Leicestershire Partnership NHS Trust

Preparing for Adulthood and Transition Planning in Leicestershire Partnership NHS Trust

This policy provides clear guidelines on processes and standards for all clinicians working with young people aged between 14 years and 25 years across Leicestershire Partnership NHS Trust.

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Which Relevant CQC Fundamental Standards?	9, 10, 11, 12, 13, 15, 16, 17, 18, 19, 20, 20A	

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Version Control and Summary of Changes

Version number	Date	Comments (description change and amendments)
A1	Sept 2014	Initial protocol developed for a FYPC CQUIN
A2	July 2017	New version developed to reflect NICE guidance and standards published in 2016
A2	June 2019	Extended for 1 year due to review of service
A3	October 2021	Interim policy pending further work
3.1	September 2024	QF Approved 3 month extension
3.1.1	January 2025	QF Approved 3 month extension

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Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population, and workforce, ensuring that none are placed at a disadvantage over others.

It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all.

This document has been assessed to ensure that no one receives less favorable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy, and maternity.

In carrying out its functions, LPT must have due regard to the different needs of

different protected equality groups in their area.

This applies to all the activities for which LPT is responsible, including policy development and review.

Due Regard

LPT must have **due regard** to the aims of eliminating discrimination and promoting equality when policies are being developed. Information about due regard can be found on the Equality page on e-source and/or by contacting the LPT Equalities Team.

Definitions that apply to this Policy

Transition	A period of adjustment and planning in preparation for transferring to another service or pathway
Transfer date	Agreed date that a young person's care will end with children's services and be transferred to the direct equivalent adult service or alternative
Preparing for Adulthood	A general term that encompasses a wide agenda for complete organizational support for young people to promote independence and to improve life chances
Person Centred Planning	A process of continual listening and learning, focusing on what is important to someone now and in the future and acting upon this in alliance with their family and friends
Young Person	Includes terms service user, client, young adult between 13 & 25 years
SEND	Special Education Needs and or Disability. Reforms as part of the Children and Families Act 2014
EHC Plan	Education Health & Care Plan a document that details the Education, Health and Social Care support that is provided for a child or young person who has SEND. It is drawn up by the local authority following an EHC assessment. Health providers have a duty to contribute to a young person's EHC plan where a Young Person has health needs that effect their learning
Local Offer	Information on what is available in a local geographical area for children and young people with SEND published by the Local Authority
FYPC.LD	Families, Young People and Children's**.** Learning Disabilities Directorate
AMH	Adult Mental Health Directorate
CHS	Community Health Services
LPT	Leicestershire Partnership Trust

LPT Position Statement

All staff working with patients aged between 14 to 25, both those currently looking after them as well as those who will be receiving them under their care, are required to familiarise themselves with this policy so that they are fully aware of their roles and responsibilities to ensure a smooth and successful transition of care.

Overarching Principles

1. To pro-actively identify those who would require transition and start planning early.

2. To be aware of local pathways and referral mechanisms in the transfer to Adult Services.

3. To involve patients and their carers in the process of transition planning.

4. To ensure transition is developmentally appropriate.

5. To use a young person centred approach.

6. To take an integrated approach.

7. In complex cases, to consider keyworker involvement or additional support from the LPT Transitions Team in order to advise, signpost and coordinate the transition process.

8. To ensure that the transferring service does not discharge the patient until after they have been seen by the receiving service and the transition process is complete.

9. If no receiving service is identified, to discharge to GP.

1.0 Purpose of the Policy

The key aims of this policy are:

- To enable young people and their families to be actively involved in planning their future health needs to ensure that their transitions process is a smooth one.

- To enhance the young person's sense of control and independence in relation to their healthcare needs.

- To ensure joined up planning, appointments, and transfer across LPT directorates.

- To ensure that everyone involved in preparing young people for transition to adult health services is aware of their role and responsibilities in working together across directorates.

- To act as a driving force for improving young people's experience of transitions by embedding preparing for adulthood best practice within clinical care pathways and practice.

- To enable LPT to comply with the requirements of the SEND agenda for young people (this applies to young people up to the age of 25 years if they are accessing an education provision)

2.0 Summary and Key Points

2.1 This policy applies to all LPT staff that have a duty of responsibility for delivering clinical care to Young People up to the age of 25 years, if accessing an educational setting beyond 19 years. The policy is designed to help provide health professionals with the information and guidance on how to improve the transition process for young people with ongoing health needs as they move into adult services, as required by legislation, which will have a positive impact on their independence and life outcomes into adulthood.

2.2 We acknowledge that positive life outcomes cannot be achieved by health professionals alone and therefore the policy emphasises the need for joint working with partner organisations. It also acknowledges that staff training is necessary to have an informed workforce and includes how this will be achieved.

2.3 To improve the transition process Education, Health and Care plans (EHC) have been introduced and are used to assess the needs of children with additional needs from 0-25 years. At 14 years (year 9) the emphasis of the EHCP changes in order to consider the life outcomes for the young person, including planning for good health. As health professionals we have a legal obligation to comply with requests for health information to inform the EHC plan. The EHC plan adopts a person centered approach to include the young person's life aspirations giving more control to the young person and their carers.

3.0. Introduction

3.1 Transitions takes place at a pivotal time in a young person's life. A loss of continuity of care can be a disruptive experience, particularly during adolescence, when young people are at enhanced risk of psychosocial problems. Poorly managed transitions can result in disengagement with services and deteriorating health (Watson, 2005).

