Darlington Borough Council

Guidance to staff on the Transitions pathway (School Year 7 onwards) from Children’s Social Care to Adulthood.

**Who does this apply?**

This policy and guidance relates to young people in Darlington who have special educational needs or a disability. They must be active to Children’s Social Care and may also have an EHC (Education Health and Care) Plan or other SEND (Special, Educational Needs and Disability) involvement. This process does NOT apply to those who do not have active Social Care involvement. (I.e. those with a disability without Social Care but with SEND involvement).

This guidance aims to assist the process of transitions, helping workers to enable the young person and their carer to have a smooth and clear transition plan into adulthood; it enables those young people with likely needs as an adult, to be identified and discussed with adult social care at an appropriate time. For those who are unlikely to meet the eligibility criteria for Adults, this will allows Children’s Social Care and SEND to plan an appropriate transition to adulthood.

Early identification of likely levels of need will assist in ensuring the use of the progression model, identifying strengths to maximise independence into adulthood.

**Who should be aware of this guidance?**

This is applicable to staff working with children under 18’s in The Life Stages Service (Disabled Children and Young Adult’s Team), Looked after through Care Team (LATC), Assessment and Safeguarding teams A-D and those working in SEND. This is applicable to staff in all adult teams who may work with an individual, either to undertake transitional work or casework with a young adult post 18 years of age. This guidance will apply until the age of 25 where a young person is a care leaver or there is still active SEND involvement.

*“The Care Act 2014 and the associated regulations and guidance set out the requirements on local authorities when young people are approaching, or turn 18 and are likely to require an assessment for Adult care and support.*

*The transitions from children’s to adult’s services needs to be well managed and should take place at a time that is appropriate for the individual. This is particularly important when young people’s assessed needs do not meet eligibility criteria for adult’s services.*

*Young people and their families should not be expected to repeatedly provide duplicate information to different service, or to attend numerous reviews, or receive support that is not coordinated and joined up. There should be clear and joined up decision making processes and lines of accountability for considering when the transitions to adult services should take place and ensuring children’s services continue to be in place for as long as required.”*

*Special education needs and disability code of practice 0 to 25 years. DFE, Jan 2015.*

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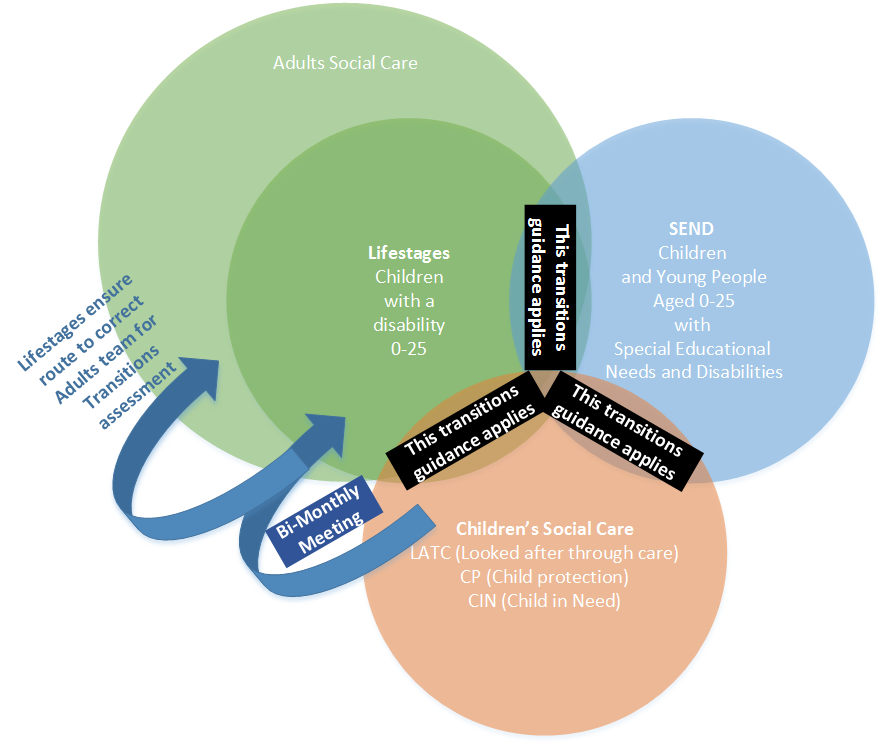


