Milton Keynes Protocol for Transition From Childhood to Adulthood

For children and young people with care and support needs and their carers

Multi-Agency Guidance

Working in partnership to improve outcomes for children and families

Approval date / Approved by			
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Part A. Background and Context of the Protocol

1.0 Foreword

1.1 On behalf of Milton Keynes Council and partner agencies we are pleased to present Milton Keynes Multi-Agency Transition Protocol. The protocol has been reviewed following changes in legislation, specifically the Care Act 2014 and the Children and Families Act 2014, which incorporate the Special Education Needs and Disability (SEND) reforms

1.2 Transition to adult care and support comes at a time when a lot of change can take place in a young person's life. Transition includes exploring and preparing for:

- Independent living – young people having choice, control and freedom over their lives and the support they have, their accommodation and living arrangements, including supported living
- Participating in society - having friends and supportive relationships, and participating in, and contributing to, the local community
- Being as healthy as possible in adult life
- Higher education and/or employment – exploring employment options, such as support for becoming self-employed, volunteering and help from supported employment agencies.
- Adjusting to changes in the care and support received from education, health and care services and/or involvement with new agencies.

1.3 The Protocol sets out our commitment to vulnerable young people and their families, particularly for young people who will have a need for care and support in adulthood.

1.4 Helping vulnerable young people to experience the same opportunities as other young people in the move to adulthood is a challenge for all agencies because of the complex range of issues involved in matching up responsibilities and services with aspirations.

1.4.1 The protocol is relevant to all the professionals and agencies in Milton Keynes who have a responsibility in ensuring a successful transition. This includes professionals involved in planning and commissioning services as well as those actually delivering them.

1.4.2 The protocol clarifies the role of each agency so we can promote a better understanding and simplify processes wherever possible. It does not replace internal processes within individual agencies, but is intended to support multi-agency planning. The protocol will be underpinned by specific pathways.

1.5 A Milton Keynes Multi-Agency Transition Planning Group[1] will be established to support transition planning for young people and carers. The group will coordinate the transition of:

- Young people, under 18, with care and support needs who are approaching transition to adulthood;
- Young carers, under 18, who are themselves preparing for adulthood; and
- Adult carers of a young person who is preparing for adulthood

2.0 Purpose of the Protocol and Outcomes

2.1 The purpose of the protocol is to:

- Ensure every young person and their parents/carers have a positive transition experience.
- Make clear the transition planning and review processes that support the move from adolescence to adulthood for young people from thirteen up to their 25th birthday.
- Facilitate joint working, good quality transition planning and positive outcomes for young people who are likely to have care and support needs in adulthood and their carers
- Make clear how we will ensure that vulnerable young people who may be in need of care and support in adulthood are identified;
- Ensure that young people and carers likely to be in need of care and support in adulthood are offered a transition assessment at the most 'beneficially significant' time

[1] Milton Keynes Multi-agency Transition planning group – terms of reference see Appendix 1

- Ensure that the most appropriate adult pathway is identified at an early enough point in the young person's transition to facilitate a smooth transition;
- Set out outcomes, performance measures and standards to be achieved
- Set out the roles and responsibilities of all the services working with young people at the transition stage and ensure the process is coordinated, systematic and consistent
- Support the local and sub-regional commissioning cycle enabling us to commission services and opportunities effectively, based on early identification of he needs of the local population.

2.2 The outcomes of a good transition are:

Young people…	Young people and their parent/carers …
• Make decisions and take the lead or are supported by people that can advocate for them • Are supported to plan what they want to do and achieve • Are able to access the same opportunities as other young people • Have access to good transport services to enable them to access services • Can try things out beforehand • Can change their mind	• Are listened to and fully involved • Have one point of contact to link with • Feel supported • Receive consistent messages • Have easy access to understandable information • See agencies stick with and pursue agreed plans, but are flexible to accommodate change • Young people subject to a protection plan should experience a service that is seamless and ensures they remain safe as they move in to adulthood

3.0 Transition Principles

3.1 All agencies involved in this protocol are committed to the following principles:

3.1.1 **Person-centred transition planning:** The young person should be at the centre of the transition planning process, giving them choice and control over their own future ensuring the focus is on their needs, hopes and aspirations. Person-centred planning and reviews that support young people, where possible, to express their views, should inform support planning and ensure positive outcomes for young people.

3.1.2 **Involvement and consultation of parents and carers:** Young people and their families should be recognised as partners in the process and be actively involved in planning their future. The experience of young people and their families should inform strategic planning and commissioning.

3.1.3 **Partnership working across agencies:** A shared vision, which places young people and their families at the centre and focuses on improving life chances, should be developed across all partners. Partners must be committed to working together and have a clear understanding of the specific roles and responsibilities of all the key agencies involved in transition.

3.1.3 **Provision of accessible and clear information:** Clear information should be shared with young people to help raise aspirations by illustrating what has already worked for others. Information should be developed with young people and their families to ensure it is relevant, accessible and understandable. Young people should be encouraged to develop the skills and understanding they need to make informed choices. Even if they are not eligible for services and transition assessment good information and advice about support in the community can be helpful for young people who may not be aware of support available in the community.

