Walsall Children's and Adult Services

Transition Toolkit

Walsall Council

1. Introduction:

Approaching adulthood is a difficult and sometimes worrying time for young people. Although it comes with lots of new and exciting opportunities, it is also a time of significant change and comes with additional complexities, especially for those that have additional needs and those who are young carers with a range of caring responsibilities.

There are many decisions and choices for young people, their families and carers to make about the future related to daily life. This can be complicated and so support from Education, Health and Social Care may change at different points and particularly when they get to 18. Not everyone receiving children's social services will be eligible for Adult social care services, as the eligibility criteria is different and Adult Social Care may need reconsidering for parent who receive daily care from their children.

That is why preparing for adulthood should start early to plan the right support for young people, to achieve the outcomes they want. Improving transition support specifically for Young Carers is vital and seeks to ensure young carers are supported to reach their full potential, to make positive transitions between the ages of 16 to 24 and develop skills and confidence to make decisions about their future, opportunities to become more independent without worrying about their caring roles and responsibilities. Joint working with Adult Social Care in preparing for adulthood should start early to plan the right support for family members and to either reduce caring roles of support or to become adult carers.

Walsall Right 4 Children Partnership are listening to young people, their families and each other in terms of how the preparation to adulthood process should work more collaboratively in order to improve experiences and outcomes, whilst also ensuring our statutory duty and responsibilities for young people and young carers are adhered to.

For a successful and supported transition, it is important that everyone works together and is clear about their own and other people's roles. This transition toolkit is a resource pack which can be used by anyone involved in supporting a young person and/or young carer transitioning into adulthood.

Transition means change and is the term used for young people aged 14 -25 with special educational needs and disabilities (SEND) who are preparing for adulthood. The Children and Families Act 2014 sets the requirements for children with SEND as outlined in the SEND Code of Practice (2014) and in the Special Educational Needs and Disability Regulations 2014.

The aim of this toolkit is to ensure that the transition between adults and children's services is in line with legislative frameworks and based on restorative practice and strengths based practice. Along with key partners in Health, Education and Voluntary Sector agencies, our aim is to secure the best outcomes possible for young people by providing clear guidance and support for practitioners and to help parents, carers and young people, to understand:

- what help they can expect
- when they will receive it
- who is responsible for each element of the services and support they may expect or aim to receive.

In addition to this toolkit, a separate guidance for young people and their families is being devised.

2. How to use the Toolkit:

- This toolkit acts as a practice guide in relation to young people and young carers who will need support from services post 18. The needs of the young people may vary, as will their circumstances, (i.e being a child in care, if part of transition is to become an adult carer) so this will also determine what support is provided and by whom.
- If a young person is likely to require support once they turn 18, the Local Authority has a duty to assess those needs. This may lead to services to support them or signposting to services in the community so the young person can remain as independent as possible. If a young person does not meet Adult social care eligibility, then there may be support in the community to enable them to maximise their independence.
- This toolkit aims to assist in decision making when supporting young people transition into adulthood. How and by whom this is started may differ depending on their personal circumstances (i.e whether they have an Education, Health and Care (EHC) Plan). In this circumstance, this should commence when a child is in year 9 (aged 13 or 14) and should be guided by the completion of the year 9 annual review (as part of the Special Educational Needs and Disabilities (SEND) process).
- The Local Authority has a duty under the Care Act 2014 to carry out a needs assessment for a young person or carer if they are likely to have needs once they (or the child they care for) turn 18
- The Care Act also places a duty on local authorities to provide young carers with a transition assessment before they turn 18 yrs of age and when it will be 'of significant benefit' for them to so. Local authorities must also assess the needs of young carers as they approach adulthood regardless of whether they currently receive any services, but where it appears that the young carer is likely to have needs for support after they turn 18 and when they think that there would be 'significant benefit' to the carer. Working with a young carer to prepare them for their transition assessment is important, particularly when they are considering options at school or for further education and employment, or if there are particular pressures at home. The transition assessment should allow for the young carer and the practitioner to plan together for the future – including what support may be needed beyond 18 – and plan for their transition from Children's Social Care Service to Adult Social Care Services.
- For children in care, the range of responsibilities in relation to care planning, placement and review for looked after children also needs to be considered as part of transitioning our children in care into independence. This will commence with the preparing for adulthood assessment to be undertaken at 15 years and 9 months which informs the Pathway Plan and replaces the Care Plan at age 16.
- This toolkit has a number of documents to support assessments and clearly outlines the responsibilities of Walsall Local Authority and partner agencies, in supporting children transition into adulthood.
- Key issues need to be considered when supporting young people transition into adulthood – these include:

  a) Resources and access to relevant services

  b) Link with other services such as Early Help as part of early preparation and support

  c) Consider who needs to be involved in the plan for the young person i.e Education/Health/ CAMHS/Youth Services and other lead professionals.

- This toolkit has a number of documents to support improved decision making, for example legislation and any other relevant practice guidance. These can be found at the end of this toolkit.
- This toolkit should be used flexibly and dynamically - the documents and resources are from a variety of agencies and may be updated/deleted as required.

Stages of Transition

In order to provide clarity on when preparatory work should commence, this toolkit has broken the stages of transition into 3 sections according to age and when levels of support are needed. All young people are treated individually and the levels of support will differ according to their needs. Disabled Children and Young People have a range of complexities that mean additional support post 18 will be extensive and as such the planning for their transition may need to start sooner. Equally, some young people may develop additional needs much later and may require additional support from adult mental health services as they approach the age of 18 As circumstances for young people will differ, the need to fully assess and understand their needs as soon as possible is a critical part of ensuring the right support is identified as part of the transition process.

Stage 1 – Getting Ready (age 14 – 16)

Once a child reaches year 9, consideration now needs to be given to what support they will require in order to achieve their goals and aspirations as adults. EHCP's will be amended in year 9, in collaboration with other professionals to determine what support is needed as the child approaches adulthood. Other professionals will also prioritise this transitional year to update the advice contributing to the plan. We need to consider how can these be achieved and who will be able to assist, which services need to be involved and what support will they need to offer? Preparing for adulthood is an ongoing process and the Year 10 annual review is the second of several transition/planning meetings that takes place every year with the young person until they leave school in Year 11 or Year 14. Through the transition the annual review will help to ensure that the child's needs are identified, and relevant services put in place. The EHC plan will be amended when required, to reflect their changing needs as they grow older.

In order to consider these points the following actions may need to be taken:

Education, Health and Care Plan and Needs Assessment

Childrens Social Care

- Update Child and Family assessment for those young people whom already have an allocated Social Worker. This needs to consider wider aspects of support such as family/friends and community links. For children in care aged 15 years and 9 months, this assessment will trigger the start of their Pathway Plan which replaces a child's care plan.
- Transition to adulthood passport to be completed by children's Social Worker via Mosaic.
- Adult social care referral for transition to be considered - timeliness for assessment taken into consideration to avoid delay and discuss with adults what support they can offer at this stage.
- Attend transitions Operational Group. This is a multi-agency forum chaired by Adult social care. This is where a young person can be presented to discuss what future support may be required and how this can be accessed.
- Review the young person's EHC Plan (this is triggered by the young person's school and SEND caseworker and we will need to be involved for complex situations).
- Lead professional to review level of support in school for those with additional needs but no EHC Plan.
- Consider what additional support may be required in regards to education. For Children in Care, support from the Virtual School, Impact and any preparation for further education and training will now need to be discussed with the young person and built into their care planning and discussed within their Personal Education Plan meetings.