Previous guidance has highlighted that all young people with health and mental health needs are at risk during transition (DH, 2006).

A study of young people transitioning from CAMHS to Adult Mental Health Services indicates that two thirds of teenagers are either "lost" from or have interruptions in their care during this time (Singh et al, 2010). Other groups of young people are also seen as being at particular risk of difficulties during transitions. For example, young people with complex and multiple needs (Crowley et al, 2011), young people with palliative care needs, young people leaving residential care (Beresford and Cavet, 2009), young people with neurological disorders, those with learning disabilities and those with physical and sensory disabilities.

3.2 Effective transitions for young people are built on effective communication between services, knowledgeable staff that are trained to work with young people during this challenging time, clear and transparent processes, and multi-agency working. Recent changes in the Children and Families Act 2014 and the Care Act 2014 promote joined up working across agencies with the Young Person at the centre of decision making. All organisations are required to have a policy setting out clear guidelines and expectations for all staff.

Preparing for Adulthood begins from birth and those working with younger children should be aware that preparation and consideration is given the earliest opportunity. Supporting aspirations and life outcomes, promoting independence, employment opportunities, access to leisure, community and opportunities and planning for good health are key areas to consider.

3.3 This policy is the result of listening to staff, parents' and young peoples' views and consultation with key stakeholders about the need to have clear guidelines on processes for preparing young people for their transition to adult health services. All clinical staff working with young people who are in school year 9 upwards or are aged between 14 & 25 years, and are still receiving education, have a responsibility to be aware of this policy and to implement the guidance into their practice.

This policy supports those young people who may have direct transfer to an equivalent adult service, where these exist, and also those where there is no direct transfer (i.e. – the equivalent paediatric service is not replicated in adult services but the young person has ongoing health needs that need to be met now or in the future).

3.4 Through implementation of this policy, based on NICE quality standards, we aim to ensure that young people who are using our services:

- ✓ Have time to consider the move to adult services and that a conversation has begun by the time the young person is in school year 9, (the school year in which they turn 14 years old) or at the earliest opportunity.

- ✓ Have an annual meeting to review needs and progress.

- ✓ Know who is involved during the transition process and that the right professionals are involved at the right time.

- ✓ Have a health plan in place that may include how to maintain good health in adulthood and that can be included with their overall transition plan or Education, Health and Care plan where one is in place.

- ✓ Have access, if needed, to a named worker who co-ordinates, supports and navigates the young person through services and the move into adulthood.

- ✓ Have been introduced to clinicians in the Adult setting.

- ✓ Are identified and supported post transfer, in the event of missed appointments with adult services.

3.5 This policy applies specifically to those young people who are known to services provided within FYPC during the planning time running up to transition (this includes those young people whose episode of care is likely to end prior to the actual transfer date) and:

- Have a disability defined by the Disability Discrimination Act 1995 (physical or mental impairment which has a substantial and long-term adverse effect on his or her ability to carry out normal day to day activities)
- Have a life limiting or life-threatening condition and may be at the end of their life.
- Have an Education Health and Care Plan where the health element is completed.

3.6 There is a well-established body of legislation and policy that already applies to transition this protocol has been informed by the following national guidance:

- NICE Guidelines Transition to Adult Services (2016)
- Children's and Families Act (2014)
- SEND Code of practice (2014)
- Care Act (2014)
- From the Pond into the Sea – CQC report (2014)
- A Transition Guide for all Services (2007)
- DH/DfES (2006), Transition: Getting It Right for Young People, Improving the transition of Young People with long-term conditions from Children's to Adult Health Service
- Improving the Life Chances of Disabled people (2005)
- The transition from Child and Adolescent Mental Health Service to Adult Mental Health Services, Health and Social Advisory Service (2006)
- Mental Capacity Act (2005)
- All Parliamentary Group on Autism (2009), Inquiry into transition into Adulthood for Young People on Autism Spectrum
- East Midlands NHS Principles for Transition Guidance materials to improve transition into adult life for young people with additional needs.
- Lost in Transition – RCN (updated 2013)
- These are all our children – DH (2017)

4.0. Flowchart/process chart

The following process should be followed by all staff working with young people during their transition phase 14-25 years.

Transition Planning for Young People from Children's to Adult Health Services

Parallel planning with Education, Health and Care plan

Advocate a person centred approach in all planning and decision making

Stage 1 - Getting Ready

THINK

Preparing for Adulthood – Young Person 14 years – School Year 9

All staff should recognise the ongoing needs and aspirations of the young person and start to plan and discuss with the young person and their families what they may need in terms of support and knowledge of how to manage their health condition in the future.