3.1.5 **Working towards positive outcomes:** Transition planning should keep focussed on life outcomes, promoting independence and support young people to lead meaningful and enjoyable adult lives. This includes where transition planning involves consideration of personal budgets or other forms of allocating resources.

3.1.6 **Early assessment and transition planning:** Early assessment and transition planning facilitates more responsive and flexible forward planning. Timely transition assessments are essential for Commissioners to plan services and budgets in advance, for the projected support needs of young people moving into adulthood.

3.1.3 **Relevant information sharing:** Information sharing is vital to support an effective assessment and planning process which fully identifies needs and outcomes and the education, health and care provision needed by the child or young person. As far as possible, there should be a 'tell us once' approach to sharing information during the assessment and planning process so that families and young people do not have to repeat the same information to different agencies, or different practitioners and services within each agency. Local Authorities must discuss with the child and young person and their parents what information they are happy for the Local Authority to share with other agencies. A record should be made of what information can be shared and with whom.

3.1.8 **Quality and monitoring for outcomes:** Mechanisms need to be built in to ensure the quality of provision meets appropriate standards and that the transition process is as effective as possible

3.1.9 **Safeguarding:** It is a fundamental principle that disabled children have the same right as non-disabled children to be protected from harm and abuse. Often disabled children have additional needs related to physical, sensory, cognitive and/or communication requirements and many of the problems they face are caused by negative attitudes, prejudice and unequal access to things necessary for a good quality of life. For all practitioners and agencies, ensuring young people are safeguarded should therefore always be integral to everything they do. Practitioners should ensure that any young person subject to a protection plan is supported to remain safe as they move in to adulthood.

Milton Keynes Council employees and partners will ensure that all appropriate Safeguarding checks are in place and the safety and welfare of the young person is paramount when arranging transition between children's services and adult services. We will ensure that all staff working with vulnerable young people and adults have had the appropriate Disclosure and Barring Service (DBS) or appropriate background checks, and are provided with safeguarding training and management supervision in order to minimise risks and provide a high level of protection to the young person. Staff will respect confidentiality and will adhere to local guidance related to sharing information[2]. Staff can access information and procedures about safeguarding[3] on the Council's website.

[2] Milton Keynes Information Sharing Policy: http://staffintranet/directorates/adult-social-care/adult-social-care-policy-and-procedures

[3] http://www.milton-keynes.gov.uk/social-care-and-health/adult-social-care/safeguarding-adults-policies-and-procedures

Part B. The Transition to Adult Care and Support Process

4.0 Transition Assessment

4.1 Assessment is how a Local Authority decides whether an Individual needs care and support. Assessment is a service response in itself and can, but will not always, lead to the provision of care and support from the Local Authority.

4.1.1 Transition assessment is an ongoing process of collecting data on the young person's needs, preferences, and interests regarding personal care, social interaction, education and work. Each service area has its own specific assessment process (e.g. Child's needs assessment, young carer's assessment, child's carer's assessment, Care Act assessment) which will form a basis for and contribute to the transition process.

4.2 Assessment for transition to adult care and support must involve the young person and anyone else they want to involve in the assessment.

4.2.1 The Care Act places a duty on Local Authorities to provide an independent advocate to facilitate the involvement in assessment where an individual would experience substantial difficulty in understanding the necessary information or in communicating their views, wishes and feelings – and if there is nobody else appropriate to act on their behalf. This duty applies to young people or carers who meet the criteria, regardless of whether they lack mental capacity as defined under the Mental Capacity Act.

4.3 Assessment for adult care or support must be appropriate and proportionate to the complexity of the person's needs and it must consider:

- Current needs and how these impact on wellbeing;
- Whether the young person is likely to have needs after they turn 14, regardless of whether the child or individual currently receives any services; and
- If so, what those needs are likely to be and which is likely to be eligible needs
- The outcomes the young person or carer wishes to achieve in day-to-day life and how care and support (and other matters) can contribute to achieving them.
- The views and wishes that matter to the young person.

4.4 A transition assessment can be carried out through an annual review of a young person's Education, Health and Care (EHC) Plan. All EHC plans must include the provision to assist in preparing for adulthood from school year 9 (age 13 to 14 years). The transition assessment must be carried out in accordance with the Milton Keynes Council Care Act Policy 2014[4]

4.5 The Care Act sets a national minimum eligibility threshold[5] which must be followed by all Local Authorities in England. The criteria for adult care and support consists of three elements, all of which must be met for an adult's needs to be eligible based on identifying:

- Whether a person's needs are due to a physical or mental impairment or illness
- To what extent a person's needs affect their ability to achieve two or more outcomes (specified in the regulations) and
- Whether being unable to achieve outcomes is having, or is likely to have a significant impact on their wellbeing

4.6 Having carried out a transition assessment, the Local Authority must give an indication of which needs are likely to be regarded as eligible needs so the young person understands the care and support they are likely to receive once children's services cease. Where a young person's needs are not eligible for adult services, Local Authorities must provide information and advice about how those needs may be met and the provision and support that young people can access in their local area.

