Buckinghamshire
Strengthening Transitions Arrangements
Multi-Agency Protocol Update
July 2015

Buckinghamshire's Multi-Agency Transition Protocol

Supporting Young People with Special Educational Needs and Disabilities from Aged 14 (year 9) Into Adulthood

Contents

Introduction

In November 2014, the Buckinghamshire Strengthening Transition Arrangement Board tasked a Task and Finish group to refresh and update the Buckinghamshire Transition Protocol in light of the various legislative changes, which had come into effect since the sign off the previous protocol. This group was set up and consisted of the following agencies:

- Connexions
- Children and Young People's Commissioning
- Children's Social Care
- Adult Mental Health Services
- Child and Adolescent Mental Health service
- Buckinghamshire Continuing Care
- Adult Learning Disability Service

Further feedback and information was given by the following:

- Special Educational Needs Team
- Children in Need
- Children in Care
- Safeguarding Children and Adults

Authorisation and Endorsements of the Transitions Protocol

The protocol was authorised by**:**

- Children Joint Executive Team 23rd July 2015
- Adult Joint Executive Team 25th March 2015

This protocol is a reference for professionals outlining the vision, values, principles, roles and responsibilities of the agencies involved in the transitions and planning process for young people with special educational needs and disability (SEND) young people living in Buckinghamshire.

The protocol and transitions pathway requires support at strategic, management and operational levels to be effective and to ensure that we support young people in Buckinghamshire with the best possible start to adulthood.

By signing this document, the agencies below consent and give their commitment to implement this protocol and pathway.

David Johnson Strategic Director Children and Young People Buckinghamshire County Council	Trevor Boyd Strategic Director Adults & Family Wellbeing Buckinghamshire County Council
Aylesbury Clinical Commissioning Group	Chiltern Clinical Commissioning Group
Bucks Healthcare Trust (BHT)	Oxford Health (Mental Health, CAMHS and SALT)
Southern Health Foundation Trust (SHFT) Learning Disabilities	Connexions
NHS Arden (Continuing Care /Continuing Healthcare)	FACT Bucks

Transition Protocol

Transition is a time of change and challenges. Young people and parents/carers may be unsure about what to expect and what help may be available in order to plan for the future. There may be uncertainty about the roles of different agencies and the support that can be received. It is important that we actively engage these young people and parents/carers in the planning, design, implementation and evaluation of transition services.

We have agreed to use the social model where possible and within the law. This involves challenging practices and any social factors and attitudes that create barriers and deny opportunities for disabled children and young people. It also aims to remove barriers that exist and improve opportunities.

Children First

- We believe that disabled children are children first and that they should be entitled to the same services as other children. All services should be designed so disabled children can lead as normal a life as possible.

Becoming an Adult

- All people, whether disabled or not, legally become adults at the age of 18. It is important that we recognise and reinforce a young disabled person's adult status. However, individuals mature at different rates and have different abilities.

- As a result, the availability of continued support and guidance to help the person enforce their rights is important. Some family carers may also need support when the young person reaches 16, including their role in protecting or supporting young adults and the possible change in the parent and child relationship. This change in status does not mean service providers no longer have a duty of care.

Purpose

The Buckinghamshire Strengthening Transitions Arrangements Programme Board has developed this protocol in order to:

- Set out the roles and responsibilities agencies/departments and representatives involved in the transition planning process
- Make clear our commitment to ensure that disabled young people with complicated needs receive appropriate co-ordinated support to help them move from adolescence to adulthood
- Set out who will provide this co–ordination
- Set out outcomes, performance measures and standards to be achieved which closely align with national policy set out in the Children and Families Act/Care Act
- Set up an effective planning and review process;
- Clarify which young people we should offer support to through the planning process
- Include, where appropriate, the process in schools with the move from children's to adult's services
- Provide guidance on both practice and process for all professionals involved in the planning process

Aims

This protocol sets out to provide the professionals with information about:

- What should happen
- When it should happen
- Who should take responsibility
- How partners should work together to ensure a seamless transition

The above is essential to ensure that the transition process benefits young people with Special Educational Needs, disabled young people and involves their parents/carers.

Scope

The protocol will apply to those vulnerable young people who have:

- A statement of Special Educational Need or an Education, Health and Care Plan where there is a legal requirement for them to have transition reviews.

The protocol will also apply to those vulnerable young people identified below where the professionals involved agree that formal planning will be helpful to the young person. This includes those:

- with learning difficulties and/or disabilities
- complex or long-term physical health needs
- mental health difficulties
- alcohol or substance misuse
- significant sensory needs
- 'looked after' by Buckinghamshire County Council or care leavers

The transition being discussed will include the transition from the following:

- Children to Adult Social Care now known as Communities, Health and Social Care
- School to College
- Children services to adult mental health and Learning disability services
- Children's Continuing Care to Adult Continuing Healthcare
- Children's Services to Adult Continuing Healthcare

Out of Scope

The following transition will not be part of this Protocol:

- Primary Care
- Acute settings

This protocol is aimed at Professionals, not young people and their families.
For information for young people and their families, please go to
www.bucksfamilyinfo.org/transitions

Section 1
Definitions and Policies

Definition of Transition

There are many important transitions in children's lives but they are too many and too varied for us to deal with in one document. For the purposes of this protocol, 'transition' is a planned process that happens when adolescents move to adulthood. It involves physical and psychological developments, coupled with changes to roles and relationships with family and friends, care staff and the wider community.

Transition from adolescence to adulthood brings particular challenges for young people who have complicated needs because they are undergoing changes that are far broader than other youngsters and that involve considering the medical, psychological, educational or vocational and social needs of the young person.

Definition of Disability

The law defines disability in a number of different ways. For the purpose of this protocol, we have used the definition set out in the Equalities Act 2010, which is:

"a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on your ability to do normal daily activities."

As a result, this will include those young people who have:

- an Education, Health and Care Plan as there is a legal requirement for them to have transition reviews or complicated or long-term health or mental-health difficulties where professionals agree that formal planning will be helpful to the young person
- an Statement of Special Educational Need

Safeguarding

- Buckinghamshire County Council employees and partners will ensure that all appropriate safeguarding checks are in place and taken in to account when arranging a transfer between children's services and adult services. We will also ensure that all staff working with vulnerable young people and adults have the appropriate training and management supervision in order to minimise risks and provide a high level of protection to the young people, adults and professional staff.

- Staff will respect confidentiality and will adhere to local guidance related to sharing information. Staff will have access to up-to-date safeguarding protocols.

Section 2

Legislative and National Policy Frameworks

Legislative & National Policy Context

Outcomes

The successful delivery and implementation of the Protocol should contribute to the following outcomes:

- **Being Healthy** – enjoying good physical and mental health and living a healthy lifestyle.
- **Staying Safe** – being protected from harm and neglect and growing up able to look after themselves.
- **Enjoying and Achieving** – getting the most out of life and developing broad skills for adulthood.
- **Making a Positive Contribution** – to the community and to society and not getting involved in antisocial or offending behaviour.
- **Economic Wellbeing** – overcoming socio-economic disadvantages to achieve their potential in life.
- **Improved Health** – enjoying good physical and mental health (including protection from abuse and exploitation). Access to appropriate treatment and support in managing long-term conditions independently. Opportunities for physical activity.
- **Improved Quality of Life** – access to leisure, social activities and lifelong learning and to public and commercial services. Security at home, access to transport and confidence in feeling safe outside the home.
- **Making a Positive Contribution** – being actively involved in the community through employment or voluntary opportunities, keeping involved in local activities and being involved in developing policy decision-making.
- **Choice and Control** – providing as much independence as possible and access to information.
- **Freedom from Discrimination or Harassment –** equal access to services
- **Economic Wellbeing** – access to enough income and resources for a good diet, accommodation and involvement in family and community life. Ability to meet costs arising from specific needs.
- **Personal Dignity** – keeping clean and comfortable. Enjoying a clean and tidy environment. Having personal care available.