Young Person	Family/Friends	Practitioners	Guidance Standards
At the Centre of decision making – *"Nothing about me without me"*	Parents supported to consider the future and the aspirations for their young	Identify young people with ongoing healthcare needs that are likely to require support to manage their condition into adulthood prior to their 14th birthday	**NICE Guidance Quality Standard – Planning Transition, named worker identified** East Midlands Best Practice Guidance – Nov 2014 Children and Families Act 2014– SEND Reforms Together for short lives From the Pond into the Sea – CQC
Supported to start to make decisions for myself (self- advocacy)		Liaison with other relevant healthcare professional	
Understanding that services will be different in Adulthood and that many of the people who support you with your health care may no longer be involved	Parents supported to consider the 4 life pathways of independent living, employment, leisure, and planning for good health	Start the discussion with the young person around adulthood and identify people that may be able to support the young person	
		Identify the most likely age when a young person will transfer to another adult service or leave children's services.	
		If the young person has an EHC plan, consider the young person's aspirations and how health input can support the aspirations.	
		Consider accessing additional support from the SEND Transitions Team, if required. Provide advice about Local Offer.	
		Ensure that all correspondence is now addressed to the young person and not their parents/	

Identify and agree a named worker to be a continual point of contact throughout the whole transition process

Parallel planning with Education, Health, and care plan - Consider Mental Capacity and decision making

Stage 2 – Keeping Me Steady

SIGNAL

Ongoing planning and preparation for Adulthood

All staff should remain focused on the young person's aspiration and life outcomes and the impact of their condition. Identifying issues early and seeking solutions – highlighting and raising these with the plan coordinator if the young person has an EHC plan and/or relevant healthcare professional.

Young Person	Family/Friends	Practitioners	Guidance Standards
Gradual increase in confidence and skills to promote autonomy in their involvement in decision making and how to manage and take charge of own health care needs	Parents supported to consider implications of Mental Capacity Act	Contribute to EHC plans at appropriate school reviews and remain focused on supporting life outcomes and aspirations.	NICE Quality Standard – Annual meeting, named worker and Introduction to Adult Services East Midlands Best Practice Guidance – Nov 2014 Children and Families Act 2014– SEND Reforms Together for short lives
	Consider opportunities for joint clinics with Adult Services over 6 months to a year prior. Make / accept referral for ongoing care. Start the dialogue with Adult colleagues		
At the centre of decision making, present at any meeting or consultation	Inform Divisional Management Team, Designated Clinical Officer and Commissioners of any gaps in care, when adult services are not available to transfer into.		
	Continued support to consider the future and the aspirations for their young person	Use annual review of the EHC plan as a platform to discuss transition of young people with complex needs. Consider how partner agencies may be able to help. Consider if referral to the SEND Transitions Team is required.	
	Continued support to consider the 4 life pathways of independent living, employment, leisure, and planning for good health	Inform GP and any other relevant people i.e. plan co-ordinator/LA/Education when a young person is discharged/ episode of care completed. Signpost to Local Offer.	
		Ensure that if discharging a young person at this stage information is provided on how to manage their healthcare condition in the future.	

Work collaboratively with named worker to ensure smooth transition

Advocate a person centred approach in all planning and decision making

Parallel planning with Education, Health, and care plan

Stage 3 – Before I Go

MOVE

Transferring to Adult Services and settling into Adult Services

All staff should compile a robust and comprehensive discharge summary report which outlines how a young person can plan for their health and wellbeing in adulthood.

Young Person	Family/Friends	Practitioners	Guidance Standards
I know who to contact in Adult Services to help me manage my health condition	Continued support to consider the future and the aspirations for their young person	Agree with the Young Person/Parent/Carer and onwards services what information will be shared and when with consent of the young person or	**NICE Quality Standard – Introduction to Adult services, missed appointments after transfer** East Midlands Best Practice Guidance – Nov 2014 Children and Families Act 2014– SEND Reforms Together for short lives
I know questions that I should ask about how to manage my health care conditions	Continued support to consider the 4 life pathways of independent living, employment, leisure, and planning for good	Complete a robust written transition plan with the young person. Report to be available on SystmOne. See appendix 9	
I know that I can access the Local Authorities Local Offer to find out information.		Notification of missed appointments after transfer to adult services to agreed named worker.	

Agree named worker in Adult services

Acceptance in Adult Services should be reflected on clinical need rather than staffing levels.

Advocate a person centred approach in all planning and decision making

5.0 Duties within the Organisation

5.1 The Trust Board has a legal responsibility for Trust policies and for ensuring that they are carried out effectively and to nominate a transition champion for the organisation at trust level.

5.2 Quality Assurance Committees have the responsibility for ratifying policies and protocols.

5.3 Service Directors and Heads of Service are responsible for:

- Identifying and making provision for training and development needs for all staff in relation to this policy.
- Ensuring compliance with mandatory and statutory requirements.
- Promoting a culture of Person-Centred Care
- Communicating with commissioners where resource is an issue.
- Reporting on the monitoring of compliance and effectiveness of the delivery.

5.4 Managers and Team leaders are responsible for:

- All staff in their service are aware of and adhere to this policy
- There is a clear process for dissemination of this policy
- Staff are released to meet their training needs
- Line managers are supported in monitoring compliance with the LPT transition policy
- Preparing for Adulthood and Transitions is embedded within relevant clinical care pathways
- Promoting a culture of person centred care

5.5 Responsibility of Staff

Clinical staff and /or the main person providing care

- Adhering to the policy and relevant care pathways
- Ensuring that young people, parents, and families are fully involved and lead the planning process
- Adopt a person centred approach to discussions and decisions
- Start the planning process at an appropriate stage, as early as possible
- Facilitating good communication between services is vital
- Ensuring that there is a period of preparation and not just a single event
- Informing line managers where there may be issues around funding with onward care
- Ensuring they have the right information in order to be able to meet the Young Person's needs
- Clearly agreeing with the young person how and when transfer to Adult Services will occur.
- Being proactive throughout the process

Transition Lead

In addition to the above responsibilities:

- Supporting staff through provision of training and advice to adhere to this policy, evaluating and reviewing the process.
- Gathering patient journeys/lived experiences and analysing data and views on the Preparing for Adulthood agenda.
- Informing commissioners of identified gaps in services.