[4] Care Act 2014 Policy – http://staffintranet/directorates/adult-social-care/adult-social-care-policy-and-procedures

[5] Care Act 2014 Policy, Appendix 3 Eligibility Tool for Adults – http://staffintranet/directorates/adult-social-care/adult-social-care-policy-and-procedures

5.0 When should transition assessment be offered?

5.1 If a young person or carer is likely to have needs when they, or the child they care for, turn 18 the Local Authority must assess them when it considers there is "significant benefit" to the individual in doing so

5.2 'Likely to have needs' means an individual has any likely appearance of need for care and support as an adult; not just those needs that will be deemed eligible under the Care Act .

5.2.1 Most young people who receive transition assessment will be 'Children in Need' as defined under the Children Act 1989 and will already be known to Milton Keynes Council. . It is likely that young people and carers who are in receipt of Children's Services would be 'likely to have needs' in this context.

5.2.2 There may also be some young people who are not receiving children's services but are likely to have care and support needs as an adult. These young people could include:

- young people with degenerative conditions;
- young people who needs have been largely met by their educational institute but who once they leave, will require their needs met in some other way;
- young people detained in the youth justice system who will move into an adult custodial establishment;
- young carers whose parent(s) have needs below Milton Keynes' eligibility threshold but may nevertheless require advice or support to fulfil their potential
- young people and young carers receiving Children and Adolescent Mental Health Services (CAMHS) may also require care and support as adults even if they did not receive children's services from Milton Keynes Council.

The Milton Keynes Multi-Agency Transition Planning Group will, as early as possible, identify young people who may be in need of care and support who are not in receipt of Children's Services.

5.3 The significant benefit consideration is about getting the timing right to undertake the assessment. The assessment should be carried out early enough to ensure the right care and support is in place when the young person moves to adult care and support. The assessment will generally be undertaken at the point when the young person's needs for care and support as an adult can be predicted reasonably confidently.

5.4 When considering if it is of 'significant benefit' to assess, we should consider the circumstances of the young person or carers, and whether it is an appropriate time to undertake an assessment which helps them to prepare for adulthood. When considering whether it is of significant benefit we should consider key factors e.g.

- The state they have reached at school and any upcoming exams;
- Whether the young person or carer wishes to enter further/higher education or training;
- Whether the young person or carer wishes to get a job
- Whether the young person is planning to move out of their parental home into their own accommodation;
- Whether the young person will have care leaver status when they become 18;
- Whether the carer of a young person wishes to remain in or return to employment when the young person leaves for time education;
- The time it may take to carry out the assessment;
- The time it may take to plan and put in place the adult care and support;
- Any relevant family circumstances;
- Any planned medical treatment.

5.5 The 'Special Educational Needs and Disability Code of Practice (Department of Education /Department of Health 2015): 0 to 25 years' states that Local Authorities should minimise disruption to young people and their families and should endeavour to combine assessments and planning where this is appropriate.

5.6 The Care Act 2014 suggests that for young people who are Looked After the statutory 'Pathway Planning Process' can be used to carry out a transition assessment, where this is appropriate.

5.7 A young person or carer, or someone acting on their behalf has the right to request a transition assessment. On receipt of a request the Local Authority will need to consider whether the likely

need and significant benefit conditions apply - and if so a transition assessment must be carried out. If the Local Authority thinks the conditions do not apply and refuses an assessment on that basis the reasons for the refusal must be put in writing in a timely manner and it must provide information and advice on what can be done to prevent or delay the develop of needs for support.

5.8 If the Local Authority judges that the young person or carer is likely to have needs for care and support after turning 18, but that it is not yet of significant benefit to carry out a transition assessment the Local Authority should indicating when it believes the assessment will be of significant benefit. In these circumstances the onus is on the Local Authority to agree the timing of the assessment rather than leaving the young person or carer with uncertainty or having to make repeated requests for assessment.

5.9 Where a young person or carer has been refused an assessment but later makes a further request the Local Authority will need to consider whether the likely need and significant benefit conditions apply, and carry out the assessment if they do.

6.0 Carers

6.1 Local Authorities must assess the needs of an adult carer where there is a likely need for support after a young person turns 18 and it is of significant benefit to the carer to do so. This may be where a carer is able to remain in employment with minimal support while their child has been in school. However once the young person leaves education, it may be the case that a carer's needs for support increase and additional support and planning is required from the Local Authority to allow the carers to stay in employment.

6.2 Transition assessment for young carers or adult carers must also specifically consider if a carer:

- Is able to care now and after the child in question turns 18;
- Is willing to care now and will continue to after 18;
- Works or wishes to do so;
- Is, or wishes to, participate in education, training or recreation.

6.3 As stated in the Milton Keynes Children's Services policy 'Assessment of services for parent carers and young carers'[6] in most circumstances the local council should ensure that the person cared for is receiving sufficient services so that a young person age 14 to 17 is not undertaking a regular and substantial load of caring responsibilities. The council should ensure that such young peoples' futures are not adversely affected by caring responsibilities that may undermine their own need to participate fully in education, training or work.

6.4 There are, however, a small number of situations where a 14 to 17 year old may choose to undertake a substantial caring role for a period, for example if a parent is terminally ill. Where local councils are satisfied that the child's welfare can be promoted and safeguarded as they take on a substantial caring role it could decide, in these circumstances, that it would be more helpful to a young person to be assessed and receive services. The Care Act 2014 states that these young people will need to be offered a transition assessment. Young carers will be identified via children services with the information being shared at the Multi-Agency Transition Planning Group.

