

TRANSITION ARRANGEMENTS FOR CHILDREN WITH SPECIAL NEEDS

Protocols for case transfer from Joint Agency Teams to Adult Services

1. Introduction

- 1.1 This protocol should be universally applied throughout Devon (excluding Plymouth and Torbay) where there are Joint Agency Teams in place, and should be adopted by all Adult Services in those areas. The arrangement should also apply to those cases held, for whatever reason, in mainstream Child Care teams. This will also include arrangements in South and West Devon.
- 1.2 The protocol seeks to complement and inform the Devon Transition Protocol that covers all aspects of transition planning for Young people in the defined area. In this “overarching” protocol arrangements are described that support integrated planning at all levels, and across Social Services, the NHS and Partnership Trusts, Education, Schools and Connexions.
- 1.3 The principles contained in that protocol will equally apply to this one, and are described in Appendix 2.
- 1.4 Reference is also made to Care Leavers, but there is a separate “subsidiary” protocol covering this area, as there is for the “Child to Adult Psychiatry” transitional arrangements. *However all the protocols are linked and cannot be considered in isolation.*

The protocols in this document describe the hand over arrangements for children where there are identified special needs and where services may be required at 18yrs and beyond.

2 Prior to Year 11

- 2.1 The main protocol describes planning from Year 7 onward. It is considered that in most cases the Child Adult transfer arrangement will, systematically, commence from Year 11. However there is nothing to suggest that an earlier consideration cannot be given in special circumstances or as part of local arrangements. Specifically, under the Disabled Person’s Act 1986 an initial list of names will have been identified of young people “subject to a statement of Educational Need, who are disabled and who may require services from the Local Authority when leaving school”
- 2.2 The process for identifying these children and in coming to a view about the nature of their disability is referred to in the main transition protocol under Year 9. The detailed process will be described in one of the other ancillary protocols.

3 Year 11 (age 15/16)

- 3.1 The annual review of the transition plan at year 11 will build on the list described above and identify all young people who are likely to need services in adulthood. The list should be checked and added to, if necessary, by the cases known to the Joint Agency Team. This will be the explicit responsibility of the Practice Manager for that Team. Detailed planning for Adult Services should in all identified cases start from this point in time (if not already in progress)
- 3.2 Information will be forwarded to the appropriate Adult Services Team using the "Children in transition pre-referral form". (Appendix 1). This could be to the Adult Learning Disability, Physical Disability, Sensory Disability or Mental Health Teams. The mechanism/frequency for doing this can be determined locally, but the idea is that a spreadsheet of basic information is established and maintained by the Children's Joint Agency Team, and that the list is kept under regular review. This "pre-referral" list should indicate which Adult Team the Children's key worker considers it most appropriate to refer to. It might, occasionally, indicate more than one Team.

Core information should include: -

- Name of young person
- date of birth
- address
- area of difficulty (using the joint agency classifications)
- likely needs in adulthood

- 3.3 Regular "transition planning meetings" will be set up by an identified children's (JAT) Practice Manager, for each PCT area. A mechanism should be developed locally so as not to exclude any children held by mainstream children's teams. These meetings may be on a quarterly basis or otherwise as agreed. Their purpose will be to share information on individuals, discuss how the individual planning process might proceed, agree action, monitor progress, and where there is doubt, decide which Adult Team is primarily indicated. The meeting may also identify policy issues that need raising or resolution at a County monitoring group.
- 3.4 In some instance further clarity of a general nature may be needed in determining which Adult Services are responsible for different types of special need – e.g. as in Asperger's Syndrome. The Locality transitional planning fora are expected to make recommendations in respect to these and similar issues, or where eligibility could otherwise be an issue. The County Forum will make a formal recommendation in relevant cases.
- 3.5 Adult Practice Managers (or their representatives) must attend on a needs' basis according to the list of young people under discussion.