- Agree who will help young person to develop a Career Plan and/or Vocational Profile. Plan out post 16 education and employment options including what work experience may be available. The responsibility for this may differ dependant on the professionals involved.
- If likely to have a change of environment post 16 e.g., move from school to college, consider what might be needed for a smooth transition. In some complex cases a multi-agency panel will consider the options and make recommendations.
- Work with school to identify how the curriculum will provide opportunities to explore the world of work and gain work experience for the young person.
- If the young person is educated out of area, start thinking about how to access Walsall local services in the event that their care plan may be for them to return.

Health

- Learning disabled young people are entitled to an Annual Health Check from age 14. This can be accessed via GP or for children in care will form part of their Looked After Child Medical. If this is required for a young person then now would be the time to access this. Further guidance for parents can be found on the NHS link attached to this document.
- Consideration as to whether a Continuing Health Care (CHC) assessment is required. This could also be for young people who experience behavioural challenges as well as those with complex health care needs. Further guidance and information can be found on the NHS link attached to this document.
- Ensure a young person has access to any therapy and emotional support that they may need. Has a referral been made to Children Adolescent Mental Health Services (CAMHS)? For children in care, have they been offered support through FLASH? Flash is a streamlined therapeutic service for children in care.
- For disabled children, consideration will need to be given as to whether a referral needs to be made to occupational therapy.
- Consider whether the young person will need support from services such as physiotherapy or speech and language. If so, ensure that the correct referrals are completed in order to access them.
- If a child has been assessed as being eligible for continuing care, the adult Continuing Health Care assessor should be informed when that child is 14. Currently, Learning Disability CHC have access to the child's continuing care database so are aware of who is coming through. This database is currently managed by Walsall Healthcare Trust. Once a child on continuing care reaches 16, if it is considered there is a possibility they will require an Adult Continuing Health Care assessment, the adult team should receive a referral. In Learning Disability, the child will be referred to the LD community transition nurse. At this point transitional meetings should be attended by representations from adult Continuing Health Care – in the case of Learning Disability, the community transition nurse does this and feeds back to the Clinical Commissioning Group.

Independence Planning

- For all young people, independence planning such as travel training, learning how to budget and life skills will need to be part of their transition planning. This work needs to start from age 14 so that the young person develops the confidence and skills needed to be as independent as they can once they reach adulthood. At this stage, consider a referral to the all age disability hub.
- Begin to plan how resources/services will be accessed in adult life e.g. equipment, therapies, specialist support, prescriptions, dentist, optician, diet & exercise, sexual health etc.

- Consideration should be given as to whether a carers support is required.
- Children's services may need to apply for a National Insurance number if the child/young person is in the care of the authority.
- Ensure young people and family/carers know how to access information in regards to potential housing options post 18
- Consider whether the young person requires the support of an advocate or for Children in Care and Independent Visitor
- Consider how you will support the young person to keep in contact with those that are important to them once they reach independence.

Young Carers

- Meet with the young carer and their family to start discussing transition support, it is important to include schools here as the young carer may need additional support during exam periods etc.
- The assessment should take account of choices related to their post-16 future and help them to plan for this future. Leaving this until just before they turned 18 was too late for them to receive appropriate support. The assessment should not just focus on the current needs of the young carer and their family, but also on the likely ways in which these needs will change over the coming years as the young person transitions to adulthood
- Complete with the family the young carers transition assessment, considering how changing from being supported by a young carers service to possibly an adult service may impact them, discuss with the young carer their aspiration for the future
- Consider the impact of the caring roles and responsibilities and the level of care they provide, include a review with adults social care
- Once the transition assessment has been completed, provide a copy to the young carers and their family, the report should contain what you have talked about, what will happen next, whether the young carer, the person they care for or someone else in the family should get help, what support will be provided and what other services might be able to provide and if any referrals need to be made.

