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All Age Transition Policies: Best Practice Review

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1 Introduction

1.1 In December 2022, Facilitate Consultancy were commissioned by Jean Stephens, Assistant Director of Wirral Council's All Age Independence Team to conduct a comprehensive review of disability services across Wirral. The recommendations for workstreams following this review were approved by the Adults and Health Committee in June 2023, and a programme plan developed.

1.2 Facilitate were recommissioned in July 2023 to lead the refresh of Wirral's All Age Disability transitions policy, alongside the All-Age Disability strategy. This report summarises the findings of a review for best practice for All Age Disability transition policies, including the accessibility of these policies. These findings will inform the approach to the several planned coproduction engagements with people with lived experience and will be considered alongside the outcomes of these sessions when developing the strategy.

1.3 As set out in the scope of work, this review is to explore 3 example policies in depth. During the search process, we sought out policies that ideally are:

- produced after 2020 (this threshold was increased from 2022 due to limited results)
- for all disabilities, not just learning disabilities
- coproduced alongside people with lived experience
- produced by a Wirral statistical neighbour, and/or an authority that emerged as having best practice during the research and discovery phase of the review.

1.4 The recommendations of this report do not consider the content of the previous Transitions Policy for Wirral (2016-20). Hence, Wirral's existing Transition Policy may already include some content that is discussed in these principles.

1.5 Based on the parameters listed above (section 1.3), few examples were to be found with many being health-orientated, surface level or developed many years ago. This considered, the following policies demonstrated good practice and some lessons to take forward:

- Richmond upon Thames' Moving from Children's to Adults Services Transition Protocol (Date Unknown)[1]
- Herefordshire's Multi-Agency Protocol for Children and Young People with Disabilities and Complex Needs Preparing for Adulthood 2020[2]
- Sefton's Transition from Childhood to Adulthood Protocol 2020[3]

[1] London Borough of Richmond upon Thames (DATE UNKNOWN) Moving from Children's to Adults Services Transition Protocol https://www.richmond.gov.uk/media/22291/transition_protocol.pdf
[2] Herefordshire Council (2020) Multi-Agency Protocol for Children and Young People with Disabilities and Complex Needs Preparing for Adulthood https://www.herefordshire.gov.uk/downloads/file/3567/herefordshire_transition_protocol_-_from_school_to_adulthood_for_young_people_with_send
[3] Sefton Council (2020) Transition from Childhood to Adulthood Protocol https://search3.openobjects.com/mediamanager/sefton/fsd/files/transitions_protocols_26_5_2020.pdf

1.6 These examples – referred to as protocols – are evaluated over the following sections. The language of a 'protocol' opposed to a 'policy', ensures that these authorities clearly set out expectations from teams and organisations, allowing for consistency and efficiency.

1.7 Lastly, the National Institute for Health and Care Excellence (NICE) have published a Transitions from Children's to Adults' Services for Young People using Health or Social Care Services Guideline (NG43). This guideline forms the basis of Quality Standard 140 and is endorsed by the Department of Health and Social Care as required by the Health and Social Care Act 2012[4]. Hence, this guideline is also included in this review.

2 Richmond upon Thames' Moving from Children's to Adults Services Transition Protocol[1]

2.1 This example developed by Richmond upon Thames is evidently well considered and well produced. The date of development is not stated on the document, nor could be established from the Council's website. Without this date, it is hard to know whether the information is provided is likely to be outdated etc. However, the protocol references legislation from 2021, and the webpage hosting the PDF was last updated in 2022, suggesting it is a recent example, yet this should be explicit.

2.2 The protocol is aimed at all young people eligible for council support, including for "learning difficulties, disabilities, mental health issues, and additional needs" (p. 3). The sections of the protocol are distinct and easy to navigate to the information applicable to you. It begins with an outline of the principles of a good transition towards being supported, informed, and empowered (through personalisation, preparation, transparency, independence. and partnership), followed by a commitment to best practice and an outline of relevant legislation.