Clearly Learning Disability Managers will be involved on a more frequent basis than, say, their colleagues in the Sensory Services. Each PCT area will need to agree the logistics of how these meetings are scheduled, which may vary according to local considerations.

- 3.6 In accordance with the main protocol, relevant information on the longer term (Adult Services) options, future planning arrangement and legal responsibilities must be conveyed to the parent/carers, and if appropriate, the young person. Information should include direct payments for 16/17 year olds. A benefit check (if not already completed) must be instigated and consideration should also be given in all appropriate cases as to whether the young person's name should be registered for accommodation with the District Council.
- 3.7 For children where longer term planning arrangements are being considered at this stage, and particularly when Adult Services may not yet be fully involved, it is imperative that account is taken of the longer term financial implications as described in paragraphs 4.3 and 4.8 and 4.9 below.

4. Year 12 (age 16/17)

- 4.1 By the time of the Year 12 review or within 3 months of the young person's 17th birthday (whichever is the earlier) the key worker (or Practice Manager if not allocated) in the Children's team will make a formal referral to the appropriate Adult Team. Attached to the referral will be the most recent care plan for the child and any other relevant information. It is anticipated that details of these arrangements will have already been agreed in one of the transitional planning meetings.
- 4.2 The Adult Services Team Manager will allocate a "shadow" Key Worker/Care Manager to link with and work alongside the key worker in the Children's Team, and to undertake a joint assessment where necessary.
- 4.3 When considering services at this stage, proper regard should be given as to whether the young Person will continue to need, (and be eligible for) those services in his/her adult life. Account should be taken of the requirements of "Fair Access to Care" that will apply post 18.
- 4.4 The Year 12 annual review is a crucial one and must be attended by representatives of both Children's and Adult Teams, as well as other relevant participants. If for any reason it has not been possible to allocate a key worker from the appropriate Adult Team the Practice Manager (or their representative) from that team should attend instead. Occasionally, where it is still not decided which Adult Team is primarily indicated, a representative from more than one Adult team may be invited – so that a definitive view can be reached after listening to the views of all participants.

- 4.5 In cases of particular complexity, or where agreement has still not been reached on important matters, the Joint Agency Manager or Locality Manager should convene a “strategy meeting”, to include appropriate senior staff, so the issues can be resolved. It is important that this is not left until the “last minute”.
- 4.6 In the case of a Looked After Child special arrangements are expected to be in place from April 2004. There is a separate Care Leavers protocol for Children with special Needs – and this protocol will need to be considered at both the transitional planning meetings and the appropriate annual review. This is because the options contained within it may affect the responsibilities of the other team(s) in a variety of ways.
- 4.7 Similarly, where the transition plan indicates a referral to the Mental Health team, the Child– Adult Psychiatry protocol may also need to be considered.
- 4.8 The Adult Practice manager /care manager is responsible for ensuring the post 18 plan is relevant, age appropriate and meets the necessary eligibility criteria. Submission to the appropriate adult panel will be the responsibility of the Adult care manager. However any child being presented to the Children’s panel must also take into account the post 18 services. In some situations both panels may need to be approached and plans confirmed by both before arrangements are finalised. Panel chairs may need to liaise in such cases.
- 4.9 The above is particularly pertinent in relation to plans for longer term residential care or other expensive care packages. In such cases it may be sensible to approach the Adult panel and other implicated funders (e.g. Education, Health) first in order to get a preliminary view. In some cases this approach may need to be taken at an earlier stage, e.g. following the Year 11 review, if such plans are being formulated at this stage. (see paragraph 3.7)
- 4.8 Case management and financial responsibility stays with the children’s team until the child’s 18th birthday. In exceptional cases and by agreement with the Adult Services Practice Manager case management responsibility may transfer across sooner where this is in the best interests of the young person.

5 Age 18 (from the child’s 18th birthday)

- 5.1 Case management and financial responsibility for the young person transfers to the appropriate adult team on the child’s 18th birthday. (*N.b but note there may be a variation to this in relation to the care leavers*)
- 5.2 The Year 13 review should check that the transfer has been effective or that the case is proceeding smoothly to such a transfer.