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# Legislation

This guidance should be read in conjunction with all SEND and Social Care legislation, however some of the more relevant legislation has been listed below for easy reference:

Children and Families Act 2014

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

Care and Support Statutory Guidance

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

Special Educational Needs and disability (SEND) code of practice

<https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/398815/SEND_Code_of_Practice_January_2015.pdf>

The Children Act 1989 guidance and regulations

<https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/397649/CA1989_Transitions_guidance.pdf>

Education Health & Social Care SEND code of practice

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

The Care Act 2014

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

Children & social work act

<http://www.legislation.gov.uk/ukpga/2017/16/contents/enacted>

Children & families act 2014

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

Working together 2015

<https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/592101/Working_Together_to_Safeguard_Children_20170213.pdf>

Local Darlington procedures and guidance can be found at:

[*http://www.proceduresonline.com/darlington/cs/chapters/p\_leaving\_care.html*](http://www.proceduresonline.com/darlington/cs/chapters/p_leaving_care.html)

Children and Young People Aged 0-25 with Special Educational Needs and Disability

[*http://www.proceduresonline.com/darlington/cs/chapters/p\_child\_disability.html*](http://www.proceduresonline.com/darlington/cs/chapters/p_child_disability.html)

Children (Leaving Care) Act 2000

<http://www.legislation.gov.uk/ukpga/2000/35/contents>

# When does the transitions process begin?

There are a number of points in life which will be considered a transition, however for the purposes of this document “transition” is used to describe the life stage of moving from being a child to being an adult.

* **Transition planning in Darlington will begin in year 7 (or as soon as possible for those who become known to social care after this point).**
* **Placement changes (Education or Social Care) would require realignment of meeting cycles to ensure joint working.**
* **The realignment of meetings should be focused around the EHC plan and meeting which is at least annually.**
* **If there is any joint funding or likelihood of joint Health funding please see the additional guidance in section 14.**

The EHC plan brings together the outcomes for Education, Health and Social care into one plan, for the young person. This ensures coordination and collaborative working across all parties. This should be used as an opportunity to align meetings across all internal and external agencies, to avoid duplication.

SEND and Social Care Guidance states that the EHC Plan:

*16.11 For young people with special educational needs (SEND) who have an Education, Health and Care (EHC) plan under the Children and Families Act, preparation for adulthood must begin from year 9 - see Special Educational needs & Disability (SEND) Code of Practice ‘Preparing for Adulthood’ . The transition assessment should be undertaken as part of one of the annual statutory reviews of the EHC plan, and should inform a plan for the transition from children’s to adult care and support.*

*16.12 Equally for those without EHC plans, early conversations with local authorities on preparation for adulthood are beneficial – when these conversations begin to take place will depend on individual circumstances. For care leavers, local authorities should consider using the statutory Pathway Planning process as the opportunity to carry out a transition assessment where appropriate.*

[Care and support statutory guidance](https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance).

**Years 7-11**

Between years 7 and 11 key meetings should be aligned where possible, preferably around the EHC plan meeting at least annually.

**Year 11 (and those leaving any educational setting including sixth form)**

At year 11 (or when they are school leaver) they will have an EHC plan, detailing their on-going needs including transition, finalised and issued by March 31st. This details the further education plan, including the named providers. Changes in SEND funding from 2018 onwards now mean that DBC will be funding educational placements from a set budget. It is important that Social Care and SEND work closely together to ensure that the placement maximises the young person’s independence, is cost effective (for both budgets) and reduces future demand.

Refer those young people, with a “likely needs” as an adult, to the bi-monthly Transition to Adult Social Care (TASC) Forum meeting following this point [(go to section 3](#_Identifying_those_with)).

**Year 11 to 25 years of Aged (for Looked After Children only)**

For young people who are looked after, between the ages of 15¾ and 16¼ the Pathway Plan Part 1 must commence (Year 11). Following this plan a personal advisor will usually be identified and will work with the young person depending on their wishes up until the age of 25. They will offer advice and support around accommodation, education and financial affairs.

This will normally happen as part of the joint aligned EHC/Year 11 review. At this point individuals should move from a care plan to a pathway plan. At this meeting it should be considered if they are likely to have needs for support beyond 18 years of age.

Responsibility for opening the pathway plan on Children’s Liquidlogic will be the allocated Social Worker and once produced should be presented to the IRO (Independent Reviewing Officer) at the next LAC review. The IRO will record in Recommendations and Decision in the Looked after review that this has commenced.