In the development of this Multi-Agency Protocol all relevant local polices and strategies have been considered.

Legislative Framework

The following provide the legal framework within which planning takes place:

- Children and Families Act 2014
- Care Act 2014
- The Children Act 1989
- The Carers (Recognition and Services) Act 1995
- The Children (Leaving Care) Act 2000
- The Carers and Disabled Children Act 2000
- The Learning and Skills Act 2000
- Leaving Care Act 2000
- Mental Health Act 1983
- Human Rights Act 1998
- Health and Social Care Act 2001 Carers and Disabled Children
- The Children Act 2004
- The Disability Discrimination Act 2005
- Equalities Act 2010

The following summarises the main Acts and the main points from the Acts of Parliament relevant to transition for young people. It is not a full summary of the law.

The Children Act 1989

Stated that disabled children including those with a mental disorder are ‘children in need’; and says that disabled children are children first.

The Mental Health Act 1983

Lays a joint duty under Section 117 of the Act upon primary care trusts and local authorities to provide aftercare services for people with mental health problems who have been detained in hospital for treatment under Section 3, 37, 45A, 47 or 48 who then cease to be detained. An important aspect of this duty is that people whose circumstances fall within Section 117 are not liable to contribute towards the social care element of their aftercare services.

The Carers and Disabled Children Act 2000

Allows local authorities to make direct payments to people with parental responsibility for a disabled child under the age of 16 or to a disabled young person aged 16 and over
Carers have a right to ask for an assessment so the local authority can:

- decide whether the carer is eligible for support;
- decide on the support needs of the carer (in other words, what will help the carer in their caring role and help them to maintain their own health and wellbeing);
- see if those needs can be met by social or other services.

The Children Act 2004

The act sets the legal foundation for the action agreed through' Every Child Matters'.
The act includes:

- a condition that each children's service in England should arrange to promote co-operation between the authority, its partners and other appropriate organisations to improving the wellbeing of children in the authority's area relating to areas, which include education and training. This condition says that any arrangements made may apply to the 19 to 25 age group who have learning difficulties

Children and Families Act 2014

The Act introduces**:**

The local offer, which according to the act should lead to:

- Children, young people and their families being provided with information and advice as to what they can expect from all services involved in their care and support including what will happen as part of the preparation for adulthood

Personal Budgets, which according to the act means that:

- Young people and their families with an Education , Health and Care Plan have the right to request a personal budget from the local authority

Education, Health and Care Plans according to the act should:

- Be person centred and outcome focused
- Have clear evidence of the preparation for adulthood beginning in year 9

  The act states that the local authority must secure an EHC needs assessment for the child or young person if, after having regard to any views expressed and evidence submitted under subsection (7), the authority is of the opinion that;

  (a) The child or young person has or may have special educational needs, and

  (b) It may be necessary for special educational provision to be made for the child or young person in accordance with an EHC plan

- Where, in the light of an EHC needs assessment, it is necessary for special educational provision to be made for a child or young person in accordance with an EHC plan:

  (a) The local authority must secure that an EHC plan is prepared for the child or young person, and

  (b) Once an EHC plan has been prepared, it must maintain the plan.

Care Act 2014

The Act states:

- The provisions in the Care Act relating to transition to adult care and support are not only for those who are already receiving children's services, but for anyone who is likely to have needs for adult care and support after turning 18.
- A young person or carer, or someone acting on their behalf, has the right to request a transition assessment. The local authority must consider such requests and take into consideration whether this assessment would be of significant benefit to the young person at that time not
- Transition assessments should take place at the right time for the young person or carer and at a point when the local authority can be reasonably confident about what the young person's or carer's needs for care or support will look like after the young person in question turns 18.
- A transition assessment must be conducted for all those who have likely needs (see above) however, the timing of this assessment will depend on when it is of *significant benefit* to the young person or carer.
- There is no set age when young people reach this point; every young person and their family are different, and as such, transition assessments should take place when it is most appropriate for them.
- The assessment needs to be outcome and person – centred focused

NHS Act 2006

- Section 82, which states that the Local Authority and the NHS must cooperate to with one another in order to secure and advance the health and welfare of people of England and Wales

- As health service commissioners, CCGs have a duty under Section 3 of the NHS Act 2006 to arrange health care provision for the people for whom they are responsible to meet their reasonable health needs. (NHS England may also have commissioning responsibility for some children and young people – for example in some secure children's homes – and therefore a similar duty to meet their reasonable needs.) This is the fundamental basis of commissioning in the NHS. Where there is provision which has been agreed in the health element of an EHC plan, health commissioners must put arrangements in place to secure that provision.

General Information

Charging for social services;

- The local authority provides all children's services free to those who meet the relevant conditions for eligibility
- The local authority have a duty to make sure that people get all the benefits they are entitled to and it can take resources into account when disabled people's needs are assessed for community care services.
- However, the local authority balances this by weighing people's needs against available resources. (In other words, resources should not be the only factor.) Local authorities can take account of their resources when deciding how to meet needs as long as need is genuinely met.

- You can see Buckinghamshire County Council's charging policy on our website which can be found at www.buckscc.gov.uk

The exercise of this protocol will be in line with the requirements of the Public Sector Equality duty (Equality Act 2010) as we have a duty to ensure that we eliminate discrimination, harassment and victimisation, promote equality of opportunity and good relations for those people with protected characteristics under the Act.

National policy framework

The Government has long recognised the need for service providers to improve multi-agency working so that disabled children, young people and their families can access services more easily. Improving the move for young people between Children's and Adult Services across agencies is a priority.

The following documents provide a policy framework;

- SEND Code of Practice 2015
  https://www.gov.uk/government/publications/send-code-of-practice-0-to-25
- Care Act 2014 Final Guidance
  https://www.gov.uk/government/publications/care-act-2014-statutory-guidance-for-implementation
- Valuing People: A Strategy for Learning Disability for the 21st Century (2001)
  https://www.gov.uk/government/publications/valuing-people-a-new-strategy-for-learning-disability-for-the-21st-century
- Valuing People: Towards Person Centred Approaches – Planning with People (2002)
  http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009374
- The National Services Framework for Children, Young People and Maternity Services (2004)
  https://www.gov.uk/government/publications/national-service-framework-children-young-people-and-maternity-services
- 'No Health Without Mental Health' (The National Mental Health Strategy) February 2011
  https://www.gov.uk/government/publications/the-mental-health-strategy-for-england

- Winterbourne View Review Concordat; A Programme of Action 2012
  https://www.gov.uk/government/uploads/system/.../**Concordat**.pdf

- NHS England Draft Protocol for Children and Young People: Guidance to Professionals (2015) No Link available

The above web links are valid as of April 2015

Special Educational Needs and Disability (SEND) Code of Practice 2015

This code sets out the following:

- Some young people will be able to have an Education, Health and Care Plan until they are 25
- What is needed as part of the Local Offer for post 14's
- How and when the Local Authority should start the preparation for adulthood which is year 9
- How personal budgets will work and how some young people will be able to have their own budget from 16
- The need for the Local Authority to cooperate with Clinical Commissioning Groups to ensure that everything is in place when the young person turns 18

Care Act Final Guidance 2014
Please see above

Valuing People: A New Strategy for Learning Disability for the 21st Century (2001)

This strategy does the following:

- It sets out the new vision for services under the four main principles of rights, independence, choice and inclusion.
- It highlights the possible loss of co-ordinated healthcare when young people, particularly those with severe learning disabilities and complicated health needs, are transferred from children's to adults' services without proper health plans

'Our Health, our Care, our Say' (2006)

The document:

- puts people at the centre of the assessment process
- increases the take-up of direct payments
- introduces individual budgets that will give people greater freedom to choose the type of care or support they want

A range of policies also emphasise the need for health and social care agencies to work together to plan the transition of young people from children's' services to adults. These include:

No Health without Mental Health (2011)

Emphasises the following:

- the need for Health and Social Care agencies to work together to plan for the transition of young people.
- more people have a positive experience of care
- fewer people suffer harm
- more people will have good mental health

Winterbourne View Review: Concordat: A Programme of Action (2012)
Emphasises the following:

- the Department of Health and the Department of Education will work together to consider how to prioritise improvement outcomes for young people with challenging behaviour and how best to support young people with complex needs in making the transition to adulthood

NHS England Draft Protocol for Children and Young People: Guidance to Professionals (2015)

- ACDS and NHS England specialist Commissioning, Department of Health and the Department of Education are working together to improve tri- partite oversight of safety / care education and health needs and improve admission

and discharge arrangements for young people in assessment and treatment and other in – patient and specialist residential units.

- The focus has been on young people with a complex learning disability or Autistic Spectrum Disorder.
- All of these young people require Care and Treatment Review under NHS regulations including those who are due to transition into adulthood.
- There is also a commitment to work with each other to improve information sharing of all children in specialist residential placements (hospitals or Tier 4 specialist psychiatric provision)

Local policy

Buckinghamshire Children and Young People's Plan

This states that all partners will work towards achieving the following outcomes:

- Children and young people live fulfilling lives
- Children and young people reach their potential in education and in other aspects of their lives

It makes the commitment that:

- Children and adult services will work together where appropriate
- Work with young people so they successfully move into further education , training or apprenticeships or work and adulthood

For further information please go to:

- **http://www.buckschildrenstrust.org.uk/strategies-and-policies/children-and-young-peoples-plan/**

Adult and Family Well Being Portfolio Plan

This states that we will aim to achieve an effective transition for young people with complex needs. This includes the commitment to start preparing for adulthood early. This includes all relevant Communities, Health and Social Care (Adult Social Care) staff reporting against the following local indicator

"Proportion of all young people making timely transitions between children's services to adult social care (no later than 17 and 1 month). To fulfil this commitment all children's agencies will be expected to refer in good time normally from when the young person is 16 years old.

Buckinghamshire Safeguarding Children Board Preventing Violent Extremism

All local partnerships should have agreed processes in place to safeguard vulnerable young people against radicalisation including those in transition.

In Buckinghamshire, there is a multi – agency Channel panel which is an agreed mechanism for referring those who are at risk and providing support.

Channel guidance states that if the young person is under 18 then the Chanel co – ordinator must liaise with social care / or the Care co – ordinator as to how best manage the case or how to proceed. The Channel guidance makes it clear this support could be extended to some young people to 25. For further information please go to the Buckinghamshire Safeguarding Children Board website which is www.bucks.lscb.org.uk

Child Sexual Exploitation Practitioner Guidance

All local partnerships / professionals need to be aware of the Buckinghamshire Safeguarding Children Board (BSCB) information on Child Sexual Exploitation. One of the potentially at risk groups, identified in the BSCB Practitioner Guidance, are young people with disabilities. For further information please go the Buckinghamshire Safeguarding Children Board website which is **www.bucks.lscb.org.uk**

Section 3
Appendices

APPENDIX 1

Transition Summary

This sets out a summary of the transition related responsibilities for all services involved in the transition of young people with complex needs.

Children's Services Responsibilities

Children's Services includes the following:

- Schools
- Connexions
- Children Social Care Teams
- Children's Continuing Care
- Special Educational Needs Team

Children's services will;

- Identify and Inform adult services of those who will be coming into adult provision in the next year
- Ensure all referrals for an Communities, Health and Social Care (Adult Social Care) assessment by the time the young person is 16 ½
- Ensure all referrals for an adult health assessment are made when the young person is 17 and 1 month
- Ensure there is no gap in service provision once the young person is 18
- Case manage and co – ordinate the support and various plans until the young person is 18
- Pass on any Safeguarding information to adult services if needed including information on risk as well as risk management
- Have undertaken relevant Safeguarding Adult training
- Invite adult services to Children in Care reviews for young people who could need ongoing support in the future
- Be aware and understand the implications of the Mental Capacity Act
- Assess the needs of young carers

Adult Services Responsibilities

Communities, Health and Social Care services will:

- Assess young people by the time they are 17 and 1 month
- Provide information to young people and their families as to whether they are eligible
- Provide an indicative budget to young people and their families
- Ensure services are in place by the time the young person is 18
- Be aware as part of the assessment process of any young carers within the household who might need an assessment and inform children's services

Adult Community Health Services will:

- Assess young people by the time they are 17½ if they require adult community health input
- Carry out joint assessments with all relevant agencies
- Carry out a Mental Capacity Act assessment
- Input into various plans including Education, Health and Care Plans and Pathway Plans from year 9 onwards
- Keep young people and their families informed of the progress of their assessment
- Inform young people and their families of the outcome of this assessment
- Provide information and advice to those that are not eligible as to what other support they can access through utilising the Local Offer / Information, Advice and Guidance
- Have undertaken relevant Safeguarding Children training
- Ensure that they have all relevant information regarding Safeguarding Children

Joint Responsibility

Both adult and Children‘s services will identify and manage risk when working with young people in transition.

For further information on Transition, please go to:

www.bucksfamilyinfo.org/transitions

APPENDIX 2

Referrals and Eligibility Criteria

Children's Social Care Referrals

All referrals for the following teams need to come through to First Response:

- Children with Disabilities
- Children in Need
- Children in Care

Eligibility

For information on eligibility please see the thresholds document, which can be found at: http://www.bucks-lscb.org.uk/bscb-procedures/

Safeguarding Children

For information please see the thresholds document, which can be found at: http://www.bucks-lscb.org.uk/bscb-procedures/

All children's services will:

- ensure that any relevant Safeguarding information which is known to the referring agency is passed over to the relevant adult service from 16 onward
- any support and plan is put in place by the time the young person becomes 18
- know where to report Safeguarding Concerns regarding adults

This information will include**:**

- An up to date risk assessment
- All relevant plans such as a Pathway plan and Protection Plan

Safeguarding Adults

Referrals / Eligibility

The safeguarding duties apply only in particular circumstances and that is where an adult:

- has needs for care and support (whether or not the local authority is meeting any of those needs) and;
- is experiencing, or at risk of, abuse or neglect; and;
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

  For further information, please go to: http://www.buckinghamshirepartnership.co.uk/safeguarding-adults-board/

- Where someone is 18 or over but is still receiving children's services and a safeguarding concern is raised, the matter should be dealt with by Safeguarding Adults First Response and the wider safeguarding adult arrangements. For example, this could occur when a young person with substantial and complex needs continues to be supported in a residential educational setting until the age of 25.

Where appropriate, adult safeguarding services must involve children's safeguarding colleagues as well as any relevant partners (e.g. the Police or NHS) or other persons relevant to the case.
However, the level of needs is not relevant, and the young adult does not need to have eligible needs for care and support under the Care Act 2014, or be receiving any particular service from Buckinghamshire County Council, in order for the safeguarding duties to apply.