It is acknowledged that our partner organisations also have responsibilities in securing the Preparing for Adulthood agenda.

6.0. Training needs

Staff working with young people aged 0-25 years will complete the Transitions E-Learning package (accessed via u Learn) as part of the development of their role.

This will include information about transitions planning and preparing for adulthood and of the pathways/processes in place for transfer to Adult Services.

7.0. Monitoring Compliance and Effectiveness

Ref	Minimum Requirements	Evidence for Self-assessment	Process for Monitoring	Frequency of monitoring
	Identification of YP on caseload who will be turning 14 years and contribution to Year 9 annual review, including likely plan for transfer or discharge at 18/19 years, if known (NICE Statement 1)		Documentation in S1	Quarterly
	Details of Local Offer given to young person/ parent-carer		Documentation in S1	Quarterly
	Details of relevant Adult Service given to YP/parent, or alternatively details of mechanisms for future re referral if needed		S1 – cc of letter sent to YP/carer and their GP	Quarterly

8.0. Standards/Performance Indicators

This protocol links with the standards set out in the Care Quality Commission (CQC) recommendations: From the Pond into the Sea (June 2014), and NICE Transition guidance and Quality Standards (Dec 2016).

This protocol contributes to CQC Essential Standards:
Outcome 1 – Respecting and involving people who use services
4 – Care and Welfare of people who use services
6 – Co-operating with other providers
14 – Supporting workers
16 – Assessing and monitoring the quality of Service Provision.

TARGET/STANDARDS	KEY PERFORMANCE INDICATOR
NICE Guidance on Transition – 2016 Quality Standard 1. Planning Transition	Transitions planning to be discussed during Year 9 and documented in records
NICE Guidance on Transition – 2016 Quality Standard 2. Annual Meeting	Engagement with Year 9 Annual Reviews and contribution of health information
NICE Guidance on Transition – 2016 Quality Standard 3. Named Worker	
NICE Guidance on Transition – 2016 Quality Standard 4. Introduction to Adult Services	
NICE Guidance on Transition – 2016 Quality Standard 5. Missed appointments after transfer to Adult Services	

9.0. References and Bibliography

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3/SEND_Code_of_Practice_approved_by_Parliament_29.07.14.pdf (accessed February 2015).

Singh et al (2010) Process, Outcome and Experience of Transitions from Child to Adult Mental Healthcare: A Multiperspective Study

Watson AR (2005) Problems and Pitfalls of Transitions from Paediatric to Adult Renal Care. Paediatric Nephrology 20: 113-7

Appendix 1

The NHS Constitution

The NHS will provide a universal service for all based on clinical need, not ability to pay. The NHS will provide a comprehensive range of services

Shape its services around the needs and preferences of individual patients, their families and their carers	**X**
Respond to different needs of different sectors of the population	**X**
Work continuously to improve quality services and to minimise errors	**X**
Support and value its staff	**X**
Work together with others to ensure a seamless service for patients	**X**
Help keep people healthy and work to reduce health inequalities	**X**
Respect the confidentiality of individual patients and provide open access to information about services, treatment, and performance	**X**

Appendix 2

Stakeholders and Consultation

Key individuals involved in developing the document

Name	Designation
Gill Hardy	SEND Transitions Lead – LPT
Janet Harrison	Head of Service for Group 2/Interim SEND Lead - FYPC

Circulated to the following individuals for comment

Name	Designation
PSEG Representatives	
Heather Darlow	Governance Lead, CHS and FYPC.LD
Teresa Norris	Community Nurse, CAMHS
Zayad Saumtally	Head of Nursing
Rachel Shead	Directorate Quality and CQUIN Co ordinator, AMH.LD
Laura Smith	FYPC.LD Service Group Manager
Alison Taylor-Prow	LPT Mental Capacity Act Lead
SEND Delivery Group	

Appendix 3

Due Regard Screening Template

Section 1	
Name of activity/proposal	Review of Transition planning protocol across LPT directorate
Date Screening commenced	
Directorate/Service carrying out the assessment	FYPC.LD/AMH/CHS
Name and role of person undertaking This Due Regard (Equality Analysis)	Gill Hardy SEND Transition Lead
Give an overview of the aims, objectives, and purpose of the proposal:	
AIMS: To review the existing protocol from children to adult health services to include quality standards from NICE guidance.	
OBJECTIVES: Consultation will be sought through the Preparing for Adulthood steering group with members from FYPC.LD, AMH and CHS directorates and with Parents and Carers of young people who have undertaken the process of Transition from child to adult health services. NICE guidance will be reviewed and included within the policy. Service areas will be made aware of the reviewed document and encouragement given to include principles in services standard operating procedures.	
Section 2	
Protected Characteristic	**If the proposal/s have a positive or negative impact please give brief details**
Age	The policy promotes early transition planning and discussion with young people and the people who support them. It will encourage liaison with adult services earlier to promote effective planning. Service provision is currently based on commissioning arrangements by age criteria, this limits flexibility between children's and adult services
Disability	The policy will support the needs of all young people who have been known for FYPC services and require ongoing support from adult health services. The policy will not cover young people know to audiology as this is an assessment only services
Gender reassignment	The policy will support links with other agencies and support in order to meet the aspirations and preferences of young people
Marriage & Civil Partnership	The policy will support links with other agencies and support in order to meet the aspirations and preferences of young people
Pregnancy & Maternity	The policy will support links with other agencies and support in order to meet the aspirations and preferences of young people

Race	The policy will ensure the use of interpreters and translation services including access to easy read information and use of sign language where English is not the first language. Service users may find difficulty accessing venues and services, the protocol supports a multiagency approach to
Religion and Belief	The policy promotes a focus on the aspirations of young people, through person centred planning and family centred care. It promotes preparation for using adult services in the young person's own right or being aware of how to access advocacy services in order to do so.
Sex	Although there are certain age restrictions set by legislation, the policy will encourage flexibility in transitions planning by using person centred approaches and a developmentally appropriate time to transfer to services.
Sexual Orientation	The policy will support links with other agencies and support in order to meet the aspirations and preferences of young people
Other equality groups?	The policy promotes a person centred approach, with partnership working across agencies.