In mainstream Children’s services the responsibility for maintaining this plan is the Social Worker’s until the individual is 18 year of age. Within the Life Stages Service, this plan will continue to be maintained by the allocated worker if they have continuing needs into adulthood.

Those individuals who do not have the appearance of eligible social care needs, but who meet the criteria of a former looked after child will continue to be supported by the Looked After Through Care (LATC) Team up until the age of 25. If there an EHC plan, then the LATC worker should continue to contribute to this.

If an individual is not eligible under the Care Act 2014, the worker conducting the transition assessment will close the case on Adults liquidlogic. If they meet the criteria as a former looked after child then responsibility for the young person and continued support post 18 will remain with the LATC team who record on Children’s liquidlogic.

**Closing the child off as a Looked After Child**

At a minimum of 15 days before the child’s 18th birthday, a final LAC Review must take place. On their 18th birthday, the allocated social worker must end the child as being looked after as the Children Act (1989) no longer applies, and the child ceases to become looked after. End the allocated social worker’s involvement, and re-assign to the LATC worker as the allocated case worker. Ensure there is a case note added in Adult’s Liquidlogic that clearly states the child has been ended as looked after, and who the new allocated case worker is within the LATC Team.

# Identifying those with likely needs as an adult.

## The process for their transition to adulthood.

A bi monthly Transitions to Adult Social Care Forum (TASC Forum) is held (see Appendix A for the terms of reference). Any young person with ‘likely needs’ as an adult should be referred to this meeting and this should be done in school year 11 aged 15 1/2, or at the very latest, following the young person’s 16th birthday (or as soon as possible after this point for individuals who become known to Social Care after this point).

For these individuals the aim of this meeting is to discuss and plan for those with likely needs as an adult, with adult social care and for their assessment and support plan to be developed at an appropriate time. For those who are unlikely to meet the eligibility criteria for Adults, this will allows Children’s Social Care and SEND to plan an appropriate transition to adulthood.

Workers will need to gain consent to share information with adult services colleagues.

## The process for transitioning at the end of an educational placement.

For individuals who continue to access education following their 18th Birthday another referral should be made to the TASC forum as soon as the allocated worker is aware that an educational placement is planned to, or is likely to end. This will enable their review / reassessment to be planned to ensure their needs are met following this change.

## When and how to share information between Children and Adult Social Care.

If the young person has the appearance of likely needs and are not known to the Life Stages Service, the individual needs to be discussed at the bi-monthly TASC forum to consider if a referral to Adult Social Care for a transitions assessment would be of significant benefit. For further information about this meeting, please see the terms of reference Appendix A.

**Steps to take:-**

* The Young Person’s Social Worker will gain appropriate **consent** from the individual and person with parental responsibility. Two aspects are required – the consent to discuss with Adult Social Care (ASC and consent to refer for a Transitions Assessment, should it be deemed appropriate).
* The Young Person’s Social Worker will Complete and submit the bi-monthly TASC Forum **referral form** to get the case on the agenda form. Appendix 1 in Appendix A – This document should also be available on Liquid Logic Childrens.
  + NB. In addition it should be noted if there are unpaid adult carer(s), or young carer(s) where there may also be a duty to conduct a transitions assessment. These should be referred at the same time, there is space on the form for this information.
* Forward the referral form to Life Stage Service 0-25 team email : [LifeStages0-25Team@darlington.gov.uk](mailto:LifeStages0-25Team@darlington.gov.uk)
* Record that you have sent the form as a case note on Children’s liquidlogic under “Transitions Planning”.
* This will then be added to the next bi-monthly meeting agenda
* The Young Person’s allocated worker will be sent an invitation via outlook as a meeting request. If the allocated worker is unable to attend, an appropriately briefed substitute should attend.

**Care Act Advocacy**

Under the Care Act 2014 if an individual has substantial difficulty in being involved in decisions around their care and support then an advocate should be sought. If there is not an appropriate person to support them an independent advocate must be appointed. This needs to be an advocate who has been trained as a Care Act Advocate. The Local Authority has commissioned Care Act Advocates who can fulfil this role. N.B this is different to other advocates.

**Additional Notes:-**

Consideration should be made to the relevance of Ordinary residence (See chapter 19 of the Care Act Guidance see link in chapter 1) for individuals living outside Darlington who may need to be referred to the Adult Services Team within the area in which area they will be Ordinary Resident. For those individuals it would be appropriate to contact the relevant local authority and obtain details of their transitions arrangements.