7.0 Continuity of Provision

7.1 Under no circumstances should young people find themselves suddenly without support and care as they make the transition to adult services. Very few moves from children's to adult services will or should take place on the day of someone's 18th birthday. For the most part, transition to adult services for those with EHC plans or engaged with other aspects of Children Service's should begin at an appropriate annual review and in many cases should be a staged process over

[6] http://staffintranet/assets/attach/6086/Assessment_of_services_for_parent_carers_and_young_carers_-_Dec_20101.pdf

several months or years.

7.2 Under the Care Act 2014 Local Authorities must continue to provide a young person with children's services until they reach a conclusion about their situation as an adult, so that there is no gap in provision. Reaching a conclusion means that, following a transition assessment, the Local Authority concludes that the young person:

- Does not have needs for adult care and support, or
- Does have such needs and begins to meet some or all of them, or
- Does have such needs but decides it is not going to meet them (either because they are not eligible needs or because they are already being met)

7.3 The Local Authority can also decide to continue to provide care and support from children's services after the young person has turned 18. This can continue until the EHC plan is no longer maintained but when the EHC plan ceases or a decision is made that children's services are no longer appropriate, the Local Authority must continue the children's services until they have reached a conclusion about their need for support from adult services

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8.0 Statutory Care and Support Plans and Education, Health and Care (EHC) Plans

8.1 A Care and Support Plan (for young people with care and support needs) or a Support Plan (for carers) must be created regardless of the setting where needs are met. The plan should 'belong' to the individual and the council's role is to support its production and to 'sign off' the plan. The planning process should involve the adult, carers and any other person they want to involve, this could be a friend or relative, support planner, third sector organisation or Adult Social Care staff.

8.2 Where young people aged 18 or over continue to have EHC plans, and are receiving care and support, this will be provided under the Care Act 2014. The statutory adult care and support plan should form the 'care' element of the young person's EHC plan. While the care part of the EHC plan must meet the requirements of the Care Act 2014 and a copy should be kept by adult services, it is the EHC plan that should be the overarching plan that is used with these young people to ensure they receive the support they need to enable them to achieve agreed outcomes.

8.3 Milton Keynes will use the Multi-Agency Transition Planning Group to ensure that local systems and processes for assessment and review of EHC plans and care and support plans are fully joined up for young people who will have both. Every effort should be made to ensure that young people with both EHC plans and care and support plans do not have to attend multiple reviews held by different services, provide duplicate information, or receive support that is not joined up and co-ordinated. We will use the Milton Keynes Multi-Agency Transition Planning Group to join up the planning processes for young people.

8.4 When a young person's EHC plan is due to come to an end, Local Authorities should put in place effective plans for the support the young person will be receiving across adult services. Where a care and support plan is in place, this will remain as the young person's statutory plan for care and support. Local Authorities should review the provision of adult care and support at this point as the young person's circumstances will be changing significantly as they leave the formal education and training system.

8.5 Where a safeguarding issue arises for someone over 18 with an EHC plan, the matter will be dealt with by the adult safeguarding team. They will involve colleagues in the child safeguarding team where appropriate as well as any relevant partners**.**

9.0 Personal Budgets

9.1 Where a transition assessment identifies needs that are likely to be eligible Local Authorities should consider calculating an indicative Personal Budget to provide an idea of how much care and support will cost when the individual enters the adult system. Young people and/or their family are legally entitled to have a Personal Budget and to know how much it is.

9.1.1 At the beginning of the planning process this will be an indicative amount (estimate) only. This estimated amount will be based on the outcome of his/her transition assessment.

9.1.2 The individual must be advised that their Personal Budget amount will be finalised when their support plan is signed-off by the council and it may be less or more than the

indicative amount as a result of the detail the plan.

9.2 The young person can choose to use their Personal Budget as:

- A Direct Payment
- A Managed Budget (managed by Milton Keynes Council)
- A combination of these two options

9.3 They must be given information and help in order to understand the options and how they can be helped to use them in a way which best enables their support

10.0 Transition to Adult Health Services

10.1 Support to prepare young people for good health in adulthood should include supporting them to make the transition to adult health services. A child with significant health needs is usually under the care of a paediatrician. As an adult, they might be under the care of different consultants and teams. Health service and other professionals should work with the young person and, where appropriate, their family. They should gain a good understanding of the young person's individual needs, including their learning difficulties or disabilities, to co-ordinate health care around those needs and to ensure continuity and the best outcomes for the young person. This means working with the young person to develop a transition plan, which identifies who will take the lead in co-ordinating care and referrals to other services. The young person should know who is taking the lead and how to contact them.

10.2 For young people with EHC plans, the plan should be the basis for co-ordinating the integration of health with other services. Where young people are moving to adult health services, the Local Authority and health services must co-operate, working in partnership with each other and the young person to ensure that the EHC plan and the care plan for the treatment and management of the young person's health are aligned.

10.3 The Clinical Commissioning Group (CCG) must co-operate with the Local Authority in supporting the transition to adult services and must jointly commission services that will help meet the outcomes in the EHC plan.

