA Assessments
- Clarify Court of Protection Work

The Local Authority allocated worker is responsible for co-ordinating support and planning until the young person is 18. The young person will transfer to Continuing Health Care services on their 18th birthday. This includes financial responsibility for the young person's support package and placement. During the transfer period the Local Authority allocated worker will invite CHC Case Manager to all meetings to ensure they can participate in planning discussions with all relevant professionals and care givers.

Commissioning

CHC Case Managers will check what costs of care have been agreed at Children's CCC Panel.
CHC Case Manager and allocated Local Authority worker will collaborate to review the on-going appropriateness of the current service and plan for post 18 support, according to individual assessed need.
CHC Case Manager will follow CCG process for cost approval.

Finance

The Local Authority Social Worker will ensure that the young person has been supported to apply for benefits prior to their 18th birthday. The Local Authority will ensure that an Appointee has been considered where appropriate.

Mental Capacity Act

Up until the young person's 18th birthday, the Local Authority allocated worker is responsible for undertaking Mental Capacity Assessments in preparation for adulthood, such as decisions around finance, contact with others, care, support, and residence.
Should a young person living in a care setting or their own home or be potentially deprived of their liberty this should be identified prior to their 16th birthday. An application should be made to the Court of Protection by the Local Authority.
If a change is being made to a young person's support during their transition, such as a change of residence, which would constitute a deprivation of liberty, the Local Authority is responsible up until a young person's 18th birthday to make an application to the Court of Protection for the plan to be authorised.

Section 117 Aftercare

If a child or young person has been detained on Section 3 of the Mental Health Act, they are eligible for section 117 aftercare. This is a statutory duty, from the Mental Health Act, that the local authority and the clinical commissioning group must ensure they provide the necessary support to ensure they reduce the likelihood of readmission to hospital. The aim of section 117 aftercare is also to support the young person to recover and reduce dependency on services. See link for more details of this legislation: www.legislation.gov.uk/ukpga/1983/20/section/117

Section 117 aftercare can come in many forms. It can be the young person's care coordinator in CYPS (which the CCG fund in their health contracts) or, for those with greater needs, it can be commissioned home support or therapeutic placements.

When commissioned services are needed the local authority are the lead commissioner for this and the CCG are the funding partner. The CCG is alerted of all admissions into Ferndene and can be available to offer support. All commissioned services are funded 50:50 in s117 and the CCG sign their side off in the Children's Continuing Care (CCC) panel. Please ensure the CCG (see below contacts) are involved in the planning of services for discharge

If a child or young person has CCC shared funding prior to the detention in hospital. The CCC funding will stop at the point of admission and s117 aftercare funding will take over from discharge.

If a child or young person is fully CCC funded prior to detention, then some specialist discussions will need to be had as soon as possible to support the discharge planning.

For those children and young people with learning disabilities and/or autism please contact Rachel Lucas and for those with mental illness / or trauma presentations please contact Erin Harvey.

For any general s117 funding stream queries please contact Erin Harvey.
erin.harvey1@nhs.net
rachel.lucas1@nhs.net

Transitional Safeguarding

Transitional safeguarding is about recognising that the needs of young people do not change or stop when they reach 18, although the laws and services supporting them often do. It is about making sure they have the help they need to keep themselves safe and as independent as possible.

See: Transitional Safeguarding 7-minute briefing

Glossary of terms

CCC	• Children's Continuing Care
CHC	• Continuing Health Care
CCG	• Clinical Commissioning Group
CIN	• Child in Need
COP	• Court of Protection
CYPS	• Children & Young People's Service
DST	• Decision Support Tool
EHCP	• Education Health Care Plan
MCA	• Mental Capacity Assessment
MDT	• Multi Disciplinary Team

Authors

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