## What are the steps if the young person is NOT eligible for Adults Social Care

A young person, carer, or someone acting on their behalf, has the right to request a transition assessment. Such requests must be considered whether the likely need and significant benefit conditions apply – and if so a transition assessment must be undertaken.

If we think these conditions do not apply and we refuse an assessment on that basis, we must provide reasons for this in writing in a timely manner. This correspondence is undertaken by the chair of the Transition To Adult Social Care (TASC) Forum meeting. We also must provide information and advice on what can be done to prevent or delay the development of needs for support for the individual.

Should the worker not agree with the decision then they should discuss with their team manager who will decide if this should be escalated (See Appendix A, Transition to Adult Social Care Forum (TASC) Terms of Reference).

# Making the formal referral to commence Adults Assessment

The Social Worker responsible for the young person will need to formalise the request for the commencement of a transitions assessment at the appropriate time via Adults Social Care First point of contact team. Please contact 01325 406111.

Consent should have already been given by the individual to do this referral.

For those young people known to the Life Stages Service the responsible worker will initiate the LL contact prior to the commencement of the transitions assessment as agreed (see 3a).

# Features of a transitions assessment (adult social care applicable)

The transition assessment should support the young person and their family to plan for the future, by providing them with information about what they can expect. All transition assessments must include an assessment of:

* Current needs for care and support and how these impact on wellbeing.
* Whether the child or their carer is likely to have needs for care and support after the child in question becomes 18.
* If so, what those needs are likely to be, and which are likely to be eligible needs.
* The outcomes the young person or their carer wishes to achieve in day-to-day life and how care and support (and other matters) can contribute to achieving them.

# Cooperation between professionals and organisations

People with complex needs for care and support may have several professionals involved in their lives, and numerous assessments from multiple organisations. For children with special educational needs, the Children and Families Act 2014 brings these assessments together into a coordinated Education, Health and Care (EHC) Plan (see SEND Code of Practice, Chapter 9).

We must cooperate with relevant partners, and this duty is reciprocal. This includes an explicit requirement which states that children and adult services must cooperate for the purposes of transition to adult care and support. Often, staff working in children’s services, such as Social Workers or Personal Advisors will have built relationships and knowledge about the young person or carer in question over a number of years. As young people prepare for adulthood, children’s services and adults’ services should work together to pass on this knowledge and build new relationships in advance of transition. This person would be best placed to assist in coordinating meetings.

# Providing information and advice once a transition assessment is complete.

Having carried out a transition assessment, the allocated worker from Adult Social Care must give an indication of which needs are likely to be eligible needs (and which are not likely to be eligible) once the young person in question turns 18, to ensure that the young person or carer understands the care and support they are likely to receive and can plan accordingly.

This should include:

* The different systems for children’s and adult care and support mean that there will be circumstances in which needs that were being met by children’s services may not be eligible needs under the adult system.
* Signposting to relevant organisations or support available in the community.
* Adult care and support is also subject to means-testing and charging.
* For individuals who may be eligible, however their needs are not met by services commissioned by the Local Authority (and so will not be reviewed by Adult Social Care) are aware of how to re-refer if their circumstances change.
* Share the outcome of the assessment with relevant partners, with the individuals consent, including the EHC Plan.
* How to request an update to review their transitions plan, if their circumstances change.

# Provision of age appropriate local services and resources

The Care Act requires us to arrange preventative services, and to ensure a diverse range of quality providers of care and support in our local area. There are similar requirements in relation to the Local Offer in the Children and Families Act. In Darlington the People’s Information Point Acts as central hub to provide information and advice.

<https://darlington.fsd.org.uk/kb5/darlington/fsd/home.page>

# Combining EHC plans with care and support plans after the age of 18

Where young people aged 18 or over continue to have EHC plans under the Children and Families Act 2014, and they make the move to adult care and support, the care and support aspects of the EHC plan will be provided under the Care Act. The statutory care and support plan must form the basis of the ‘care’ element of the EHC plan.