2.3 The main body of the protocol explains what to expect throughout the process of transitioning and defines the purpose of an EHCP Annual Review, various other meetings and several checklists and plans, including those specifically for Children Looked After. This section is very clearly broken down by age/year group (see Appendix 1), detailing the responsibilities of groups across 5 areas of a young person's life:

- Education
- Social Care
- Children Looked After
- Health, and
- Transport

2.4 Lastly, the protocol list 14 organisations and teams that young people and their families may encounter as part of this process and offers the contact details of several key contacts.

[4] https://www.nice.org.uk/guidance/qs140

2.5 Overall, the protocol for Richmond is very easy to locate within their website and is accompanied by a Transitions Pathway booklet[5] that is aimed more at young people and their families and details the pathways within each service area by age. Richmond's overall webpage(s)[6] for Preparing for Adulthood and Transitions are very thorough and easy to understand. It is straightforward to find the information you need, as well as offers additional information that helps build understanding and contextualise the transitions process. The other content available include:

- a video (with accompanying transcript) introducing the idea of transitioning to adulthood
- the framework for mental health transitions
- a guide to the Mental Capacity Act 2005
- links to a Care Act eligibility checker, the Local Offer website and a service director
- three case studies detailing the experience of 3 young people and their journey, highlighting the benefits of a good transition

2.6 The main critique of Richmond's offer is the lack of information provided in other formats (e.g., easy-read, other languages, large text) other than the introductory video mentioned. Secondarily, there is no explicit mention of any coproduction that happened during development. Nonetheless, the exemplar content and structure of the documents themselves will be utilised in the development of a policy for Wirral. Furthermore, by having the other resources available as links enables just those who require that information to access it, keeping the main resource itself short as to not make it overly long.

3 Herefordshire: Multi-Agency Protocol for Children and Young People with Disabilities and Complex Needs Preparing for Adulthood 2020[2]

3.1 Herefordshire Council developed this protocol to apply to a wide group of young people, for example those with an EHCP, known to the Children with Disabilities team, have complex or continuing needs including health, and/or have significant support needs. It appears to be applicable to all disabilities, including physical and learning. The protocol was codeveloped vis the SEND Strategy group and is overseen by an operations group.

3.2 The opening sections of the protocol explain the aims and underlying principles (p. 7-11). Appendix C (p. 17-29) then describes the roles and responsibilities many parties. These descriptions include the general activities to be complete, often Business As Usual activity, and where appropriate, sets out what support should be provided for specific ages and/or year groups. The parties included in the protocol are listed in Table 1.

[5] https://www.richmond.gov.uk/media/22290/transition_pathways.pdf

[6] https://www.richmond.gov.uk/services/adult_social_care/adult_social_care_information_and_advice/who_we_can_help/moving_from_childrens_to_adult_services

Table 1: Parties with Detailed Roles and Responsibilities (Herefordshire)	
young people	PFA Transitions lead
parents/carers and	Young Adults Transitions Team within ASC
'lead professionals' (the single point of contact for families when a range of services is involved)	Adult operational and commissioning teams
schools	Health Services from the NHS
post-16 education and training providers	Community Child Health Services and Hospital Services
SEND Team EHCP Officers	Primary care
Educational Psychologists	Mental Health
post-16 learning and skills team within commissioning	Job Centre Plus
independent travel trainers	Supported Housing, including commissioning
Early Help	the SEND information, advice, and guidance service
Children's Social Care	Youth Offending Service

3.3 The number and breadth of parties considers in developing this strategy is effective in establishing where responsibility lies and ensures the transition services adopts a holistic approach across an individual's circumstances. However, this section is particularly long, and runs the risk of being overwhelming for some audiences.

3.4 The protocol also clarifies the escalation and dispute resolution policy.

3.5 Overall, the protocol covers the roles and responsibilities of a wide range of individuals, groups, and services. However, it is very text heavy, although it is likely designed for practitioners, families may benefit from access to this information. Herefordshire state they will develop a user-friendly version and an easy-read version, including diagrams of pathways, but none were located from a browser search or within the Council's website, although some additional information aimed at families was available re the things to think about when entering transitions was available.