11.0 Transition from Children's to Adult NHS Continuing Healthcare

11.1 Clinical Commissioning Groups (CCGs) should use the National Framework for NHS Continuing Healthcare (CHC) and supporting guidance and tools to determine what ongoing care services people aged 18 year or over should receive. CCGs should ensure that the adult NHS Continuing Healthcare Team is appropriately represented at all transition planning meetings regarding young people whose needs suggest that there may be potential eligibility. The Framework sets out best practice timing of transition steps as follows:

- Children's services should identify young people with likely needs for NHS CHC and notify the relevant CCGs when a young person turns 14;
- There should be a formal referral for adults NHS CHC screening at 16;
- There should be a decision in principle at 17 so that a package of care can be in place once the person turns 18 (or later if agreed more appropriate)

11.2 Where a young person has been receiving children's continuing care from a relevant CCG, it is likely that they will continue to be eligible for a package of adult NHS CHC when they reach the age of 18. Where their needs have changed such that they are assessed as no longer requiring such a package, they should be advised of their non-eligibility and of their right to request an independent review and mediation. The CCG should continue to participate in the transition process, in order to ensure as appropriate transfer of responsibilities, including consideration of whether should be commissioning, funding or providing services towards a joint package of care.

12.0 Transition from Child and Adolescent Mental Health Services (CAMHS) to Adult Mental Health Services

12.1 CAMHS provides a service to meet the needs of eligible children and young people up to their 18th birthday. This includes providing an interface with other services commissioned to ensure the

child or young person has well integrated care.

12.2 Where a young person is approaching their 18th Birthday and it had been identified that they will require on- going mental health support following their 18th Birthday, a transfer of care process needs to take place. It is paramount for the health and well-being of the young person that this transfer process is undertaken as seamlessly as possible and with as little disruption as possible to their treatment pathway. Further advice on the transfer of care for young people with mental health needs is expected from the National Institute of Clinical Excellence (NICE) in 2016.

12.3 The CAMH service will:

- have protocols in place to ensure that transitions between services are robust
- work together with multi-agency and other services, the service user and carers to plan in advance for transition
- provide a written and agreed care plan detailing what service they will receive post-CAMHS
- provide a written and agreed plan, if no further interventions or treatment are planned, so that the young person and, where appropriate, parents/carer knows what to do if they become unwell

12.4 CAMHS Service Transition Protocols will:

- Identify those children and young people that will need continuity of care and make that known to adult mental health services
- Ensure that any risks or safeguarding concerns are clearly considered and documented
- Make arrangements for transition planning to take place.

13.0 Transition and Mental Capacity

13.1 Young people over compulsory school age have the right to participate in decisions about the provision that is made for them and be consulted about provision in their areas, although there is nothing to stop them asking their parents, or others to help them make the decision. However, some young people, and possibly some parents, will not have the mental capacity to make certain decisions. Provision is made in the Children and Families Act to deal with this. Under the Act, lacking mental capacity has the same meaning as in the Mental Capacity Act (MCA) 2005.

13.2 The right of young people to make a decision is subject to their capacity to do so as set out in the Mental Capacity Act 2005[7]. The underlying principle of the Act is to ensure that those 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. Decisions about mental capacity are made on an individual basis, and may vary according to the nature of the decision. Someone who may lack capacity to make a decision in one area of their life may be able to do so in another.

14.0 Joint Commissioning

14.1 The statutory guidance 'Special Educational Needs and Disability Code of Practice (Department of Education/Department of Health 2015): 0 to 25 years' requires Local Authorities to place children, young people and families at the centre of their planning, and work with them to develop co-ordinated approaches to securing better outcomes, as should Clinical Commissioning Groups (CCGs). They should develop a shared vision and strategy which focuses on aspirations and outcomes, using information from EHC plans and other planning to anticipate the needs of children and young people with special educational needs (SEN) and ensure there are pathways into employment, independent living, participation in society and good health.

[7] Mental Capacity Act Policy - http://staffintranet/directorates/adult-social-care/adult-social-care-policy-and-procedures

Part C. Roles and Responsibilities of Agencies

15.0 Children and Families Partnership

15.1 Milton Keynes Children and Families Partnership is responsible for ensuring that the needs of all children and young people in Milton Keynes are met, and services work together to ensure that young people achieve the best outcomes, including successful transition to adulthood and future economic wellbeing.

16.0 Schools

16.1 Schools in Milton Keynes Council and out of authority schools which are commissioned by the LA to provide education to Milton Keynes children and young people will:

1. Arrange Transition Reviews for pupils who have a EHC plan in Years 9 and above in accordance with Milton Keynes Schools Annual Review Guidance and the SEND Code of Practice, ensuring that dates are negotiated in advance with professionals whose attendance is essential and that other agencies and the young person/parents/carers are given adequate notice.
2. Arrange Transition Reviews for other vulnerable young people who meet the criteria for this protocol with involvement of the Youth Faculty and other relevant agencies.
3. Conduct Transition Reviews in an appropriate way to ensure meaningful involvement of the young person and their parents/carers. A person centred approach should be used in all reviews, in mainstream and special, maintained and independent/non-maintained school settings.
4. Ensure actions on Transition Plans which are the responsibility of the school are carried out.
5. Arrange year 11 Transition Reviews for the autumn term where possible to facilitate the process transition planning for people leaving school at the end of year 11.
6. Inform the SEN Case Officer of all young people with learning difficulties & disabilities leaving at the end of the academic year, by the middle of the summer term each year, with details of intended destinations.