All adult services will:

- provide information as to where this information needs to go
- highlight potential risks and monitor
- action plan to mitigate this risk
- If the young person is not able to access statutory services they will provide information and advice as well as support to access services which could help
- know where to report any Safeguarding concerns regarding children

Communities Health and Social Care
Referrals
All referrals for Communities Health and Social Care services need to come through the Community Response and Reablement Team.

Eligibility
From April 2015 the eligibility criteria for Communities Health and Social Care services will be:

- Do the needs arise from a physical or mental impairment or illness?
- Do these needs mean that the adult is unable to meet two or more of the listed outcomes?
- Is there consequently a significant impact on the adult's wellbeing?

Eligibility outcomes:

- Manage and maintain nutrition with specific regard to religious and cultural needs
- Maintain personal hygiene
- Manage toilet needs
- Being appropriately clothed
- Maintain a habitable home environment
- Develop/maintain family and other personal relationships
- Access/engage in work, training, education or volunteering
- Make use of community services
- Carry out caring responsibilities for a child

Health Continuing Care

Referral
Continuing care is for young people or a young person under 18 where needs cannot be met by universal or specialist services alone.

Continuing Healthcare

Referral
Continuing Healthcare referrals will be for those who have been identified to have a primary health need. This care will be provided for those aged 18 and over to meet the needs, which have arisen as a result of disability, accident or illness.

Eligibility

Information on eligibility criteria please go to:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213138/NHS-CHC-Checklist-FINAL.pdf

Child and Adolescent Mental Health Service
Referrals / Eligibility
For information on how to make a referral and eligibility please, go to
http://www.oxfordhealth.nhs.uk/resources/2011/01/Bucks-Criteria-7Aug12-pdf.pdf

Adult Mental Health Service

Referrals are made via:

- GP
- Police
- Local Acute Trusts including Accident and Emergency
- 3rd Sector
- Social Care
- Other NHS Mental Health providers including the Child and Adolescent Mental Health Service

All of the above can refer directly for an assessment for those who were or are in treatment and were transferred with a contingency plan and relapse signs and identified triggers.

Anyone referred to the AMHT will receive the following:

- a core assessment detailing the presenting issues
- This will include a risk assessment
- Receive a Cluster Allocation

The assessment will look at;

- the bio – psychosocial mental health needs of the transitioning young person
- if the transitioning young person meets the criteria for cluster 4-17

Eligibility

The following indicators are used to decide eligibility and treatment intervention:

Non – psychosis (cluster 4-7)

- Moderate to Severe depression and/or anxiety and / or increasing complexity of needs
- May experience of disruption to everyday life and there is an increasing likelihood of significant risks
- Moderate to Severe disruption to everyday life

First Episode Psychosis (cluster 8)

- Psychotic disorders which can be very disabling
- In need of a team approach looking at the bio-psychosocial elements of a individuals presentation

Complex needs Service (cluster 10)

- Wide range of symptoms and chaotic and challenging lifestyles
- Moderate to severe repeated deliberate self-harm
- Impulsive behaviour

Ongoing Recurrent Psychosis (cluster 11 -17)

- presenting with a psychotic presentation, cluster is dependent on level of severity

Adult Mental Health teams focus on providing services to the following:

- Those patients with functional severe and enduring mental health needs clusters 4-17 plus
- those who are eligible for Communities, Health and Social Care (Adult Social Care) services and who cannot be managed appropriately or safely within primary care

This includes the following:

- Non psychosis
- Psychosis
- Personality Disorder

Access to services

Oxford Health NHS Foundation Trust is the provider of mental health services and access to these services can be found on the website: www.oxfordhealth.nhs.uk

Adult Learning Disability

Referrals
Any agency can refer to the team

Eligibility

- The individual must be resident within the Aylesbury Vale CCG and Chiltern CCG areas in Buckinghamshire or covered by the Responsible Commissioner Guidance.
- The services are available to all adults with learning disability criteria who are the funding responsibility of Buckinghamshire CCGs. This includes people who are the responsibility of Buckinghamshire CCG and are transferring back into the area.
- Definition;
- Learning disability includes the presence of;

    - A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with;
    - A reduced ability to cope independently relating to self-care, health and wellbeing (impaired social functioning); which started before adulthood, with a lasting effect on development
    - The above should have been present before the age of 18 years old and may be evidenced through an IQ of 70 or below and/or history of poor education attainment with statement or attendance at special needs school.
    - Specific health problems related to learning disability

- The presence of a low intelligence quotient (IQ) is not, of itself, sufficient for diagnosis of a learning disability. Social functioning and communication skills should also be taken into account when determining eligibility and may include a;

    - Diagnosis of learning disability and mental illness
    - Diagnosis of learning disability, developmental disorder and mental illness
    - Diagnosis of autistic spectrum disorders or Asperger's syndrome with learning disabilities

- Adapted Health Care is needed if;

    - They require the specialist learning disability expertise and skills as health needs cannot be met in mainstream services including mainstream services.

- Exclusion thresholds include;

    - Under 18 year olds with the exception of those currently in transition and requiring input for community services upon reaching 18.
    - People who are placed out of area into Buckinghamshire whereby Psychology and Psychiatry are part of the commissioned package of care delivered by the independent commissioned provider service/ agency.

APPENDIX 3

Roles and Responsibilities

EDUCATION

From September 2014 Education, Health and Care Plans will begin to replace SEN Statements and Learning Difficulties Assessments (LDA'S). For students with a current statement or LDA the Local Authority has a strategy to consider whether or not they need to be converted to an EHC Plan.
The Local Authority is required to convert existing statements into EHC Plans where one is required between September 2014 and end of March 2018.
For further information about the conversion to EHC plans please go to the Bucks Family Information website, which can be found at **www.bucksfamilyinfo.org.uk**

Special Educational Needs and Disabilities Team (SEND)

1. Recommendations will be made at the Transition review from year 10 onwards where the young person expresses a wish to leave that educational placement
2. Following this recommendation the SEND Team undertake any actions if this is required the SEND Team will :
    - Notify any young person if the statement is to cease Consider when new referrals come in if an assessment is required for an EHC Plan
    - Carry out an EHC assessment, if required within 14 weeks of the date the LA initiates assessment. A decision whether or not an EHC Plan is required will be made and if required an EHCP will be drafted/issued with the level of support identified
    - If an EHCP is not required – Meeting will be arranged and discussion to draw up a SEND Support plan
3. N.B In order for the SEND team to understand whether a plan will be required they will need to be clear on what the educational placement can provide with their delegated resources.
4. Once the EHCP is agreed then the SEND team will meet with the young person and/or parents, if they want to be involved send the draft plan to the Young Person (no placement will be named in the plan) for agreement/change and for the Young Person to state a preference for placement – they have 15 days to respond. The Local Authority will;
    - Consult with the young person's preferred placement and/or the nearest appropriate placement
    - Consider efficient use of their resources
    - Once the placement is decided then the SEN team will issue the final EHC Plan naming the relevant placement.
    - Placement details including costs for all possible placements sent to the SEN Team. This will then be presented to the decision making panel.
5. Once the placement is decided then the SEN team will issue the final plan
6. Placement decided and SEN team will issue the final plan

Year 9 AGE 13 to 14	
	• Ensure that the year 9 review takes place and starts the process of preparing for adulthood. In particular, the EHC Plan will need to specify desired outcomes for adulthood.
Year 11 -14 AGE 15 to 19	

	• SEN Team need to ensure by 31st March each year, that the provision is named and issued on the EHC Plan (if it is agreed that one is required)
	• Work with schools including, out of county, to ensure referrals are made to Adults and Family Wellbeing before the young person turns 17

Schools

Schools in Buckinghamshire and out of authority schools which are commissioned by Buckinghamshire to provide education to Buckinghamshire children and young people will:

1. Make sure EHC planning is focused on outcomes around Preparing for Adulthood. from year 9
2. Engage with Further Education providers or college as early as possible so they can plan for the transition.
3. Engage with other agencies including Adults and Family Wellbeing to plan for the future.
4. If it is appropriate for the young person to stay at school post 16, the school will need to decide what education programme they are going to provide.
5. The SENCO will co–ordinate the provision
6. The SENCO will be the key point of contact and liaise with external agencies
7. The SENCO will liaise with next education providers
8. Arrange year 10/11/12/13/14 Transition Reviews for the summer term where possible to facilitate a move to a further education college or apprenticeship where this is the intention.
9. Liaise with the Connexions Service regarding young people leaving school at the end of year 12, 13 or 14 to ensure that necessary actions are completed in good time

Year 9 AGE :13-14	
	• Arrange Transition Reviews for statemented pupils or those with an EHC Plan. In Years 9 and above in accordance with Buckinghamshire Annual Review Guidance and the SEN Code of Practice, ensuring that dates are negotiated in advance with professionals whose attendance is essential (e.g. Connexions at the Year 9 review) and ensuring that other agencies and parents/carers are given adequate notice. • Provide information about further education options
Year 10 -14 AGE :15-19	
	• Complete the AR paperwork and send to the SEN team within 2 weeks of the meeting. This to include relevant information to enable potential conversion/updating of EHC Plans, including up to date reports from all involved professionals. • If the young person will not need additional funding (i.e. above the usual element 1 & 2) at college, serious consideration should be given to recommending cessation of the statement/EHC Plan when leaving school. • Make a new referral for an assessment for those not already with a statement or EHC Plan if required.
	• For those who are likely to be eligible for Community Health and Social Care support schools will refer young people from 16½ via the Community Response and Reablement Team Mailbox email: crr@buckscc.gov.uk Tel: 01296 383204

Colleges

Colleges will

1. Liaise with the schools, SEN, Connexions and work to Element 1,2 and 3 funding/support and local guidance
2. Engage with SEN re. making offer to the young person with appropriate required support and work in partnership other relevant agencies involved with the young person
3. Hold Termly/Annual reviews to be carried out with the identified destination of education input at the centre of the review with evidence of progressive learning on non- accredited courses

Connexions

Connexions will:

1. Provide impartial information, advice and guidance to young people and their parents/carers on all options available post 16, (bearing in mind efficient use of resources) being involved in the transition to adulthood process as early as possible, at least from Year 9.
2. Attend SEN reviews in Year 9 and attend other reviews where possible, giving priority to Year 11 reviews and/or reviews in the final year of schooling for young people in years 11–14.
3. Work with the schools and local authority to identify young people in Years 11–14 who will be leaving school to attend further education or training, for which high needs funding is likely to be required.
4. Connexions staff will ensure a person-centred approach is embraced throughout their work
5. Work with the schools to ensure a support plan is drawn up for those not eligible for an EHCP, to ensure a smooth transition to Post 16

Year 9	
	• Meet all statemented young people or those on an EHC Plan prior to their Year 9 Annual Review and produce a report using a person centred approach in accordance with the local guidelines.
	• Attend annual reviews for all Year 9 statemented or those on EHC Plan pupils, ensuring the young person is central to the process and that their views are heard.
Year 10 – 14	
	• Meet all young people on a statement or EHC Plan prior to their Year 10 and/or leaver's Annual Review, supporting them to identify their aspirations and to give guidance on appropriate pathways, then working with the school, the local authority and other professionals to ensure these aspirations are at the centre of their draft EHCP if eligible or are incorporated into a support plan.

Children with Disabilities Social Work Team

Children with Disabilities Social Work Team will:

1. Case manage all young people who are known to them until they are 18
2. Make referrals into Adult services including Communities Health and Social Care (Adult Social Care) when the young person is 16 and no later than 17
3. Retain case management responsibility until the young person has accessed adult services or when their outcomes have been reached. Please note children's services cannot stop on the young person's 18th birthday and there should be no gap in provision
4. Provide adult services with all relevant information including any Safeguarding concerns especially any up to date risk assessments
5. Provide for children living with their families carers with the following :
    - Advice ,guidance and counselling
    - Occupational , social , cultural or recreational activities
    - Home Help
    - Facilities for or assistance with travel to and from home, to take advantage of services
    - Assistance for young people to take a Short Break
    - Care planning of the child is a child in care
6. Identify on a regular basis all those who are going to need adult services in the next year
7. Signpost parents, carers and young people to information on transition and provide information on services and options available, including self- directed support for young person if they are aged 16
8. Provide information to the young person and their parents/carers on the eligibility criteria for accessing services from Communities, Health and Social Care (Adult Social Care) teams.
9. Offer a Carers Assessment to the family if required
10. Ensure families and the young person are aware of the Local offer which can be found on the Buckinghamshire Family Information website
11. Refer a young person with medical needs to the Continuing Health Care Panel in accordance with the current procedures for children, where necessary
12. Make sure a referral has been made to the Aftercare team and Communities Health and social care (Adult Social Care) before closing a case and ensure that there are no gaps in service provision.

YEAR 9

For those on Education, Health and Care Plans who are known to the Children's with Disabilities team will:

- Complete a Children and Families Assessment in advance of the Transition Review Meeting (for young people in Years 9 and above who are known to the team) and distribute to parents/carers, school and other relevant agencies, including the SEN Case Officer and Connexions.
- Attend Transition Reviews of young people known the team in Years 9 and above.
- Start planning for the future and looking at what interventions are needed to support the young person in a person- centred way
- Liaise with adult services to discuss what to expect from adult services such as the

changes in decision making responsibilities • Contribute to the preparation for adulthood section of the Education, Health and Care Plan • Ensure any Support or Care Plan feeds into the EHC plan and make sure the interventions in these plans will lead to the outcomes on the EHC Plan	
Year 11-14	
	• Refer all those not already known to the Transitions Team at 16 onwards • Retain overall Case Management responsibility until they are 18 For those who are on Education, Health and Social Care Plans, Children's Social care will **:** • Attend the Education Annual review for year 11 and feed in all information from the Care Plan including any risk assessment • Discuss with the appropriate Community Health and Social Care Manager any proposed out of area placements before final decisions are made for young people aged 17 years onwards. • Arrange joint visits where appropriate and ensure that longer term planning and decision making processes are made clear to the school /placement, the parents / carers and the young person. • Any arrangements for an out of authority placement must follow the relevant procedures

Children in Need

The Children in Need Team will:

1. Case manage all young people who are known to them until they access step down services, such as appropriate housing and /or support
2. Make referrals into Adult services including Communities, Health and Social Care (Adult Social Care) when the young person is 16 and no later than 17
3. Send the referral for Communities, Health and Social Care (Adult Social Care) to the Community Response and Reablement Team
4. Let Schools and Connexions know if they have referred to Communities, Health and Social Care (Adult Social Care)
5. Provide adult services with all relevant information including any Safeguarding concerns especially any up to date risk assessments
6. Provide for children with the following :
    - Onward referrals if the young person does not meet their thresholds
    - Advice and guidance and counselling
    - Occasionally if the young person is on a Child Protection/Child in Need plan and to prevent family breakdown support can be provided to access occupational, social, recreational activities but would generally expect the family/ extended family to help with this
7. Provide information to the young person on the eligibility criteria for accessing services from Communities, Health and Social Care (Adult Social Care teams).
8. Offer a Carers Assessment to the family if required
9. Ensure families and the young person are aware of the Local Offer which can be found on the Buckinghamshire Family Information website which can be found at www.bucksfamilyinfo.org/transitions
10. Refer a young person with medical needs to the Continuing Health Care Panel in accordance with the current procedures for children, where necessary.