4 Sefton's Transitions from Childhood to Adulthood Protocol 2020[3]

4.1 Sefton is a CIPFA[7] statistical neighbour to Wirral. Their protocol is for children and young people (aged 14-25) with care and support needs and their carers. The protocol is thorough and takes a Multi-Agency approach, aimed at all young people with disabilities and complex needs, and some information for vulnerable young people who may or may not have a disability.

4.2 This guide is very thorough, detailing the purpose and outcomes of a transitions period, principles, the process of transitions, and accountability and governance procedures (p. 3-8). This includes explanations of several concepts that appear throughout the transition period (e.g., Adult Social Care Assessments; Care and Support Plans; Continuity of Provision; EHCPs; Personal Budgets; mental capacity; p. 9-14), and types of transitions people may experience other than social care (health; mental health; safeguarding; p. 14-18). While this information is thorough, it is rather long, so could benefit from being presented in a more user-friendly format.

4.3 The protocol then details the roles and responsibilities of agencies, listed in Table 2.

Table 2: Parties with Detailed Roles and Responsibilities (Sefton)	
the Disabled Children Family Support Team	the Career Connect service
the Children's Social Care Corporate Parenting Team	Adult Social Care
Children's Social Care Locality Teams	Housing managers
Children's Social Care Early Help Teams	Voluntary Sector organisations
Transitions Coordinators (two individuals for the area who work with young people from 14-25)	the Travel Team (who run travel training programmes)
SEN Officers	

4.4 Sefton include a succinct diagram for the transition pathway for disabled children, detailing involvement at every age (p. 33; Appendix 2), as well as a similar diagram for Looked After Children (p. 34; Appendix 2). These diagrams are informative, and alongside the earlier information of the roles and responsibilities, clearly sets out what can be expected.

4.5 Overall, this protocol offers a plethora of information for both young people and their families, and practitioners. It is also easily located on the Council website, alongside a SEND-specific Preparing for Adulthood guide[8], and links to a range of additional information and websites for other services.

[7] CIPFA is a statistical neighbour grouping
[8] Sefton SEND Preparing for Adulthood Guide https://search3.openobjects.com/mediamanager/sefton/fsd/files/send_preparing_for_adulthood_guide_2022-_digital.pdf

5 NICE's Guideline for Transitions from Children's to Adults' Services for Young People using Health or Social Care Services[4]

5.1 This guideline produced by the National Institute for Health and Care Excellence covers the period before, during and after a young person moves from children's to adults' services. The guideline informs part of the Care Quality Commission's (CQCs) inspection process (p. 4). It is aimed at health and social care providers, practitioners across health, mental health and social care, other practitioners working with young people (e.g., education and employment) and young people and their parents and carers.

5.2 The guideline is a comprehensive document, divided into several sections. These include:

(a) The overarching principles
- involving young people and carers in service design delivery and evaluations
- ensuring developmental appropriateness
- ensuring strength-based and person-centred support
- working together across services, being proactive in identifying young people with transition support needs
- safeguarding young people and their information
- ensuring registration with a GP

(b) The transition planning stage
- Setting out the timing and review of transition planning
- Identifying a named worked to coordinate care and support, and the role of this individual.
- Involving young people
- Building independence
- Involving parents and carers

(c) Support to be provided before transfer
- The roles and responsibilities of service managers
- Creating a personal folder with the young person to share with adults services (e.g., all about them in a format of their choice)
- The role of the named worker

(d) Support to be provided after transfer
- What to do if the young person fails to engage with adults services
- The development and reviewing of assessments and care and support plans

(e) Infrastructure necessary to support a transitions service
- The accountable individuals (executives and managers)
- The forums and data requirements to plan and develop a transitions service

5.3 The document also sets out a guide to getting started implementing a transition service. This section outlines several challenges, detailing why change is needed, the roles of various stakeholders in implementing the change and links for further advice and resources should policy makers require it. This guide will form the basis of developing Wirral's Transition Policy.

