

Preparing for Adulthood Transition from Children to Adult Services Operational Policy

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1.0 Introduction

1.1 Preparing for Adulthood involves lifestyle and legal changes for all young people. It can be more challenging for young people with Special Educational Needs and Disabilities (SEND) and more particularly for those who have complex ongoing health needs and/or life-limiting conditions. Young people with SEND may need to navigate several public services and systems as they move into a settled adult life. Children and Adult services are often very different, and it can be a stressful time for young people and their families as they navigate these changes. It is our collective responsibility to ensure that our system is developed in a supportive way to reduce challenges faced and improve outcomes.

1.2 A key aim of transition is to ensure that all partners work together to meet clear and identified outcomes with the young person and their family. The nature of care and support that is available to a young person and their family may change because the young person's needs or circumstances change. It is also possible that due to regulatory arrangements surrounding child and adult services, that care providers may need to change. Wherever possible, we must seek to secure consistency and personalisation as changes to their care and support arrangements are designed and delivered. Where change is necessary, it should be carried out in a planned manner, in full consultation with the young person and family. No services or funding should be unilaterally withdrawn unless a full joint health and social care assessment has been carried out and alternative funding arrangements have been put in place.

1.3 Purpose

1.3.1 The purpose of this policy is to:

- (a) Ensure relevant professionals within the ICS are supporting young people and their families through the preparing for adulthood journey, enabling young people and their families to have a good experience of their transition from children services to adult services.
- (b) Ensure there is appropriate early planning and intervention for young people.
- (c) Set out how CYPCC and CHC teams should work together, alongside the ICB, as well as partners in Social Care and Education, to facilitate the transition to CHC, joint funded care, social care, and/or universal services and specialist services.
- (d) Set out expectation of the process and timescales which will be followed during the transition between services.

1.4 Scope

1.4.1 This policy applies to:

- (a) All relevant ICS staff members



- (b) All professionals within All Age Continuing Care, HWE ICB
- (c) All professionals within 0-25 Together Team, HCC
- (d) All professionals within SEND Team, HCC
- (e) All young people aged between 14-18 years who are registered with a Hertfordshire General Practitioner (GP) or registered with HWEICB GP at the point of becoming a 'looked after child' and are in receipt of a CYPCC package of care.

1.5 Definitions

The following definitions apply in the context of this policy:

Term	Definition
HWE ICS	Hertfordshire and West Essex Integrated Care System
HWE ICB	Hertfordshire and West Essex Integrated Care Board
HCC	Hertfordshire County Council
LA	Local Authority
AACC	All Age Continuing Care
CHC	Continuing Healthcare
CYPCC	Children and Young People Continuing Care
SEND	Special Educational Needs
EHCCo	Education Health and Care Coordinator
DST	Decision Support Tool
ENF	Early Notification Form

2.0 Roles & Responsibilities

2.1 The following definitions apply in the context of this policy:

Role	Responsibilities
All staff within HWE ICS	All staff to be fully aware of the relevant pathway and policy for transition within the Hertfordshire and West Essex Integrated Care System (ICS) and work together to achieve a high-quality and safe transfer of responsibilities.
CYPCC Nurses	Support young people in their preparing for adulthood journey by following processes and procedures as set out in this policy and working in collaboration with relevant stakeholders and families.
Social Workers / Family Practitioners (0-25 Together Team)	Support young people in their preparing for adulthood journey by following processes and procedures as set out in this policy and working in collaboration with relevant stakeholders and families.
CHC Nurse Assessors	Support young people in their preparing for adulthood journey by following processes and procedures as set out in this



	policy and working in collaboration with relevant stakeholders and families.
EHCCo	Support young people in their preparing for adulthood journey by following processes and procedures as set out in this policy and working in collaboration with relevant stakeholders and families.
AACC	The AACC will ensure that it learns from the experience of families, staff and providers using a co-design, co-production approach to service development. Feedback/monitoring will be designed with the focus on improving individuals' experience of transition.
Named Worker	A young person's designated transition coordinator, responsible for the coordination of transition from children to adult health services and for inviting relevant stakeholders to appropriate meetings and/or reviews.