- 5.3 There is no transfer of resources at 18 but if the young person is also a "Care Leaver", costs may, in some instances (*yet to be defined*) be coded against the care leavers budget.
- 5.4 Where appropriate it may be agreed that the Children's Team Key worker remains involved for a limited period of time after the child's 18th birthday. Responsibility (and Key Working) would however rest with the Adult Team. This provision would normally only be used to ensure a smooth transition when it has not been possible to achieve this before.
- 5.5 Local Support Units offering Carer's Breaks should not continue to be used after a child has reached the age of 18. Alternative provision, if required, should have been identified well in advance. However given the stipulation of the National Care Standard's Act which indicates that it may not be permissible for a young people under the age 18 to access some post 18 services (and thereby be denied a gradual introduction); it is accepted that a review of these arrangement may be necessary.

Feb 04

Children in Transition “Pre-referral” form

Name of child

Dob

Address

G.P./Consultant

Nature of Disability

Summary Current circumstances including funding arrangements

Summary of future needs, including expected date of transfer

Users wishes for the future

Care Manager name

Location

Phone number

Date of Referral

Please attach a copy of the current care plan
Any recent review meeting notes
Forward to the appropriate Adult Team Manager

Appendix 2

Some Key Principles

- Transition is a continuous process rather than a series of assessments and reviews.
- The process is for the benefit of young people who must be at its centre.
- There will be a commitment to the process from all involved to ensure effective preparation for, and implementation of, transition plans. This will include preparation for meetings and reviews around transition planning, and giving adequate notice and time for such meetings. Where key professionals are unable to attend a review, parents have the right to ask for an alternative date.
- Young people and their parents/carers are partners in the transition process, and will be fully involved in developing the Devon transitions policy, protocols and procedures. Parents also have a role in supporting their young people to make realistic choices.
- It is recognized that young people and their parents/carers have equal rights within the process and, where they have differing views, these should be separately recorded.
- Young people should be informed, prepared and fully involved in drawing up their own transition plans, using communication tools relevant to the type and complexity of their needs. Independent representation/advocacy services should be made available to assist young people in this regard.
- Parents/carers of young people subject to transition planning will be fully involved in drawing up the transition plan.
- While recognising there might be differing views amongst those involved, there is a commitment from all to seeking creative solutions which benefit the young person and assists them in achieving their transition plan.
- Partner agencies will provide an integrated information service to young people and their families about all aspects of transition planning both in hard copy and electronically.
- All partner agencies will have clear policies and procedures which respect diversity and support anti-discriminatory practice.
- Services to meet needs as identified in a transition plan will be met as far as possible within the young person's preferred locality.
- The protocols and procedures for transition services will ensure minimum duplication of assessment and planning activity for young people, parents/carers and professional staff.
- These protocols and procedures will be based as far as possible on a common assessment and planning framework and methodologies.
- All transition plans will be co-ordinated by a single named keyworker employed by one of the partners, or by a parent/carer keyworker working within the parent/carer keyworker scheme. Young people and/or their parents/carers have the right to express their choice of keyworker.

- The transition plan is owned by the young person, but all information will be made available to agencies involved in the plan unless the young person or parent/carer (as appropriate) states otherwise.
- There should also be a mechanism to make sure parents/carers are fully informed of, and understand, any subsequent decisions that affect the Plan.
- The majority of the young people affected by these protocols and procedures will have a statement of Special Educational Needs (SEN). Other pupils will be identified who could come within, and benefit from, the protocols and procedures. It is envisaged that the numbers of such pupils will be greater in later years than at year 8.
- The protocols and procedures will contain jointly agreed service standards which will be subject to joint arrangements for performance monitoring and quality assurance.
- *Something needed here about a clear arbitration/disputes/complaints process – see “Work to be done”.*