6 Conclusions

6.1 This report has summarised a best practice review of three policies (often named a protocol) from Richmond upon Thames, Herefordshire and Sefton that are/are applicable to the Transitions policy to be developed by Wirral during late 2023. It also reviewed the National Institute for Social Care Excellence (NICE) guideline for transitions services that underpins national quality standards and the CQC inspection process.

6.2 To summarise the points discussed in this report, it is recommended the following priorities are considered in refreshing the Transitions Policy for Wirral:

1. Ensure the policy follows the guidance set out by NICE, utilising the implementation guide to direct development
2. Consider the language of 'protocol', as opposed to policy
3. Ensure the website has active links to a multitude of relevant information, rather than everything in one document
4. Apply visual methods to communicate the information, rather than relying on heavy text
5. Ensure the date of development is clear
6. Ensure alternative formats are available and accessible
7. Ensure it is explicit that the policy has been coproduced
8. Outline the principles of a good transitions
9. Structure the transitions process in areas/pathways with corresponding ages, as was done by Richmond
10. Ensure consideration is given to the responsibilities of all groups, however, rationalise which of these organisations are listed in the policy itself
11. Develop succinct, one-page diagrams of transitions pathways with involvement at every age, as from Sefton
12. List the organisations and teams that young people and their families may encounter
13. Offer definitions of key processes and documents (e.g., assessments, mental capacity)
14. Outline, or at least signpost to, the escalations and disputes policy

Appendix 1: Richmond's 5 Areas of Transition by Age

6.1 Young person is 14 (Year 9)

EDUCATION

EHCP will be amended in year 9, in collaboration with the PFA team and Next Steps Advisors for specialist careers guidance, to incorporate the PFA outcomes (list). Other professionals will also prioritise this transitional year to update the advice contributing to the plan.

The PfA Team flag up young people who are likely to need/be eligible for support from Adult Social Care as adults, and they are placed on the tracker (N.B. see Richmond Social Care Pathway for more information). Regular tracking meetings take place between the PfA Team and Adult Social Care on a regular basis.

SOCIAL CARE

Young people likely to need support as adults are flagged up by Achieving for Children (AfC), usually the Special Educational Needs Preparing for Adulthood Team (PfA), Children Looked After Team (CLA), Children With Disabilities Team (CWD), and Family Support Team (FST), and placed on the tracker at the regular tracking meetings.

CHILDREN LOOKED AFTER

Young people likely to need support as adults are flagged up to Adult Social Care at the regular tracking meetings.

Permanency Planning meetings start from the point that a child/young person becomes looked after and continue until a permanency plan is achieved (before age 18).

HEALTH

Young people with complex health needs are flagged up on the tracker as likely to need/ be eligible for adult Continuing Healthcare (CHC).

The Clinical Commissioning Group (CCG) and the Adult Learning Disability Transition Team (LDTT) meet every three months to track these young people.

From age 14, young people with a learning disability are entitled to a free Health Check with their G.P. once per year.

TRANSPORT

Young people likely to need transport support are flagged up on the transport tracker by Achieving for Children (AfC).

Travel training is available from AfC to those with the potential to achieve independence. Travel training support is provided by Balance.

We expect young people to travel independently when they have the skills to do so and will support those who don't to develop them wherever possible.

6.2. Young person is 15 (Year 10)

In year 10 the young person is 15. The EHCP review should focus on what is important to the young person both now and into the future. At this point, if it hasn't already, planning for post-16 options should begin in earnest. Post-16 options should be explored in both the EHCP review and Next Step interview(s).

EDUCATION	SOCIAL CARE	CHILDREN LOOKED AFTER	HEALTH	TRANSPORT
The next steps team will work with the school SENCO and Schools Career guidance Officers to to support any developing action plans. For those who are Educated Other than at School will be offered alternative arrangements. Achieving for Children (AfC) careers advisors may attend the EHCP review for some learners. All Year 10 learners are signposted to further information on Next Steps.	Tracking meetings continue between AfC and Adult Social Care on a regular basis. Young people can be flagged and added at any point.	All looked after young people, including those in the Permanency Team (PT), are given information about the Leaving Care Team (LCT). A Pathway Plan is completedwith the young person by the allocated social worker.	Quarterly meetings continue between the LDTT and CCG to track those with complex health needs and to ensure the needs are understood.	Referrals to Balance may still occur, and ongoing support with independent travel training can be provided to young people already referred to Balance. We expect young people to travel independently when they have the skills to do so and will support those who don't to develop them wherever possible.