17.0 SEN Case Officers (Milton Keynes Council)

17.1 **SEN Case Officers will:**

1. Ensure that the information held on all young people is up to date, that their EHC plan is reflective of their need and that this is recorded on the relevant Education Records System (currently Capita ONE) for every young person who has an EHC plan.
2. Provide a complete list of all Milton Keynes pupils with an EHC plan in years 8 to 14 to relevant managers in the Children with Disabilities Team, Adult Social Care Teams, the 14-19 team and the Youth Faculty on an annual basis. This will be updated on a monthly basis. The list will include name, date of birth, National Curriculum Year Group, primary SEN, school, home address and type of school (mainstream, resourced or special).
3. Record whether a Transition Plan has been completed, with the date, and update for each subsequent Transition Plan Review. Record attendance of professionals and parents/carers and young people at this meeting.
4. Advise all newly commissioned out of authority schools of the Local Authority's policies on provision for children and young people with disabilities, so that assumptions are not made that children will remain in out of authority provision post 16.
5. Supply data to the local colleges on an annual basis, subject to an appropriate data sharing agreement being in place. This may be through the Multi-Agency Transition Planning Group.
6. Request details from schools, of the current situation/plans, of all anticipated leavers who have an EHC plan and their intended destinations and ensure data is collated by the summer half term.
7. Record intended destinations for all young people who have an EHC plan during Year 11 and confirm details after the young person has left school.
8. Inform Adult Social Care Teams and the Youth Faculty of destinations of all children who have

an EHC plan who meet the criteria and who have left school.

9. Attend any Transition Reviews which are problematic or where there are concerns about the quality of transition planning, giving particular priority to children in out of authority placements.
10. Provide and regularly update guidance for schools on Transition Planning.

18.0 Youth Faculty – Community Learning Milton Keynes (CLMK)

18.1 The Youth Faculty (formerly Connexions) will:

1. Produce a Transition Plan following the Transition Review meeting in Year 11, based on the input of the Young Person, their parents/carers, the School and all other agencies involved. The Transition Plan must clearly set out actions, responsibilities and timescales.
2. Provide an updated Transition Plan following Transition Reviews in years 10 and 11 and subsequent years where young people remain in School post 16.
3. Distribute the Transition Plan to the young person and his/her parents/carers, the School and the SEND team.
4. Where a young person is moving on to college or another educational institution, pass on the Transition Plan and ensure appropriate arrangements are in place.

19.0 Children's Social Care, Children with Disabilities Team

19.1 At the beginning of Year 9 the Children with Disabilities Team will through its Transition Worker:

1. Identify all young people with a Statement of Special Educational Needs or Education Health Care (EHC) Plan who may be eligible for an assessment by Adult Social Care Services. A transition assessment will need to be arranged at the most significantly beneficial time for the young person and their family. The decision around whether a young person will be identified for an adult social care assessment is based on information obtained from the Statement of Special Educational Needs or EHC Plan, school and parents. The decision is shared with parents, school, and Adult Social Care Services.
2. Provide Information and signposting in a leaflet which parents receive with the decision letter in Year 9. Decisions can be revisited at the end of Year 11 if there is any new information which may identify the needs of the young person has changed.
3. Ensure that Children's Social Care workers who are working with young people with a Statement of Special Educational Needs or EHC Plan will attend Transition Review Meetings.

20.0 Youth Offending Team

20.1 Milton Keynes Youth Offending Team (YOT) works with young people who have offended or are at risk of offending. The overall aim is to prevent offending behaviour by young people aged 10-18 years of age. To support transition from childhood to adulthood the YOT staff will:

1. Conduct partnership work with the Probation Service in respect of the transfer of 17 year olds subject to Community and Custodial Orders as appropriate.
2. Liaise with Young Offender's Institutions, Secure Training Centres and adult prisons as appropriate.
3. Support school leavers in respect of obtaining further education, training or employment taking into account learning styles/needs.
4. Work with parents/carers in respect of young people who commit serious offences as a result of learning difficulties or disabilities.
5. Make referrals to partners to facilitate appropriate support, particularly the community mental health service and SEND/LLDD Services, participating in any joint meetings.
6. Provide advice, information and guidance to parents/careers and young people signposting as required.
7. Provide a voluntary Appropriate Adult Scheme and Appropriate Adult training to staff to ensure provision of service to all relevant young people under 18 during police interviews.
8. Jointly with Social Care, Housing and Accommodation Services support resettlement in the

community of young people leaving custody or home.