Section 3

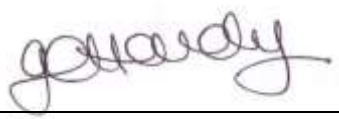
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please tick appropriate box below.

Yes		No	
High risk: Complete a full EIA starting click here to proceed to Part B		Low risk: Go to Section 4.	**X**

Section 4

If this proposal is low risk please give evidence or justification for how you reached this decision:

The numbers of young people who move into adult health services will remain the same, however this policy exists to improve the quality of the transfer and the early identification and awareness of the wider issues linked to preparing for adulthood.

Signed by reviewer/assessor		**Date**	2021

Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed		**Date**	

Appendix 4

Further information on national context

4.1 The Children & Families Act 2014 SEND Reforms

In light of legislative changes under the Children and Families Act and SEND reforms a greater emphasis is placed on preparing for adulthood.

The focus of the reforms is for greater openness and transparency in the assessment, planning and support, with one plan that will include Education, Health and Care.

For young people with special educational needs and/or disability (SEND) who have an Education, Health and Care (EHC) plan under the Children and Families Act, preparation for adulthood must begin from year 9. 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 health care and support required.

Equally for those without EHC plans, early conversations with local authorities about 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.

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 social 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.

The transition from Children's to Adult health services is regularly highlighted as a problem area for disabled young people. Eligibility Criteria can mean they are not entitled to support as an adult they depended on as a child. Planning for good health will start at 14 years to prepare young people for the changes to come and to increase their independence to manage their own health needs where possible, as they prepare for adult services.

Another key element to the reforms relates to personalisation and the option of a personal budget. This is an amount of money that is needed to support children and young people's identified needs where they cannot be met by universal, targeted or specialist services. Personal budgets are only one part of a whole system of support and must be seen within the whole context of multi-agency assessment and planning.

For further information on personal budgets, including personal health budgets please refer to the local offer or the Clinical Commissioning Group (CCG) website for the required area:

Leicester City CCG: https://www.leicestercityccg.nhs.uk/my-health/personal-health-budgets/

East Leicestershire CCG: https://eastleicestershireandrutlandccg.nhs.uk/your-health/personal-health-budgets/

West Leicestershire CCG: https://www.westleicestershireccg.nhs.uk/your-health-and-services/personal-health-budgets

Leicester City: https://mychoice.leicester.gov.uk/

Leicestershire: https://www.leicestershire.gov.uk/education-and-children/special-educational-needs-and-disability/about-the-local-offer

Rutland: http://ris.rutland.gov.uk/kb5/rutland/directory/localoffer.page?localofferchannel=0

4.2 Preparing for Adulthood

Preparing for adulthood begins when a child is born. For young people with long term conditions and disabilities it is even more important that effective planning is co- ordinated in order to ensure that an opportunity for better life outcomes is facilitated. As part of the SEND Preparing for Adulthood Agenda, 4 Better Life Outcomes have been identified that need to be considered essential. These are:

- Employment
- Independent living
- Friends, relationships and accessing leisure and community opportunities
- Planning for good health

Planning for good health includes both the move from child health services and how young people look after themselves and keep healthy in adulthood.

4.3 Using a Person-Centred Approach to Focus on Outcomes

This protocol promotes the adoption of a person centred approach for young people up to 25 years within LPT. The model embraces:

- seeing the Young Person first, rather than diagnostic labels
- using ordinary language and images, rather than professional jargon
- actively searching for a Young Person's gifts and capacities in the context of community life
- strengthening the voice of the person, and those who know the person best in accounting for their history, evaluating their present conditions in terms of valued experiences and defining desirable changes in their life

A person-centred approach to planning means that planning should start with the individual (not with services) and take account of their wishes and aspirations.

4.5 Adult Orientated Skills

From birth, a Young Person is developing the skills they will use in Adulthood. Young people with additional needs are required to learn additional skills to enable them to maintain their health into adulthood (Reiss, Gibson + Walker 2005). It is the responsibility of those who work with the Young People and their families to empower young people to manage their health where possible and to support and promote parents to 'let go' and encourage their Young Person to be independent. Where a Young Person will remain dependent on adult care throughout their life, parents/carers also need to be prepared to 'let go' as their young adult reaches the legal adult age.
This can include:

- Letters being sent to the Young Person in their own right
- Attending appointments on their own
- Being able to advocate for themselves or knowing how to receive advocacy support
- Asking questions in clinic themselves
- Knowing about their doses/medication with/without prompts/support
- Understanding what transition means and how they can be involved
- Being confident that professionals will continue to support them and who/how they need to contact others
- Taking responsibilities at home
- Understanding the importance of exercise, good diet, weight management where relevant
- Awareness of issues of puberty and sexuality, and effect on condition
- Awareness of condition, what has contributed to them being able to do what they do today and what may happen if they stop
- Booking appointments
- Getting prescriptions
- Understanding how to access emergency help
- Understanding differences between Adult and Children's services
- Understanding how health may impact on their future education, social, leisure, work, and home life

Discussions may start at 13 or younger, or when appropriate. It is important that relevant professionals start their discussions with Young People, carers or advocates as appropriate, i.e. encouraging attending appointments on their own.