6.3 Young person is 16 (Year 11)

EDUCATION

The PFA team will amend the EHC plans, for those moving between settings. Next Steps Careers Guidance will be offered to those who has been identified by their SENCOs or PFA Coordinator as needing additional support.

Year 11s might also find the Next Steps booklet useful.

N.B: see the Richmond Social Care Pathway for more information.

In the autumn young people are asked for their post-16 education placement choices. AfC then "consult" with the relevant education placement. Funding applications for college places are referred to AfC's Post-16 High Needs Funding Panel - the PfA team attend this along with social care and health when appropriate.

SOCIAL CARE

Referrals, in which information on diagnosis and support needs are contained, are made to Adult Social Care. This is logged on the tracker.

N.B. It may be appropriate for some people with complex needs to be referred at an earlier stage, this will be decided at the tracking meetings.

CHILDREN LOOKED AFTER

Young people transfer to the LCT, organised at weekly transfer and allocation meetings. If a young person is in foster care then they (and their carer) should be given a copy of the Staying Put Policy and the Independent Living Skills Checklist.

Permanency Planning meetings continue and focus on the staying put arrangements, which includes Shared Lives. If the young person is not in foster care then permanency planning meetings will focus on gaining independent living skills in a residential or semi-independent home.

HEALTH

The relevant young people on the tracker are referred/screened using the CHC Checklist.

Child and Adolescent Mental Health Service (CAMHS) and Children with Disabilities Team (or other relevant AfC Teams) will contribute to this process for the relevant young people as appropriate.

TRANSPORT

A review is conducted of all young people in Year 11 and they will be asked to re-apply for travel support from AfC for Year 12. This is the opportunity to assess whether transport needs have changed based on independence and plans post-Year 11. This decision will be based on AfC's post-16 policy.

Young people with significant SEND may continue to receive some form of travel assistance post-16, this will be based on AfC's post-16 policy. Travel assistance may take a different form than provided previously.

For those with significant SEND, travel assistance provided by AfC may continue for the duration of their school or college placement.

6.4 Young person is 17 (Year 12)

EDUCATION

The annual review will be used as a mechanism to facilitate joint planning with the family, particularly around preparation for adulthood and transition to adult services. Link to annual review guidance (year 9+)

If the YPs placement is at risk of breaking down, please contact the PFA team to discuss next steps.

SOCIAL CARE

Young people are allocated to a transitions social worker in Adult Social Care in order to complete the Care Act Assessment.

N.B. It may be appropriate for some people with complex needs to be assessed at an earlier stage. This will be decided at the tracking meetings.

Young people with a learning, physical, or sensory disability are assessed by the Learning Disability Transition Team (LDTT). Those with mental health needs are assessed directly by the Adult Mental Health Team.

A Care and Support Plan will be developed taking into account the young person's strengths, abilties and wishes , and a funding application submitted to the Preparing for Adulthood Panel.

A mental capacity assessment will also be completed if there are concerns that the young person lacks capacity to make decisions about their care and support.

CHILDREN LOOKED AFTER

Between ages 16-18 young people are entitled to a Pathway Plan which is part of the six monthly CLA review process.

By age 17 and six months:

A Personal Adviser (PA) is identified, who should attend the final CLA review.

TRANSPORT

For those with significant SEND, travel assistance provided by AfC may continue for the duration of their school or college placement.

HEALTH

Children with complex needs who are receiving continuing care are referred to CHC by specialist health colleagues from the Children with Disabilities Team to assess eligibility and to ensure a seamless transfer of care for when they turn 18.

The Transitions Coordinator from CAMHS supports young people prior to turning 18 to ensure they will get the correct support from adults services.

Active transition planning should start when the young person is 17 and 6 months. This should be agreed by CAMHS and the relevant Adult Social Care team. Young people supported for their learning disability will typically be referred to the appropriate learning disability service.