21.0 Adult Social Care Services

21.1 All social care teams working with adults with learning disabilities, physical disabilities, sensory needs, mental health needs will:

1. Take an active role in the planning and preparation of a young person's transition to adulthood, carrying out a transition assessment when it would be of significant benefit to do so. Where appropriate this will be carried out at the same time as an annual EHC review; Transition assessment for adult care or support must consider:
   - Current needs and how these impact on wellbeing;
   - Whether the young person is likely to have needs after they turn 18, regardless of whether the child or individual currently receives any services; and
   - If so, what those needs are likely to be and which is likely to be eligible needs
   - The outcomes the young person or carer wishes to achieve in day-to-day life and how care and support (and other matters) can contribute to achieving them

   The assessment should also take the following into account:
   - Fluctuating needs,
   - Supporting the person to be involved
   - If the person has "substantial difficulty" (in being involved in the process)[8]and requires an advocate;
   - Appropriate and proportionate assessments;
   - Safeguarding;
   - Considering strengths
   - Preventing needs;
   - Integrated assessments.
2. A Care and Support Plan (in the case of young people with care and support needs) or a Support Plan (in the case of carers) must be created regardless of the setting in which the needs are met. The plan should 'belong' to the individual and the councils role is to support it's production and to 'sign-off' the plan. The planning process should involve the adult, carers and any other person they want to involve, this could be a friend or relative, support planner, third sector organisation or Adult Social Care staff.
3. Identify the individual's personal budget and record the actual personal budget amount in their care and support plan.
4. Where appropriate arrange care and support provision/placements as including the contractual arrangements necessary for an independent placement and inform the school's career advisor of any provision/placements made.
5. Provide information and advice to parents, carers (including young carers) and young people to information on transition.
6. Liaise with the Youth Faculty to explore local options to meet the young person's needs. If the young person's needs cannot be met locally, liaise with the school's career advisor regarding applications for specialist colleges as appropriate.
7. Review provision six weeks after the young person's care transfers to an Adult Social Care Team and arrange subsequent reviews.

[8] See Milton Keynes Care Act Staff Manual

22.0 Milton Keynes Health Economy

22.1 Health professionals working with vulnerable young people with physical difficulties, sensory needs, complex health needs, including mental health needs or who are defined as Learners with Learning Difficulties and/or Disabilities (LLDD), will:

1. Ensure that information is provided by relevant health professionals for the Year 9 transition review and subsequent reviews as required where a young person has significant health needs which need to be taken into account in transition planning.
2. Ensure that relevant health professionals contribute to the Year 9 Transition Reviews, where a young person is likely to need health care support on leaving school, in order to advise on how the young person's health needs may impact on future placements.
3. Offer to provide appropriate health input into transition plans and to ensure that this information is developed in Years 10 and 11 and updated in subsequent years for young people who stay in school post 16.
4. Facilitate the transfer to Adult Health Care Services and ensure that referrals to relevant services are made in good time so that there is no gap in service provision. Ensure that young people and their parents/carers know when and how this transfer will take place and that sufficient notice is given. Ensure that the young people and their parents/carers know who will co-ordinate their health care provision within the Adult Health Care Services.
5. Ensure that the responsible Health/Social Care commissioner will resolve any difficulties about responsibility for the provision of health services which may arise in the case of young people placed in out of authority schools.
6. Ensure that health assessments are undertaken and referrals presented to the relevant Continuing Health Care Panel prior to the young person reaching 17 years.

23.0 Milton Keynes College

23.1 Staff at Milton Keynes College will:

1. Use accurate data supplied in a timely framework by the Multi-agency transition planning group and sub-regionally to predict demand for courses/provision that is being commissioned and plan accordingly, allowing time to ensure information can be disseminated to professionals working with young people. Courses should respond to reasonable demands and consider the whole range of a young person's needs in line with commissioners' specifications and financial guidelines.
2. Ensure that information is made available to schools, the Youth Faculty and relevant Local Authority staff on courses which are available.
3. Attend school open evenings to ensure that information is disseminated as widely as possible.
4. Work in partnership with schools to ensure appropriate arrangements are in place for the successful transition of young people from school to college placements.
5. Ensure that college staff receives appropriate training to develop inclusivity in working with young people with disabilities and increase their confidence at applying appropriate inclusive strategies.
6. Ensure experienced staff are employed to provide specialist courses to develop the range of skills necessary for adult life.

24.0 Housing

24.1 Housing managers will:

1. Use data supplied by the Multi-Agency Transition Planning Group to plan where possible appropriate housing in partnership with social housing providers to meet demand as defined by the Housing Options Allocation Scheme for Milton Keynes

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25.0 Youth Services

25.1 Youth Service managers will:

1. Use data supplied by the Multi-Agency Transition Planning Group to plan appropriate

activities to meet demand, enabling young people/adults aged 13 to 19 (25 for those with learning needs) to have access to social education activities and to meet their friends.
2. Ensure young people have a say in the nature and location of activities.
3. Consider transport and travel and training needs to enable young people/adults to access these activities.
4. Support young people to have their voice heard and to participate on an equal footing with their peers.

26.0 Community Facilities

26.1 Community Facilities Managers will:

1. Use data supplied by the Milton Keynes Multi-Agency Transition Planning Group to help to plan appropriate leisure activities to meet demand.
2. Ensure wherever possible that young people/adults have a say in the activities provided.
3. Ensure that sports, leisure, library, arts and other cultural provision including informal learning provides opportunities for access by young people with disabilities

27,0 Voluntary Sector

27.1 Voluntary agencies have an important role to play in supporting the transition process for young people with disabilities. Children and young people in need can access VOICE if they want/need an advocacy service.

28.0 Transport

28.1 All services will need to consider transport needs to enable young people/adults to access their services/activities and involve partner agencies as necessary to resolve any difficulties.