4.6 Contributing to Education Health & Care Plans

Where a Young Person has ongoing need for additional support into Adulthood and continues in education or training, the Education and Health Care plan will be used to support the transition planning into Adulthood and transfer with the Young Person.

Health professionals working in both young people and adult services should:

- familiarise themselves with the agreed local procedures
- Attend multi-agency training during the government transition period, available through the local authorities.

Health providers and professionals have a duty to co-operate with the local authority and contribute to the education, health, and care plans where appropriate.

Young People and their parents should:

- Be fully involved in making decisions about their care and support. This includes decisions about the most appropriate time to make the transition to adult services. The EHC plan or any transition plan should set out how this will happen, who is involved and what support will be provided to make sure the transition is as seamless as possible (Care Act 2014 16.7).

4.7 The Local Offer

Each authority is legally required to produce information on health, education social care and voluntary agencies for young people aged between 0 and 25 years in one place as part of the Children and Families Act 2014. This is a resource for young people their families and professionals. Health services are obliged to co-operate in order to supply appropriate information for this resource.
Staff are encouraged to use this as a resource for themselves and to direct families to this information.

The local offer can be viewed at
Leicester City https://mychoice.leicester.gov.uk/

County www.leics.gov.uk/local_offer

Rutland http://fis.rutland.gov.uk/kb5/rutland/fsd/localoffer.page?familieschannel=5

4.8 Care Act 2014

The Care Act contains provisions to help preparation for adulthood for three particular groups of people – children, young carers and child's carers. In the context of this chapter, a 'child' is most probably a Young Person in their teenage years preparing for their adult life, although it can refer to anyone under the age of 18 years. This chapter therefore uses the term 'young person'. The term 'carer' can be taken to mean either a carer of a Young Person, or a young carer preparing for adulthood. Each group has their own specific transition assessment respectively; a child's needs assessment, a young carer's assessment, and a child's carer's assessment. The term used in this chapter for all three is 'transition assessment'.

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.

Transition assessments should take place at the right time for the young person 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. 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.

4.9 Mental Capacity Act (MCA)

When a young person reaches the age of 16 years, in the eyes of the law they become adults and therefore have more decision-making powers, unless this can be disproved. Every person should be presumed to be able to make their own decisions. Under the Mental Capacity Act, a person is presumed to make their own decisions "unless all practical steps to help him or her to make a decision have been taken without success". The MCA sets out a checklist of things to consider when deciding what is in a person's best interest. Further information can be found on the Mencap website.

http://www.mencap.org.uk/

The link for the LPT MCA Policy is as follows:

https://www.leicspart.nhs.uk/wp-content/uploads/2021/09/Mental-Capacity-Act-Policy-exp-Jul-24-updated-Sep-21.pdf

We have updated MCA templates, these can be found on StaffNet:

https://staffnet.leicspart.nhs.uk/support-services/safeguarding/mental-capacity-act-documents/

4.10 Care Programme Approach (CPA)

The Care Programme Approach (CPA) is the name given to the way that mental health services deliver care. The first part is an assessment of needs and strengths and an opportunity for young people to state their preferences. The second part is agreeing the plan of care that will best meet their needs and promote recovery. These agreed plans are reviewed at regular intervals.

A care coordinator is allocated to the young person who will be the one who meets regularly with the young person to discuss the care provided and their progress.
https://www.rethink.org/advice-and-information/living-with-mental-illness/treatment-and-support/care-programme-approach-cpa/ - hyperlink for CPA information for service user's in adult mental health

Appendix 5

Stakeholder duties in relation to Preparing for Adulthood Stakeholders or any other groups with responsibility associated with this protocol, partner agencies such as Education, Social Care, Voluntary Sector, Young people and their parents/ carers.

5.1 Young Person

Young People should be supported to say what they want, need and value, to create their health plan, enabling them to make informed decisions where they have the mental capacity to do so. A person-centred approach is essential to understand and support their aspirations around the four pathways to getting a better life: employment, independent living, developing friendships and accessing leisure opportunities and planning for good health.

5.2 Parent/carer

Parents/carers have a vital role in collecting relevant information as they know all the important people and activities in the Young Person's life. They also know what they may be able to do to help in the future and to understand the choices available. Parents/carers should be supported to adjust to their changing role as their Young Person becomes an adult in their own right.

5.3 General Practitioner

General practitioners state that they are not involved in transition planning of a Young Person. It is often the case that a Young Person may not visit the GP often during their childhood and therefore the GP is not involved with the day to day management of their long-term disability or condition, as their needs are met through children's services including CAMHS, direct access to wards, or paediatricians.

Upon reaching 18 or before; if discharged by paediatricians, the Young Person's GP becomes the coordinating professional. It is therefore good practice to:

- Alert the GP early (i.e. from 14 years) that a Young Person may have ongoing health needs into adulthood.
- Include the GP in discussions about the health action plan where appropriate for example, complex continuing health care needs exist, ongoing medication required, enduring mental health needs.
- Include GPs in all phases of the transition planning and transfer to adult services, whether this is a direct or indirect transfer.