Stage 2 – Starting the Transitions Plan (age 16 - 18)

By the time a child is 16, work on their transition planning needs should be well underway. As young people develop, they should be involved more and more closely in decisions about their own future. After compulsory school age (the end of the academic year in which they turn 16) children become young people and take their own responsibility for engaging in decision making with their education provider and, where they have an EHC plan, with the local authority and other agencies.

Education, Health and Care Plan and Needs Assessment

Social Care

- Ensure that the assessment for adulthood which will inform the Pathway Plan for Children that will be leaving Care is completed
- Any children receiving Continuing Care Joint Funding, will have a review of their needs in order to inform the transition plan. In some circumstances, funding will need to be agreed at External Placements Panel or Complex Short Breaks needs panel. Consultation with health professionals must be taking place and they need to be invited to care planning meetings as appropriate.

- Transforming Care Programme (TCP) brings together, Social Care, health and Education Services across Walsall, Wolverhampton and Dudley to review and plan service provision for children and young people. It aims to ensure that individuals with diagnosed learning disabilities and/or Autistic Spectrum Disorder are supported within their local community to avoid unnecessary inpatient mental health admissions and residential care. Young people with autism and/or learning difficulties, whom also experience mental ill health, can be at risk of Tier 4 hospital admission. A 'risk of admission' (Dynamic Support) register can identify children and indicate what single or joint preventative intervention can be offered to reduce this risk or to proceed to a CETR (Care, Education and Treatment Reviews) to determine whether an admission can be safely avoided. The CCG leads on all CETRs and dynamic support Register as part of the Transforming Care Partnership (TCP). More information about this can be access in the guidance and information links at the end of this toolkit.
- Each agency is to ensure that the young person and their family know when professionals and/or services are likely to change and who will take over responsibility if applicable.
- For those young people allocated in children's social care, a referral to adult services MUST be completed by 16 years and 3 months of age, as appropriate to the individual circumstances.
- The Year 11 annual review should include Adult Social Care for those young people open to children's services and Early Help support. An adult social care worker will be allocated by the time the child reaches the age of 17.
- Adult Social Care will chair a Transition panel as a multi-agency forum to agree and take accountable action to support and plan as young people pass through the 3 stages. CCG health partners will participate in all arrangements throughout the Transition Stages for those aged 14+ and contribute to seamless transfers and referrals into agencies who provide adult health, adult social care and adult education services. This Panel is in formulation and will go live in April 2022.
- Gather information to identify and inform any key adult professionals that may be required post-18. Ensure that appropriate planned introductions and handover will need to start at this point.
- Review the EHC Plan and ensure the Social Worker attends EHC Plan and CC reviews from age 16 as appropriate to the individual circumstances.

Health

- Consider whether School Nursing workshops for physically disabled young people to be accessed around transition. Check if the child's school provides this.
- Mental Capacity Assessments may need to be undertaken. The Mental Capacity Act 2005 (MCA) relates to people aged 16 and over. People are assumed to have capacity unless an MCA assessment has deemed otherwise. These assessments can be undertaken by a social worker but this is dependent on the specific decision and who the decision maker is. The principles of the MCA are that people who lack capacity are empowered to make as many decisions for themselves as possible and that any decision made or action taken on their behalf is done so in their best interests. More information in respect of this is provided in the resources and links attached to this toolkit.
- Deprivation of Liberty Safeguards (DoLS) - Deprivation of liberty of children under the Mental Capacity Act currently requires the authorisation of the Court of Protection. According to case law, parents or those with Parental Responsibility cannot consent to the confinement of a young person who is expressing an objection to this. There are a number of circumstances under which a young person may be 'confined' i.e. be under continuous supervision and control and not permitted to leave. Liberty Protection Safeguards (LPS) will replace DoLS in 2023. Under LPS, the Responsible Body (LA, Hospital Trust, CCG, Mental Health Trust) will be able to determine (after

assessments and review) if 16- and 17-year-olds are being deprived of their liberty and authorise the arrangements without recourse to the court.