Year 9	
	For those on Education, Health and Care Plans Children's in Need team will**:** • Provide the Personal Education Plan if the young person is known to them in advance of the Transition Review Meeting (for young people in Years 9 and above who are known to the team) and distribute to parents/carers, school and other relevant agencies, including the SEN Case Officer and Connexions. • Attend Transition Reviews of young people known to the team in Years 9 and above. • Start planning for the future and looking at what interventions are needed to support the young person in a person- centred way • Liaise with adult services to discuss what to expect from adult services such as the changes in decision making responsibilities • Contribute to the preparation for adulthood section of the Education, Health and Care Plan • Ensure any Support or Care Plan feeds into the EHC plan especially the preparation for the future section. • Make sure the interventions in these plans will lead to the outcomes on the EHC Plan • If referred onto other teams for support before the young person is 18 such as Family Resilience then inform the family of referrals being made in preparation for adulthood
Year 11-14	
	• Arrange joint visits where appropriate and ensure that longer-term planning and decision-making processes are made clear to the school/ placement, parents/carers and the young person. • Any arrangements for an out of authority placement must follow the relevant procedures • Discuss with the appropriate Community Health and Social Care Manager any proposed out of area placements before final decisions are made for young people aged 17 years • Work with the young person to access relevant services using a step down approach

Children in Care

Children in care will:

1. Complete a written report in advance of the Personal Education Plan/ Annual Education Review Meeting (for young people in Years 9 and above who are known to the team) and distribute to parents/carers, school and other relevant agencies, including the SEN Case Officer and Connexions.
2. Attend Education Reviews of young people known to the team in Years 9 and above.
3. Ensure as much as possible that the PEP meetings tie in with the Education Annual review
4. Signpost parents, carers and young people to information on transition and provide information on services and options available, including self- directed support.
5. Provide information to the young person and their parents/carers on the

	eligibility criteria for accessing services from Communities, Health and Social Care (Adult Social Care) teams. 6. Offer a Carers Assessment to the family if required 7. Refer a young person with medical needs to the Continuing Health Care Panel in accordance with the current procedures for children, where necessary. 8. Discuss with the appropriate Community Health and Social Care Manager any proposed out of area placements before final decisions are made for young people aged 16½ years onwards. 9. Arrange joint visits where appropriate and ensure that longer-term planning and decision-making processes are made clear to the school/placement, the parents/carers and the young person. 10. Any arrangements for an out of authority placement must follow the relevant procedures
Year 11-14	
	• Attend Transition Review • Option for LAC Review to be combined with Transitions Review, Social Worker to consider how best to meet both sets of demands • Consider whether the young person is eligible for services under the Leaving Care Act. • Pathway Plan needs to be written in partnership with the young person • Refer any young person at 16 ½ likely to be eligible for Community Health and Social Care open to their teams using the Transitions Community and Response and Reablement Referral Form • Email: crreferral@buckscc.gov.uk Tel: 01296 383204 • NB. Excluding those young people who are in joint funded independent non-maintained special school placements • Children and Families social worker to refer all young people with mental health needs placed in out-of-county placements at 17 years to the appropriate Mental Health team • Children and Families social worker to refer all young people with mental health needs to the appropriate adult mental Health team (AMHT) at 17th birthday where social care intervention from mental health services will be required from 18th birthday • Social Workers working in Children in Need. Children in Care or Children with Disabilities will ensure that the allocated Care Manager in Community Health and Social Care is invited to the final LAC review. • Once a Care Manager has been allocated make a joint home visit, as • necessary, with Adult & Family Wellbeing – Service Provision to introduce the Care Manager provide information on eligibility for adult services. • Agree with the Community Health and Social Care Manager at what point the case will be handed over and arrange handover. • Send files including any relevant Safeguarding information /risk assessments to the Adult Social Care team within 2 weeks of the young person's 18th birthday.

Aftercare

	The Aftercare Team will : 1. Provide support and a personal advisor to advice assist and befriend if they are a "Former Relevant Child**"** A former relevant young person is

	defined as someone who is aged 18-21 (or up to 24 if in full time education) and have left care having being previously either " eligible " " relevant " or both This includes : • support for young parents and offenders , • young people with disabilities • unaccompanied asylum seekers Aftercare will: 2. Invite Communities, Health and Social Care (Adult Social Care) to any review or planning meeting if adult social care are involved 3. Work with Adult Social Care so joint planning takes place 4. Contribute to the Education, Health and Care Plan post 18 if appropriate 5. This assistance will continue until the young person is 21 unless they wish to continue with education. If this is the case then it will continue to the end of course up to age 24. 6. Review the Pathway Plan six monthly or sooner if there is significant changes to the young persons situation 7. Provide financial assistance to enable the young person to continue with education or employment or training if it is identified in the Pathway Plan and within the Aftercare financial policy 8. The Pathway plan will consider assistance regarding • accommodation • education, Training or Employment • health 9. The "New Transition to Adulthood Volume 3" states that post 21 if the young person should wish to return education then the team will provide support and advice up to the age of 25 10.Liaise closely with adult services regarding highlighting any risks such as child sexual exploitation and violent extremism

Communities, Health and Social Care

All Communities Health and Social care(Adult Social Care) teams working with adults with learning disabilities, physical disabilities, sensory needs, mental health needs will:

1. Identify all those who may be eligible for Adult Social care
2. Contribute to the Education Health and Care Plan from Year 9 onwards
3. Attend Looked After Children 's Reviews especially young people on a Section 47 of the Children's Act
4. Assess young people before they are 17 and 1 month
5. Refer young people to Brokerage if appropriate
6. Implement Support Plans in conjunction with EHC and Pathway plans
7. If the child is " relevant" or "eligible" child then work with Personal Adviser regarding the transfer of care when a Care Leaver is 18
8. Attend Looked After Child Review
9. Link Transitions Planning to LAC review and Pathway Plan
10. Contribute to the Pathway Plan and ensure that the Transitions work feeds into this planning process
11. Work closely with the Personal Adviser to ensure that the Pathway Plan is kept up

	to date 12. If young person does not want to access Education ,Employment or Training then the Transitions Team will take over the financial responsibility if they are eligible 13. Monitor and track the cases 14. Single point of contact if the placement breaks down 15. Develop work experience and employment opportunities 16. Ensure Direct Payments are in place if appropriate 17. Have a team approach to cases 18. Deliver Support plans outcomes If Support plan outcomes are delivered then close case and review on an annual basis until young person is 25 19. Set up Transitions Meeting when the young person is coming to the end of their Education placement 20. To liaise and refer into relevant Specialist Community Health Teams if required when the young person is 16-17 depending on the complexity of need.
	Year 9
	• Receive referrals of young people likely to be eligible for Community Health and Social Care services into the Community Response and Reablement Team from Children's Safeguarding. Schools, Connexions and others. • Assess young people and let the young person and their families know if the young person is eligible • Provide information and advice • In the case of ineligibility signposting to other resources will take place and if appropriate a referral to the In Touch team/ Transitions website which is www.bucksfamilyinfo.org/transitions • Contribute to the Education Health and Care Plans and Statement
	Year 10-14
	• Identify young people who might be eligible for Communities Health and Social Care (Adult Social Care) services and send letters to relevant agencies suggesting they can make a referral if one has not already been made • Attend the Annual Education Review and introduce themselves • Once a young person has been referred to a Transition/Social care team the Business Manager will allocate a Care Manager. • Carry out an assessment before the young person is 17 and 1 month Make sure that the following is carried out; • Arrange for a financial assessment to be completed on the young person to establish any financial contribution • The offer of a Carers Assessment if appropriate • Continuing Healthcare Checklist if appropriate • for further information go to Care Funding Calculator if a placement is required go to **http://www.vodg.org.uk/uploads/Protocol-VODG-Oct-2008.pdf** • Let young people and their families know their indicative budget The support plan will be agreed by the relevant panel at least 2 months prior to the young persons 18th birthday and go live on the young persons 18th birthday.
	Year 14 -15
	• Review after 6 weeks to begin with then annually. • If the situation changes before the annual review is due, a reassessment can be completed at that point. • Be the single point of contact if placement breaks down

HEALTH

Hospitals and Specialist Provision

NHS England will tell the CCG'S/ Local Authority about those young people in Tier 4 psychiatric provision and long stay hospital especially for children in rehab. All other residential placements will be commissioned by the LA, sometimes in partnership with the CCGs. Information for these residential placements will be provided by the Local Authority placement service who will also monitor and performance manage.