5.4 Transition Social Worker

It is the responsibility of Social Workers to work closely with health and other agencies to provide a range of services and support designed to protect young people from harm and promote the welfare of children in need.

A transitions assessment is undertaken by a Social Worker in accordance with NHS and Community Care Act 1990 to establish a young person's eligible needs for when they turn 18 years of age. The Care Act 2014 provides the legislative framework for undertaking transitions assessments. The assessment will identify if there are any

safeguarding issues that need addressing, the need for continuing health care assessments and a young person's eligible needs. Once the assessment is completed a support plan will be created to meet the young person's needs. Support plans will detail how the young person's eligible needs will be met through commissioned services such as direct payments or short breaks for example, or through services provided by the voluntary and independent sectors.

There are additional responsibilities under the Care Act 2014 around requesting as assessment for Continuing Healthcare.

5.5 SENCO
The school Special Educational Needs Co-ordinator (SENCO) is responsible for ensuring:

- The correct procedures for SEND are followed
- The other agencies including health contribute to reviews as appropriate
- To lead on organising statutory reviews under the Children and Families Act for all young people with Education, health, and Care plans. Transition planning (Preparing for Adulthood) is incorporated into these reviews. Adequate notification is required to ensure that all relevant health professionals can attend reviews where possible and take responsibility for implementing actions agreed in the Preparing for Adulthood implementation plan. Health Service Providers involved with Young People have a duty to comply with requests for information under the Children and Families Act (2014).

5.6 Voluntary and Charitable Sector, e.g. Rainbows
The voluntary sector provides a role in supporting young people and their families. The local offer for each area (see appendix 1.1) can provide further information.

5.7 Independent Supporters
The Independent Supporters can offer advice and information on key issues around school support and special educational provision, EHC needs assessments and plans, local policy, and the local offer, social care, and health in relation to a young person's SEND.
This role may be undertaken by different agencies.
At present part of this function within Leicester City is undertaken by SENDIASS – Special Educational Needs and Disability Independent Support Services – formally parent partnership. http://www.sendiassleicester.org.uk/
Further information can be found on each local authority Local offer website (please see appendix 1.1)

Appendix 6

Principles of an effective transition

6.1 The transition process puts the Young Person at the centre giving them more choices and control over the future

- Young people and parents are recognised as partners in the process and will be involved in all aspects of the transition thus giving greater transparency
- Sometimes young people over 16 specifically state they don't want their parents involved.
- There is a commitment from Leicestershire partnership Trust working to find creative solutions for the benefits of the Young Person.
- Families will be able to access good information about options and choices to enable them to be confident about how their health needs will be met.
- Transition planning should be individualised and person centred including co-ordination and involvement with all agencies involved in delivering services both currently and post transition and realistic in terms of what adult services offer.
- Everyone should have the right to express their views. It is important to ensure that those with more complex communication needs are enabled to express their views and preferences
- Effective communication with adult services and other providers is essential to ensuring good transition experience.

6.2 Communication

Research tells us that communication between services during transition is a common frustration for young people and families.
All staff are expected to:

- Include the Young Person in planning at all times and their families
- Be open and honest about the options that are available for ongoing healthcare to meet their needs in the future.
- Prepare the family for transfer to adult services throughout the transition period from aged 14 including consent, advocacy, and impact of mental capacity act.
- Share relevant information with the providers of the service that they are being transferred to.

Appendix 7

Accessing Children's Services

FYPC offer a range of services for young people with physical and mental health needs. These services are commissioned through various sources and therefore currently the age criteria for services are variable.

Services that accept young people up to their 18th Birthday

(Input may be extended where the Young Person remains in full-time education up to 19 - see up to 19th birthday).

- Children's Occupational Therapy, Physiotherapy and Speech and Language therapy – except those with SEN remaining in Education
- Community Paediatricians – except those with SEN remaining in Education
- CAMHS learning disabilities
- CAMHS
- CAMHS outpatient and inpatient
- Diana Services

Services that accept young people up to their 19th Birthday - if remaining in full-time education and not attending a college setting, e.g. area special schools

- Children's Occupational Therapy
- Physiotherapy
- Speech and Language Therapy
- Community Paediatricians
- School Nursing
- Paediatric Psychology

Services that accept young people across into adulthood

- Nutrition and Dietetics (whole life service)
- PIER (Up to 35 years)
- Specialist Autism Team (referrals from 14 years)

7.1 Referrals Post-14

Where a Young Person is referred to FYPC post 14/school year 9, the receiving professional should:

- Check whether a Health Action Plan has been discussed
- Discuss with Young Person/parent/carer their transition plans and needs.
- Check if the Young Person has a EHC Plan

- Contribute any new information to the EHC at an appropriate time or transition planning

7.2 Episodes of Care

It is acknowledged that few young people known to children's services will receive care on a continuous basis from birth – 18 years or 19 years. Where provision of care is based on episodes, it is the responsibility of professionals where appropriate to consider any ongoing health needs that a Young Person may have into adulthood.