- Finalise plans for future therapeutic support and what mental health support will be required for the young person post 18. Consider what is already in place and whether there are any potential gaps their current care. At 17, if needs are not likely to change, an adult Decision Support Tool will be completed – unless it is a behavioural need and not primarily a physical health need. In behavioural cases, joint funding is not agreed until adult behavioural support team have assessed. If the child does not received continuing care as a child, health will accept the checklists for a full adult DST at around 17 years of age.

Independence Planning

- Support Young Person to decide on post 16 education and training – potential link with virtual school/impact etc.
- Start to consider post 18 housing and accommodation option (for Children In Care (CIC) this may include staying put and shared lives)
- Continued development on independence planning – to include agencies such as housing/Money Home Job. For Children in Care, their Personal Advisors that are allocated to them at age 17 will be able to assist with this as part of their continued Pathway Planning. Ensure young person is travelling independently where possible and if not, what assistance is going to be needed.
- Explore how any Personal Budget or Direct Payment might be used as part of planning for independence and future aspirations. A direct payment offers greater flexibility, control, and personalisation. The person chooses who provides their services, how their needs are met, and they purchase the support that meets their needs best. Following an assessment of an adults care and support needs there is the option of meeting eligible needs via a commissioned service (where Walsall Council arranges the care directly on the person's behalf), or via a direct payment, or via a mixture of both, depending on what best meets the needs and allows the person to achieve their outcomes . Please see local procedures on the process to access a direct payments which adheres to the national guidance. Further information is available at the end of this toolkit.
- Ensure that the Adult Social Care Plan is compiled and presented to the relevant decision making forum at least 3 months before the young person's 18th Birthday.

Young Carers

- Following the completion of the transition assessment a pathway planning and support package needs to be agreed taking account of changes in need, young carer's isolation in the community and their aspirations. The support plan should be agreed by the young carer, their family and other key services such as GP, schools, housing and further education providers (Walsall College have a dedicated Young Carers Champion to support transition).
- The support plan should include further education, employment and/or works experience, financial support, housing, health needs in order to agree pathway planning

Stage 3 – The transition plan (18 – 25)

By the age of 18, the plan will need to have been completed outlining the support to be offered, by whom and for how long. Case management responsibility transfers to a social worker within the relevant Adult Social Care Team. If there is a delay in the transition to Adults Social Care, support from Children's Services should continue to ensure continuity. If the pathway is followed, this should not be necessary.

The adult care and support package starts on the young person's 18 birthday, taking into account the young person's strengths, abilities and wishes and this is reviewed after six weeks and annually thereafter. For children leaving care, their Personal Advisor will be a key professional involved in their support and is responsible for updating their Pathway Plan up until the age of 25. 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.

Social Care

Transfer to adult services to have been be completed if required. Young people transition to the relevant adult social care team, these include: young people with physical and sensory disabilities will transfer to the adult locality team; those with a learning disability to the learning disability team; those with a mental health need to the mental health team. Decisions about the most appropriate team will be made on a case-by-case basis for young people who do not fit neatly into a specific team. There is no requirement to change adult social care teams at the age of 25 years unless circumstances change

Health

- At 18, all eligible young people transition to adults Continuing Health Care and the care package starts. This will be reviewed after three months and annually thereafter by adults Continuing Health Care. When CAMHS are providing time limited intervention this may continue beyond the 18th birthday in agreement with the relevant adult's health team. In this instance CAMHS and the relevant adult service will co-work for a limited period and this will be reviewed at the Care Programme Approach (CPA) meeting. Once the adult team takes over care coordination, advice can still be sought from CAMHS.
- Some young people may need the CCG and other care providers to deliver support and care through Direct Payments. A direct payment offers greater flexibility, control, and personalisation. The person chooses who provides their services, how their needs are met, and they purchase the support that meets their needs best. Following an assessment of an adults care and support needs there is the option of meeting eligible needs via a commissioned service (where Walsall Council arranges the care directly on the person's behalf), or via a direct payment, or via a mixture of both, depending on what best meets the needs and allows the person to achieve their outcomes. Please see local procedures on the process to access a direct payments which adheres to the national guidance. These are attached to the bottom of this toolkit.
- For children leaving care, ensure that the young person has access to their Health passport which is provided to them by health professionals.