Child and Adolescent Mental Health Services

<table>
<tr><td colspan="2">CAMHS will
identify by the young person's 16th birthday where they may require an assessment under Adult Mental Health Service for potential or on-going treatment
Set up 6 monthly operational case management discussion with Adult Mental Health services , Early Intervention and Psychosis and Children 's Services(such as Children's Social Care) from when the young person is 16
Provide a list at this meeting which will be a standard agenda item at this meeting Ensure that the Care coordinator refers to Communities , Health and Social Care (Adult Social Care) by the time the young person is 16½ and 17 for health
Ensure all relevant paperwork is sent over including:
Full and current risk assessment
Exploration of the individual service user's views on their future needs and concerns
Carers Assessment
A list of other service providers
Ensure that the Care Coordinator arranges a transfer meeting which will be the responsibility of the –with Adult services and/ or Early Intervention and Psychosis
set up a Care Programme Approach (CPA) discharge meeting which will include SEN, Consultant Psychiatrist and appropriate Adult and Children's Social Care Staff
Feed the outcome of this CPA into the EHC Plan Annual review
Transfer treatment progress to relevant services</td></tr>
<tr><td colspan="2">Year 9</td></tr>
<tr><td></td><td>Contribute to the health part of the preparing for adulthood section within the EHC Plan
Forecast who is going to need adult services</td></tr>
<tr><td colspan="2">Year 11-14</td></tr>
<tr><td></td><td>Refer young people into Communities, Health and Social Care (Adult Social Care) and health services by the time they are 17
Set up handover and CPA discharge meetings before the young person is 18
Co – ordinate these meetings
Complete internal CPA discharge documentation advising of plan made at CPA Transfer meeting</td></tr>
<tr><td colspan="2">Year 14</td></tr>
<tr><td></td><td>Complete any treatment or clinical interventions still required if clinical staff think there is a need to continue
Keep adult mental health services informed about possible transfer date</td></tr>
</table>

Adult Mental Health Services

Adult Mental Health services will:

1. Ensure that Senior Operational Managers meet with CAMHS 6 monthly with the intention of identifying those who will be 17 in the next 6 months
2. Chair this meeting
3. Ask performance managers for information in the interim which will be passed onto the Business Managers
4. Acknowledge the receipt of the new referral within 5 working days
5. If the young person is already on a CPA then the referral will be acknowledged within a working day
6. On receipt of a referral from CAMHS ensure attendance at the CAMHS Care Programme Approach (CPA) review
7. Allocation of resources including care co coordinator is within agreed timescales (maximum of 4 weeks) according to severity of need and potential risk factors
8. Ensure a clinician carries out the an assessment and planning using the CPA process which should include the following documents :
   - Full and current risk assessment
   - Exploration of the individuals service users own views and future needs
   - Carers assessment
9. Assess young people at 16 ½
10. Decide eligibility based on severity and length of mental health problem
11. Let the young people and their families know if they are eligible or not both for Health and Social Care services
12. If there are mild to moderate mental health problems then whoever assesses will signpost the young person to voluntary sector such as:
    - Mind
    - Healthy Minds
    - Local Offer website
13. Ensure that the assessment planning and agreement of both future needs / levels of care to be delivered both during the transition process are made explicit and shared
14. Based on their assessment and If treatment is indicated the case will be discussed with the team and a Care Coordinator will be allocated

Role of the Care coordinator

- Contribute to the assessment planning and agreement of the transition work including Education , Health and Care plans
- Build a therapeutic relationship between young people and their workers
- Regularly brief the team manager and the Consultant Psychiatrist who will be involved once transition to the adult team is completed
- Clarify the nature of any past involvement with the individual and their family
- Clarify successful and unsuccessful interventions
- Clarify role of CAMHS in supporting current work and needs especially with the family
- Carry out liaison between Adult Mental Health teams, CAMHS and the Early Intervention and Psychosis Team
- Determine which GP will provide care for the young person

• Liaise closely with children services regarding assessments of risk if a case has been identified regarding sexual exploitation or violent extremism	
Year 9	
	• Contribute if appropriate or needed to the Education , Health and Care Plan as part of the preparation for adulthood if known to the Early Intervention and Psychosis team • Provide information and advice on adult mental health services and what to expect
Year 11-14	
	• Allocate appropriate Care coordinator within the most appropriate team preferably by the time the young person is 17 and 1 month or 16 ½ if complex such as Looked After Chid • Care coordinator to contact relevant school to highlight their potential involvement • Care coordinator to assess young person and if eligible for services to then attend the EHC Annual Review meeting so they are involved in the planning for interventions which will be needed for the young person to meet their EHC outcomes • Care coordinator to fill in the appropriate section of the EHC Plan • Care coordinator to set up meeting with CAMHS to arrange transfer of care • Care coordinator to complete a draft Care Plan
Year 14	
	• Care Programme implemented and reviewed • Care coordinator sets up review and invites all relevant agencies including schools and Children 's Social Care • Care coordinator attends Pathway Planning if the child is a Care Leaver

Continuing Care

	Continuing Care will; 1. Identify young people currently eligible for Continuing Care at the age of 14. 2. Ensure a joint assessment is carried out with colleagues in Adult Continuing Healthcare by the age of 17 and 1 month and take the assessments to the appropriate panels for ratification. 3. If a new referral and aged 17 or older then young person will be jointly assessed by Continuing Care and Continuing Healthcare (as above) 4. Ensure young person and family are fully involved in assessment and aware of the implications if found not eligible for CHC. 5. Contribute to EHC plans if eligible for Continuing Care/ Continuing Health Care. 6. Ensure joint working with colleagues in Education and Social care. 7. If post 18 care is required, only an adult checklist will need to be completed and this comment added to the reason for referral. Any other person in this age group can only be referred to CC if a change in care needs and not due to their age.