Appendix 8

Accessing Adult Services

Adult services are often organised and commissioned to provide a different type and level of service to Children's services. The culture, expectations and environments of adult services can be very different to children's services. They can move from a very specialist service into a wider, more generic service. Young People access a variety of Adult Services from a variety of providers, including LPT, University Hospitals of Leicester (UHL) and private/ voluntary providers. Service providers receiving onward referral from FYPC services, if this is required, should expect:

- Information to be provided on the Young Person in a timely manner.
- Discussion with the FYPC professional prior to referral being accepted.
- To agree with the FYPC professional on timescales, transition period and information required.
- Information on education, health, and care plan to be transferred where this is available.
- Health professionals working with young people at the time of transition to have a good understanding of the criteria of adult services, referral processes and thresholds.
- Health professionals working with young people at the time of transition should be aware of when children's services will transfer young people or end.

LPT Adult Services that support young people from their 18th Birthday, but will accept a referral from 17 years 6 months:

- Adult Community Mental Health Team
- Agnes Unit Inpatient LD Services
- Assertive Outreach teams
- Autism Service for Adult Learning Disabilities
- Community Learning Disability teams
- Community Nursing teams
- Community Therapy
- Eating Disorders for Adult Mental Health
- Medical Psychology
- Specialist Psychological Therapies
- Adult Mental Health Services Inpatients and Psychiatric Outpatients.

Services that accept young people across into adulthood:

- Nutrition and Dietetics (all age service)
- PIER (up to 35 years)
- Specialist Autism Team (from 14 years onwards)

Appendix 9

Transfer plan for Young Person

Transition to Adult Services/ Preparing for Adulthood Plan Transition plan produced in collaboration with the young person and/or their carer
Name **Addre** **ss** **DOB** **NHS number**
What is currently working well – Equipment needs, level of support / information, current treatment plan and rationale
What is important to me in the future for my health - Summary of ongoing needs
What is important to me in the future for my social, financial, housing needs – If known
Who do I contact in Adult services if I need help – for example: Referral via GP for Hand splints, Blatchfords for orthotics, where I get my medication from etc…
Transition Goals – Agreed with young person and or carer
Name and contact details of Transition Key worker / point of contact from sending service (FYPC)
Name and contact details of Transition Key worker / point of contact from receiving service (AMH/LD/CHS)

I confirm that I have had input with this plan and that I agree to the goals ☐

Name / Signature

Date

Appendix 10

Data Impact Assessment Screening Template

Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy. **The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.**			
Name of Document:	**Preparing for Adulthood and Transition Planning in Leicestershire Partnership Trust**		
Completed by:	**Gill Hardy**		
Job title	**SEND Transitions Lead**		**Date 11/08/2021**
Screening Questions		**Yes / No**	**Explanatory Note**
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.		No	
2. Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document.		No	
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?		No	
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?		No	
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.		No	
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?		No	
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.		No	
8. Will the process require you to contact individuals in ways which they may find intrusive?		No	
If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk **In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.**			
Data Privacy approval name:			
Date of approval			

Appendix 11 - Step by Step Guide for Lead Clinician to Transition Patient Transition CQUIN Requirements

Patients aged 17.5 transitioning from either Community CAMHS including Young Offenders and Looked after Children, Eating Disorders to AMHLD.

- FYPC service to establish if the patient potentially needs **transitioning** to AMH Services (CMHT, outpatients, Assertive Outreach).
- Or requires **discharge** to GP.

Transitioning

Before any referral is made to transition a patient from FYPC to AMHLD Services, a clinical conversation is to take place between referring FYPC clinician and the relevant AMHLD team manager to discuss clinical appropriateness of referral to AMHLD. There needs to be a progress note of this conversation in respective EPR systems (i.e. Systm One and RiO). Admin are to organise and enter time in clinician's diary for this discussion.

N.B. to avoid delay; do not reject a referral on the basis of not receiving a phone call before.

During the joint transition appointment the ***"Transition to Adult Services/Preparing for Adulthood Plan"*** (started in FYPC) needs to be fully completed by the AMHLD Clinician. A copy must be given to the patient.

If appropriate, FYPC clinician to refer patient to the relevant AMHLD team via their generic email address (See Appendix 1). The referral must include:

- The **part-completed "Transition to Adult Services/Preparing for Adulthood Plan"** (see Appendix 2).
- A joint transition appointment date, time and location (organised by CAMHS) giving at least three months advanced notice to patient and relevant AMHLD team. This appointment is separate from the FYPC final appointment and initial assessment with AMHLD and will include the referring clinician from FYPC, relevant clinician from the AMHLD team as well as the patient and patient's supports.

N.B. Referral will not be accepted by AMHLD if part completed joint plan is not sent with referral.

Referral to be discussed at the AMHLD team's next MDT meeting to allocate patient to appropriate clinician in the team. ***Referral only to be accepted if part completed Joint Transition Plan is received with referral.***

FYPC admin is to ***administer the Pre-Transition Questionnaire*** with the patient (Appendix 5). This is to be completed after the joint transition appointment and before discharge from FYPC/initial AMHLD appointment, and can be completed over the phone.

Relevant AMHLD admin/clinician to arrange initial assessment appointment with patient/their supports.

The ***"Post Transition Survey"*** (Appendix 3) must be completed by admin within three months from the initial appointment with the relevant AMHLD team. Completed survey to be emailed to ***Rachel.Shead@leicspart.nhs.uk***.

Discharge

- If the patient is stable then FYPC to discharge patient back to GP with a closure letter.
- ***Pre-Transition Questionnaire*** (Appendix 4) will be sent via a text link (survey Monkey) for patient to complete.
  - Responses will be picked up by Audit/quality team