Independence Planning

- Once a young person ceases to be looked after and they are a relevant child, or once they reach legal adulthood at age 18 and are a former relevant child, then the local authority will no longer be required to provide them with a social worker to plan and co-ordinate their care. The local authority must, however, appoint a Personal Advisor to support them. The PA will act as the focal point to ensure that care leavers are provided with the right kind of personal support. All care leavers should be aware of who their PA is and how to contact them, so that throughout their transition to adulthood they are able to rely on consistent support from their own key professional. All Eligible Care leavers are entitled to receive support up to the age of 25. Further information on care leavers eligibility and level of support required is provided at the end of this toolkit.

Lead Professionals and information sharing forums to track progress of all young people transitioning between Childrens and Adults Social Care.

If a child has an allocated Social Worker or Early Help Family Support Worker then they will be the lead professional overseeing this process.

If a child is life limited or has highly complex health needs, then the lead professional may need to be from health as part of their Continuing Health Care (CHC) planning. If you are social worker of a young person that has needs around continuing healthcare then this needs to be flagged with the CCG. For children in care, this may be done through the External Placement Panel. For those young people that are supported as part of TCP (Transforming Care Plan) Cohort, ensure that your young person's needs are also considered as part of the Dynamic Support Risk Register. Additional information on how to access the right support is attached to the bottom of this toolkit.

The External Placements Panel (EPP) is chaired by the Council Children's Services Director and will refer to a shared funding tool where the Council and CCG have responsibilities for children / young people where the nature and level of care requires a shared and co-ordinated approach. This arrangement allows for multi-agency discussion and evidence sharing about children Looked After or those living at home / in the community with challenging care needs and informs decision-making for joint funding of placements where the care needs require a single or any combination of Health, Education and Social Care funding to reach outcome objectives. Panel representatives include professionals from Childrens Services, Adults Social Care and Health professionals.

If a child has no EHCP and the above do not apply, the lead professional is the SENCO officer at the school or college.

Useful Documents linked to the processes outlined above:

No.	Title	Context	Document
1	Preparing for Adulthood – Year 9 Annual Review Guide	Details the pathway and practice tools for the year 9 review in line with the extension of the SEND code of practice introduced by the Children and Families Act 2014.	
2	Preparing for Adulthood – Key Topics to cover as part of year 9 Annual Review.	Outlines key areas for discussion as part of preparing for adulthood.	
4	Walsall Mental Capacity Act Guide	Walsall's guide to undertaking assessments under the MCA Act 2005.	
5	Walsall Care Act Guide	Walsall's Guide to the Care Act 2014 – Outlines the LA's responsibility as outlined within the Act.	
6	Walsall Adult Safeguarding Booklet	Outlines adult safeguarding duties	
7	Shaping our Future	Improving assessment and support for young carers transition into adulthood	

Links to Useful Resources

Walsall Care Act 2014 Booklet

Adult Safeguarding Reminder Guide Walsall

Walsall Mental Capacity Act Booklet

NHS Mental Health Factsheet

Mental Capacity Act Code of Practice

LPS and DOLS Guidance

Office of the Public Guardian

Court of Protection

In Control Resources

Transitions NICE Guidance

SCIE Resources

SCIE Transition Planning

SCIE Care Act Information

SCIE Mental Health of Young People Information

RiP Transition Guidance

DOLS DoH Easy Read Guidance

CQC Mental Health Guidance

Direct Payments and Personal Health Budget Guidance

NHS Continuing Health Care Guidance

NHS Continuing Health Care Decision Supporting Tool

NHS Learning Disabilities Health Checks

Preparing For Adulthood - Children In Care

AGE 14 YEAR 9

Identify those young people who are likely to need support from Adult Social Care (typically those with a disability or mental illness) and that they are placed on the Tracker so that they can be monitored through the Transition Process and presented to the Preparing for Adulthood Panel.