Adult Community Learning Disability

Adult Community Learning Disability services will:

1. Ensure that Clinical leads/ Team Managers meet with the CAMHS 6 monthly with the intention of identifying those who will be 17 in the next 6 mo
2. Acknowledge the receipt of the referral within 5 working days
3. Assign appropriate clinician based on highest need
4. On receipt of a referral from CAMHS ensure attendance at the CAMHS Care Programme Approach (CPA) review
5. Work collaboratively with children's services to assess young people by the time they are 18 as part of the preparation work needed for the transfer into adult services As part of this collaborative working the assigned clinical will carry out the following with children's services:
6. An up to date Risk assessment
7. Exploration of the individuals service users own views and future needs
8. Let the young people and their families know if they are eligible or not both for Health services
9. Ensure that the assessment. planning and implementation of agreed future needs and care delivery during the transition process are made explicit and shared with all stakeholders
10. 6, Contribute to the assessment planning and agreement of the transition work with the key stakeholders and service user, family and carers where relevant including Education and HealthCare plans
11. Maintain and support development of new therapeutic relationships between young people and their workers
12. Ensure appropriate and detailed history of interventions are captured as part of the initial assessment
13. Determine which GP will provide support for the young person for young people returning from out of county placements

Year 11-14	
	• Allocate appropriate Care Coordinator within the most appropriate team preferably by the time the young person is 18 identified Clinical lead to contact relevant school to highlight their potential involvement • Clinician to attend the EHC Annual Review meeting so they are involved in the planning for interventions which will be needed for the young person to meet their EHC outcomes • Clinician to work with CAMHS to provide information so the in the health section of the EHC Plan can be completed • CAMHS to set up transfer meeting with identified clinical lead Identified • Clinical lead to complete a draft Multi-Disciplinary Team Plan and identify the clinical area of practice. • Identified Clinical lead to assign or identify a care co-ordinator to a member of the Adult Community Learning Disability team if different clinician is required for implementation of the care plan.
Year 14	
	• Programme implemented and reviewed, Care Programme Approach adopted initially to ensure consistency due to complex nature of care provision. • Allocated Care co-ordinator sets up review and invites all relevant agencies including schools and Children 's Social Care

	• Allocated care co-ordinator attends Pathway planning if the child is a Care Leaver • first initial Care Programme Approach (CPA) meeting could be viewed by CAMHS as the transfer meeting

APPENDIX 4

Feedback and Support

- The Strengthening Transition Arrangements Programme Board as part of its collaborative and multi- agency commitment to ensuring an effective transition for all young people with complex needs will monitor the nature and frequency of complaints to make sure that they help develop the transition process.

- Each agency has a complaints procedure that should be followed if the young person, parents or carers are unhappy with the contribution of a particular agency. However, if the complaint is more general, it will be co-ordinated by the lead professional. This will make sure the issue is sorted out quickly

- To find more information about complaints and feedback processes go to the Buckinghamshire Family Information website which can be found at www.bucksfamilyinfo.org.uk

- If there is a need for the young person and their families to access information, support and advice then they can access the Buckinghamshire Special Educational Needs and Disabilities Information, Advice and Support (SEND IAS) service. This includes

Buckinghamshire Special Educational Needs and Disabilities Information, Advice and Support (SEND IAS) Service (with Independent Support)

Bucks SEND IAS Service (formerly Buckinghamshire Parent Partnership) is the one-stop information, advice and support service for children with SEND and their parents, and for young people aged 16 - 25 with SEND. Bucks SEND IAS provides a free, confidential, impartial service at arm's length from the local authority. Resources and information available cover:

- Education, health and social care
- National and local policy
- The Local Offer
- Rights and choices
- Opportunities to participate
- Where to find help and advice
- How to access support

Bucks SEND IAS are trained advisers with expertise in supporting parents, children and young people on any issue related to SEND. Bucks SEND IAS have a conciliatory, non-confrontational approach and work to enhance relationships between service users and educational settings. As part of this, Independent Supporters can be available to provide support during the new statutory assessment process or transfer from a statement or a learning difficulty assessment to an Education, Health and Care Plan (EHCP). Independent Support in Buckinghamshire is being provided from within our team in partnership with Adviza. Parents/carers, children and young people requiring help from our service should contact us directly on: **01296 383754** or **sendias@buckscc.gov.uk** Alternatively, with their permission, you can contact us on

their behalf.

APPENDIX 5

Glossary of Terms and Acronyms

Adults & Family Wellbeing now known as Communities , Health and Social Care	Adult Social Care department in Buckinghamshire County Council. This department carries out Care Act assessments to identify need and whether or not the young person has eligible needs and outcomes
AEN	Additional educational needs. This term is more commonly used now than 'special educational needs'
AP	Adult protection
Care manager	Registered social worker, occupational therapist or nurse
Community Response and Reablement Team	This is the single point of contact that all referrals into Communities, Health and Social Care (adult social care) need to come too
CYPS	Children & Young People's Services department in Buckinghamshire County Council. This department brings together education, safeguarding and commissioning services for children and young people.
Children Act 1989	The act that identifies our duties to 'safeguard and promote the welfare of children within their area who are in need'. (Children being those people up to age 18.)
CiN	Child in Need' as defined by the Children Act 1989.
SEN Code of practice	The SEN code of practice sets out the requirements involved in supporting children and young people with special educational needs.
Community-care assessment	The process by which we decide whether a person needs services.
Complex needs	This includes young people with medical conditions, high support needs, behavioural problems or learning difficulties (or both)
Connexions Service	A service created in 2003 that includes the Careers Service providing information, advice and guidance to young people 13-25
CP	Child protection
DAS or DASS	Director of Adult Social Services
DCS	Director of Children's Services
Direct payments	Payments made direct to young people and carers to buy services.
Education Health and Care Plan	The document which will be used instead of a Statement of Special Educational Need or a Learning Difficulty Assessment.(EHCP)
Individual Budget	This is the budget a family will receive to pay towards their social care needs. A young person is entitled to

	receive their own individual budget when they are 16
LA	Local authority
LAC	'Looked after child' – a child in our care.
LLDD	Learning difficulty or disability. Defined in the Learning and Skills Act and used by Connexions.
Learning difficulty	Defined in the Education Act 1996 as a person who has 'significantly greater difficulty in learning than most people of their age, or a disability, which prevents them from using facilities generally, provided for people of their age.'
Learning disability	*"Valuing People"*, the 2001 White Paper on the health and social care of people with learning disabilities, included the following definition of learning disabilities. *'Learning disability includes the presence of:* *a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with; a reduced ability to cope independently (impaired social functioning); which started before adulthood, with a lasting effect on development.* This definition is broadly consistent with that used in the current version of the World Health Organization's International Classification of Disease (ICD-10)
NEET	Not in education, employment, or training
Independent school	An independent school is a school, which is not dependent upon national or local government for financing its operation and is instead operated by tuition charges, gifts, and perhaps the investment yield of an endowment.
Non – Maintained school	A "non-maintained' school is run 'not for profit' usually by a charitable body.
Out-of-county placement	Where a young person goes to a school outside the local authority education area where they live.
PA	Connexions personal advisor
PCP	Person-centred planning
PCTs	Primary care trusts
PCTR	Person Centred Transitions Review
PLASC	Pupil-level annual schools census
PSHE	Personal, social and health education
SEN	Special educational needs - covers many conditions including autism, Asperger's syndrome, ADHD, dyslexia, dyspraxia, behavioural difficulties and physical disabilities.
SEN Support Plan	School document drawn up to show SEN , provision and outcomes provided by school for a young person when needs can be met by the school without an ECHP
Social Care Support Plan	A document drawn up as a result of consultation

	between Social Services and the young person and their family showing the ways in which services will meet the young person's needs.
SENCOs	The SEN co-ordinator in schools. This is the person who usually links with parents and makes all arrangements to do with the young person's needs.
SEND IAS	Organisation with a duty to provide information , advice and support to disabled children and young people , and those with and Special Educational Need and their parents . There should be an IAS service in every local authority.
Statement	A document written for school pupils with learning difficulties or disabilities, setting out the full range of needs and how these will be met.
Transfer Review	Legal process with a statutory timelines involving education, health and care needs assessment for Children and young people with statements , possibly leading to an EHCP,
Transition	The process that happens for young people between the ages of 13 and 19 to make sure of an effective move from adolescence to adulthood.

Year	**Age**
Year 9	13-14
Year 10	14-15
Year 11	15-16
Year 12	16-17
Year 13	17-18
Year 14	18-19