Some young people supported by CAMHS may not meet the criteria for adult services in such cases CAMHS may explore referrals to other organisations/agencies, this work will take place when the young person is 17 years and 6 months.

When young people are 17+ have first episode psychosis requiring a Care Programme Approach (CPA) to support their recovery, CAMHS may arrange handover of treatments to the adult early intervention service.

Young people who are in-patient on a CAMHS ward may need to transition to an adult ward when they turn 18, preparation for this should begin as early as possible in line with CPA policy. The relevant adult ward and/or community team will be invited to arrange transition

For young people requiring ongoing support, whether due to mental health needs, a learning disability, an eating disorder or a personality disorder then a CAMHS Care Coordinator will begin discussions with the relevant adults team when the young person turns 17 and make referrals as needed. Referrals will include information on current medication, relevant health assessments, Education Health & Care Plans, risk assessments, and key contacts in the network. Once referred and accepted young people will be allocated a lead healthcare professional from adult services to help facilitate the transition.

6.5. Young person is 18 (Year 13)

EDUCATION

The annual review will be used as a mechanism to facilitate joint planning with the family, particularly around preparation for adulthood and transition to adult services.

Annual Review Guidance

For those moving between pwrovisions, e.g. vocational pathways, college, university, at the end of year 13, the PFA team will liaise with the family to identify next steps and amend/ cease the plan as appropriate .

SOCIAL CARE

New adult care and support package will be in place on the young person's 18th birthday.

If there is a delay in the transition to the PfA Team, support from Children's Services should continue to ensure continuity. If the pathway is followed, this should not be necessary.

Once the care package is in place, young people with a physical or sensory disability will transfer to the adult locality team; those with a learning disability will remain with that team.

The transitions social workers can support young people with referrals to appropriate health services, e.g. Your Healthcare.

CHILDREN LOOKED AFTER

The young person transfers to a PA and if eligible should apply for Universal Credit 28 days prior to their 18th birthday.

HEALTH

Your Healthcare (YHC) Adult LD service and CHC will provide assessment and signposting as per needs.

YHC Adult LD Service – Referrals are accepted from any source including self-referrals and professional referrals.

YHC enable and support access to mainstream health services as well as providing specialist health interventions where necessary.

After assessment, a range of short-term interventions may be suggested to help people recover their skills and confidence after an episode of poor health, admission to hospital, or sudden deterioration in daily functioning.

TRANSPORT

Young people eligible for support from Adult Social Care, who have had a change of placement and have moved on to a college, may be able to get travel support as part of their care package, assuming they cannot do so independently. For more information, please see the Social Care Pathway.

The aim will be to ensure young people can travel independently when they have the skills to do so and will support those who don't to develop them wherever possible.

6.6. Young person is 19 (Year 14) and beyond

EDUCATION	SOCIAL CARE	CHILDREN LOOKED AFTER	HEALTH	TRANSPORT
Support is available to post-19 learners transitioning from school/ college into work or further education. The vocational pathways coordinator can support young people to find jobs, apprenticeships etc. The annual review will be used as a mechanism to facilitate joint planning with the family, particularly around preparation for adulthood and transition to adult services. There will be a particular focus on destination planning and identifying the steps to get there. Link to annual review guidance (year 9+) For those moving between provisions, e.g. vocational pathways, college, university and employment, at the end of year 14, the PFA team will liaise with the family to identify next steps and amend/ cease the plan as appropriate.	The young person's care and support plan will be kept under review to ensure the person is supported to live as independently as possible.	After 18 years and six months, Pathway Plan reviews will focus on independence and how the young person can step down into less supported accommodation in a manner that is appropriate for their care needs.	The young person's care package must be reviewed annually by Adults CHC.	For those with significant SEND,travel assistance provided by AfC may continue for the duration of their school or college placement. Young people receiving support from Adult Social Care may be able to get travel support to go to college and access the community. There will be a continued effort to work with young people to make independent travel achievable.

Appendix 2: Sefton's Transition Processes by Age