# Continuity of care after the age of 18

Following the guidance will ensure that there is no gap in provision of care and support. However, if adult care and support is not in place on a young person’s 18th birthday, and they or their carer have been receiving services under children’s legislation, the local authority must continue providing services until the relevant steps have been taken, so that there is no gap in provision. The ‘relevant steps’ are if the local authority:

* Concludes that the person does not have needs for adult care and support
* Concludes that the person does have such needs and begins to meet some or all of them (the local authority will not always meet all of a person’s needs – certain needs are sometimes met by carers or other organisations).
* Concludes that the person does have such needs but decides they are not going to meet any of those needs (for instance, because their needs do not meet the eligibility criteria under the Care Act 2014).
* In the case of care leavers, under Staying Put, we may choose to extend foster placements beyond the age of 18. We have a Staying Put policy to ensure transition from care to independence and adulthood is similar for care leavers to that which most young people experience. Transition planning is based on need and not on age alone.
* For some people with complex SEND and care needs, we and partners may decide that children’s services are the best way to meet a person’s needs - even after they have turned 18. Both the Care Act 2014 and the Children and Families Act 2014 allow for this.
* The Children and Families Act enables us to continue children’s services beyond age 18 and up to 25 for young people with EHC plans if they need longer to complete or consolidate their education and training and achieve the outcomes set out in their plan. Under the Care Act 2014, if, having carried out a transition assessment, it is agreed that the best decision for the young person is to continue to receive children’s services, we may choose to do so. Children and adults’ services must work together, and any decision to continue children’s services after the child turns 18 will require agreement between children and adult services.

# Safeguarding after the age of 18

Where someone is over 18 but still receiving children’s services and a safeguarding issue is raised, the matter should be dealt with as a matter of course by the adult safeguarding team. Where appropriate, they should involve the local authority’s children’s safeguarding colleagues as well as any relevant partners (for example, police or NHS) or other persons relevant to the case. The same approach should apply for complaints or appeals, as well as where someone is moving to a different local authority area after receiving a transition assessment but before moving to adult care and support.

# Ordinary residence and transition to higher education

Where a young person is intending to move to a higher or further education institution which is out of the area where they were receiving children’s services, they will usually remain ordinarily resident in the area where their parents live or the local authority area which had responsibility for them as a child. However, this is not always the case. For more information see legislation (Chapter 1). The objective should be to ensure that there will be an appropriate package of care and support in place from the day the young person or carer starts at the institution. In many cases a young person or carer studying at university will have a dual location, for example coming home to stay with the parents during weekends or holidays. Where this is the case, local authorities must ensure their needs are met all year round.

As set out in the SEND code of practice, an EHC plan will cease if someone progresses to further or higher education, but a care and support plan is likely to be required thereafter.

# Transition from children’s to adult NHS Continuing Healthcare

Clinical Commissioning Groups (CCGs) should use the National Framework for NHS Continuing Healthcare and supporting guidance and tools (especially the Decision Support Tool) to determine what on-going care services people aged 18 years or over should receive. The framework sets out that CCGs should ensure that adult NHS continuing healthcare is appropriately represented at all transition planning meetings to do with individual young people whose needs suggest that there may be potential eligibility. CCGs and Local Authorities should have systems in place to ensure that appropriate referrals are made whenever either organisation is supporting a young person who, on reaching adulthood, may have a need for services from the other agency.

The framework sets out best practice for the timing of transition steps as follows:

* children’s services should identify young people with likely needs for NHS CHC and notify the relevant CCGs when such a young person turns 14
* there should be a formal referral for adult NHS CHC screening at 16
* there should be a decision in principle at 17 so that a package of care can be in place once the person turns 18 (or later if agreed more appropriate)

Where a young person has been receiving children’s continuing health care from a relevant CCG, it is likely that they will continue to be eligible for a package of adult NHS CHC when they reach the age of 18 years. Where their needs have changed, that they are assessed as no longer requiring such a package, they should be advised of their non-eligibility and of their right to request an independent review and mediation. The CCG should continue to participate in the transition process, in order to ensure an appropriate transfer of responsibilities, including consideration of whether they should be commissioning, funding or providing services towards a joint package of care.

As set out above, where it will benefit a young person with an EHC plan, local authorities have the power to continue to provide children’s services past a young person’s 18th birthday for as long as is deemed necessary. Where there is a change in CHC provision, this needs to be recorded in the young person’s EHC plan, where they have one, and advised of their rights to ask the local authority for mediation.

# s117

If an individuals has been detained under any section of the Mental Health Act 1983 then this should be noted on the referral form. If the individual is subject to S117 funding then confirmation should be sought from the responsible local authority and responsible health authority.

# Process Summary