AGE 15 YEAR 10

Young people will be supported to complete their Independence Planning work and an updating assessment of their needs will need to be completed to inform this work by the time they are 15 years and 9 months of age. This will be reviewed periodically and will inform the pathway plan at age 16. Consider what needs to be included in this work as outlined within the 3 domains within the Transitions Toolkit (i.e health needs, education and independence planning) Start talking to the Young person about the work of the Personal Advisor and how the will support them in preparing for Adulthood.

AGE 16 YEAR 11

The First Pathway Plan is completed by the time the young person is 16 years and three months of age. They will need to be referred to the Transitions and Leaving Care Team prior to their 17th Birthday so that they can be allocated a Personal Advisor at age 17. Young people likely to require Adult Social Care support are referred for a Care Act assessment (N.B. these young people will already be on the tracker in keeping with the Transitions tracker). A Passport to Adulthood will need to be completed on Mosaic.

AGE 17 YEAR 12

Pathway Plans are reviewed and transition targets updated.

Post 18 accommodation plans should be developing, including Staying Put arrangements where applicable. Presentation at Housing Pathway Panel may also be required. Young people have a clear 18+ support network via lifelong links referral if needed and young people will have been provided with life skills work as part of their independence planning. Care Act Assessments will have been completed for those referred.

AGE 18 YEAR 13

Young people are presented to the Preparing for Adulthood Panel for the last time one month before their 18th birthday. This is where the panel will check that all necessary handover tasks for the move to Adult Services have been completed. The care package will now commence for young people eligible for support from Adult Social Care under the Care Act.

Preparing For Adulthood Pathway – Health

AGE 14 - 16

Young people with complex health needs are flagged up on the Transition Tracker as likely to need/be eligible for adult Continuing Healthcare (CHC). These young people will be tracked and progress monitored in consultation with health colleagues as part of the Preparing for Adulthood Panel.

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

For disabled children, consideration will need to be given as to whether a referral needs to be made to occupational therapy.

Consider what therapeutic support is required and whether they have been referred to CAMHS. For Children in Care, have they been referred to FLASH.

Consider whether the young person will need support from services such as physiotherapy or speech and language. If so, ensure that the correct referrals are completed in order to access them.

If a child has been assessed as being eligible for continuing care, the adult Continuing Health Care assessor should be informed when that child is 14. Once a child on continuing care reaches 16, if it is considered there is a possibility they will require an Adult Continuing Health Care assessment, the adult team should receive a referral. In Learning Disability, the child will be referred to the LD community transition nurse. At this point transitional meetings should be attended by representations from adult Continuing Health Care.

AGE 16 - 18

Mental Capacity Assessments may need to be undertaken. The Mental Capacity Act 2005 (MCA) relates to people aged 16 and over. People are assumed to have capacity unless an MCA assessment has deemed otherwise. The principles of the MCA are that people who lack capacity are empowered to make as many decisions for themselves as possible and that any decision made or action taken on their behalf is done so in their best interests.

Finalise plans for future therapeutic support and what mental health support will be required for the young person post 18. Consider what is already in place and whether there are any potential gaps their current care. At 17, if needs are not likely to change, an adult Decision Support Tool will be completed.

AGE 18+

At 18, all eligible young people transition to adults Continuing Health Care and the care package starts. This will be reviewed after three months and annually thereafter by adults Continuing Health Care. When CAMHS are providing time limited intervention this may continue beyond the18th birthday in agreement with the relevant adult's health team.

For Children in Care, ensure that the Young Person has been provided with their health passport.

101863 03/22