Part D. Monitoring and review

29.0 Multi-Agency Transition Planning Group

29.1 The Multi-Agency Transition Planning Group has strategic and operational responsibility for driving transition processes forward in Milton Keynes.

29.2 The group is chaired by a senior officer from Milton Keynes Council and attendees include officers from all agencies that have a role or responsibility for planning transition. The group will meet on a monthly basis. The group will develop its own terms of reference and will consider how it engages with families and young people. .

29.3 The group will develop and monitor mechanisms to ensure that the quality of provision meets appropriate standards and that the transition process is as effective as possible. This will include:

- capturing feedback from young people, their families and other stakeholders.
- receiving qualitative and quantitative information and data about transitions,
- monitoring and reviewing the effectiveness of this protocol
- resolving issues with the aim of improving the transition process

Milton Keynes Protocol for Transition From Childhood to Adulthood
Appendix 1 – Multi Agency Steering Group Terms Of Reference

MILTON KEYNES COUNCIL

TERMS OF REFERENCE
(currently under review)

– TO BE ADDED TO THIS PAGE

Milton Keynes Protocol for Transition From Childhood to Adulthood
Appendix 2 – Relevant Legislation, Documents and Definitions

Law and National Guidance

Together the Children and Families Act 2014 and the Care Act 2014 create a new comprehensive legislative framework for transition:

- Focus on personalised, outcome-based approaches;
- New focus on carers across both Acts – families transition rather than just the young person

Sections 56-58 of the Care Act 2014 and the Special Educational Needs and Disability Code of Practice (Department of Education/Department of Health 2015): 0 to 25 years outline the duty to carry out a transition assessment for young person or carers, in order to help them plan, if they are likely to have needs once they (or the child they care for) turn 18.

The National Institute for Health and Care Excellence (NICE) has been commissioned by the Department of Health (DH) and Department for Education (DfE) to develop a guideline on transition from children's to adult services that covers both health and social care. These guidelines are due to be published in February 2016. The focus of the guidelines will be all young people using children's health or social care services at the time when they are due to make a transition into adult health or social care services; they will not include young people who are not receiving children's health or social services.

Care Act 2014, s58-66

- The Care Act Statutory Guidance. Section 16 Transition to Adult Care and Support
- The Care and Support (Children's Carers) Regulations 2014

Carers and Disabled Children Act 2000, s 2
Children and Families Act 2014, Part 3
Children Act 1989, s 17
Children Act 2004, s 10-11
Children (Leaving Care) Act 2000
Chronically Sick and Disabled Persons Act (CSDPA) 1970, s 2
Education Act 1996, s 323
NHS Act 2006, s82
All-Party Parliamentary Group on Autism

- Transition to adulthood: Inquiry into transition to adulthood for young people with autism (2009)

Care Quality Commission (CQC)

- Care Quality Commission (2014) From the pond into the sea: Children's transition to adult health services (2014)

Department for Education

- The Children Act 1989. Guidance and Regulations Volume 3: Planning Transition to Adulthood for Care Leavers (2010)
- Care leavers in England: data pack (2012)
- Care leaver strategy: a cross-departmental strategy for young people leaving care (2013)

Department of Health

- Code of Practice for Children with Special Education Needs (2013)

Department of Education/Department of Health

- Special Educational Needs and Disability Code of Practice (2015): 0 to 25 years

Cross Government Programme

- Getting a Life Programme (2008 to 2011), part of the Valuing People Now strategy.

ADAS, ADCS, Children's Society

- Working together to support young carers and their families (2012)

HM Government

- Disabled Students' Allowances (DSAs) (2014)
- Staying put: arrangements for care leavers aged 18 years and above (2013)

Within this Protocol the following terms are used

Term	Definition
Adult Carer	An adult carer of a young person preparing for adulthood, this is equivalent to the term "child's carer" in the Care Act 2014
Education, Health and Care (EHC) Plan -	An Education, Health and Care (EHC) plan is for children and young people aged up to 25 who need more support than is available through special educational needs support. EHC plans identify educational, health and social needs and set out the additional support to meet those needs.
Learners with Learning Difficulties and/or Disabilities(LLDD)	Learning difficulties is the term used in legislation while 'learners with learning difficulties and/or disabilities' is a deliberately wide definition in common usage in the Further Education system, and includes people with mental health difficulties, autistic spectrum conditions, dyslexia, attention deficit hyperactivity disorder, physical, sensory and cognitive impairments and other identified and non-identified difficulties in learning which may (may not) have led to special educational needs **interventions at school.**
Special Educational Needs (SEN)	A child or young person has special educational needs (SEN) if he or she has learning difficulties or disabilities that make it harder for him or her to learn than most other children and young people of about the same age.
Transition	The process of moving into adulthood, typically, (but not always), moving from eligibility under the Children Act 1989 to eligibility under the Care Act. Transition is seen as beginning at age 14
Young Carer.	A young carer under 18 themselves preparing for adulthood
Young Person	People under 18 with care and support needs who are approaching transition, rather than the legal term "child" contained in the Care Act itself.
Young person/Young People	This is the general term used in this protocol for young people and young carers. It also implicitly includes their carers. Where something does not apply to all three groups, the specific groups to whom it does apply are specified using the terms above

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Appendix 3- Transition Pathway