2.2 Implementation

2.2.1 This policy will be made available via the HWE ICB and ICS intranet.

2.2.2 Training will be provided jointly / in rotation by relevant professionals within the ICS to relevant professionals / stakeholders within Hertfordshire.

2.3 Monitoring

2.3.1 This policy will be reviewed on an annual basis.

2.3.2 Compliance to timescales as set out on this policy can be monitored through the Preparing For Adulthood (PFA) Monitoring List. This will also include costs of the young person's package of care to allow the ICB to forecast potential cost to the CHC budget.

2.3.3 AACC will adopt Key Performance Indicators (KPIs) for CYPCC transition:

- Evidence in the case management record of notification to CHC at 14 years of age for whom it is likely that adult NHS Continuing Healthcare will be necessary.
- Evidence of discussions around transition needs, linked to Year 9 Transition Planning and as part of the Education, Health and Care Planning (EHCP).
- Evidence of formal referral for screening for CHC at 16 years of age.
- At 16-17 years of age, there is agreement in principle at the CYPCC annual review that there is evidence of a primary health need for CHC.

2.4 Key documents and legislation

2.4.1 National Framework for Children and Young People's Continuing Care – January 2016.



2.4.2 National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care – July 2022 (Revised)

2.4.3 “Transition from children’s to adults’ services for young people using health or social care services” – NICE Guideline (2016)

3.0 Policy for Transition Pathway

3.1.1 The planning for transition will start as early as when the young person turns 14 years old. All relevant assessments will be complete as soon as the young person turns 17 and there will be thorough transition planning during the 12 months before the young person turns 18. This will ensure that, on the transfer date, the family are well prepared for any changes and have a good understanding of adult CHC services. It will also ensure that all the necessary support is in place when the young person turns 18, including the care package, supplies, equipment, and training for staff. Preparing for adulthood process map outlines the stages (Appendix 1).

3.1.2 The Transition Pathway is summarised as below:

- **Age 14:** the young person should start their Transition Support Plan, with their CYPCC nurse. They should be brought to the attention of the ICB as likely to need an assessment for CHC by completing an Early Notification Form (ENF). A Transition Co-ordinator should be identified.
- **Age 15:** the Transition Support Plan and the ENF should be updated.
- **Age 16:** the Transition Support Plan needs updating. A referral to CHC should be undertaken using the CHC checklist, and an agreement in principle that the young person has a primary health need and is therefore likely to need CHC; or identification they are likely to be solely social care funded, joint funded and/or need universal/specialist services. CHC begins to become more involved and could attend the annual assessment.
- **Age 17:** the Transition Support Plan needs updating, a joint assessment completed and a CHC DST completed. Agreement for on-going care package should be made. Transition of teams and care package should begin.
- **Age 18:** full transfer to CHC and/or social care and/or universal and specialist health services should have been made, except in instances where this is not appropriate.
- **Age 18+:** follow up and CHC review meeting three months after the transfer of care.

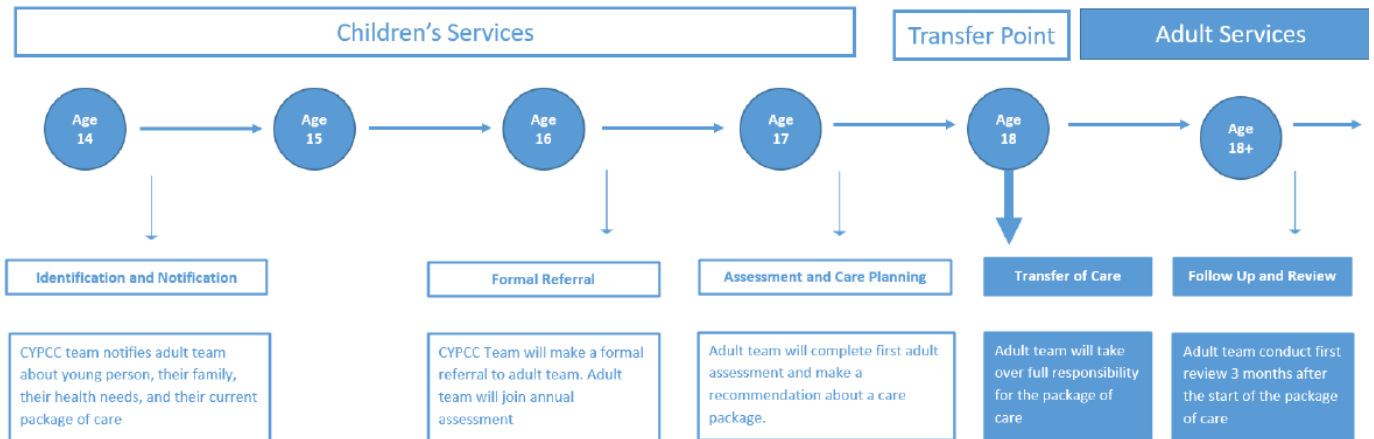
3.1.3 There are five ‘Touchpoints’ in the Transition Pathway:

- Touchpoint 1: Age 14 – Identification and Notification
- Touchpoint 2: Age 16 – Formal Referral



- Touchpoint 3: Age 17 – Assessment and Planning
- Touchpoint 4: Age 18 – Transfer of Care
- Touchpoint 5: Age 18+ – Follow up and Review

3.1.4 Each Touchpoint can be seen against the Transition Pathway as below:



3.2 Touchpoint 1: Age 14 and 15 – Identification and Notification

- 3.2.1 Every young person with a package of Children and Young People's Continuing Care approaching adulthood should have the opportunity to complete a Transition Support Plan (Appendix 2). The Support Plan is designed to be used by the young person and their family alongside their CYPCC Nurse as they prepare for adulthood and is intended to be built upon year on year.
- 3.2.2 The support plan asks the young person to consider what is currently working well for them, what they think they want to keep the same as they move towards adulthood, and what they want to change. If the young person is CYPCC eligible, the CYPCC Team should factor in the transition support planning alongside the annual Children and Young People's Continuing Care assessment.
- 3.2.3 It is important that during the period from when the young person turns 14, the differences between the CYPCC National Framework and the NHS CHC National Framework are explained to the young person and their family. The CYPCC nurse will initiate these discussions for those who are CYPCC eligible.
- 3.2.4 A young person moving through to adulthood will need to be prepared through a multi-agency approach irrespective of need which includes physical disabilities, behavioural and/ or mental health needs. As per the NICE Guideline "*Transition from children's to adults' services for young people using health or social care services*", a single practitioner would act as a 'named worker' to coordinate the transition of care and support. For CYPCC eligible young people, this would be their CYPCC Nurse; for others, the most appropriate professional within the ICS will be identified as a 'Named Worker'.

- 3.2.5 The Named Worker will bring the young person to the attention of CHC using the Early Notification Form (ENF) (Appendix 3) and notify all relevant stakeholders within Health, Social Care and Education. If the young person is CYPCC eligible, the most recent DST and review documents will also be shared with CHC.
- 3.2.6 HCT Transition Nurse will only notify Adults CHC if a child is late for transition. At the age of 17 they will complete the adults check list and if positive they will submit this for urgent DST for consideration for Adults CHC funding. Throughout the process from 14 yrs to 18yr the transition nurse may be involved in the MDT where a DST is being considered for Adults CHC eligibility.
- 3.2.7 The young person will be added to the Preparing for Adulthood (PFA) Monitoring List including the date the ENF was submitted.
- 3.2.8 At age 15, the young person and their family should be given the opportunity to review and update the Transition Support Plan, including any significant health changes over the past year and will allow them to ask any questions or concerns they may have. The ENF should also be updated to include any recent changes to the young person's care needs.
- 3.2.9 For CYPCC eligible young people, their CYPCC Nurse should send copies of most recent assessment / review to CHC at this Touchpoint.
- 3.2.10 By this stage, there should be a much clearer indication about which funding stream the young person will follow, and the professionals involved in their care in adulthood.

3.3 **Touchpoint 2: Age 16 – Formal Referral**

- 3.3.1 As in previous years, the Transition Support Plan should be reviewed and updated with the young person and their family. Their health needs should be updated, and they should be encouraged to raise any questions or concerns.
- 3.3.2 At this stage of the transition process the Support Plan begins to prompt the young person to consider more in-depth issues such as
- Mental Capacity and Liberty Protection Safeguards,
 - Consent,
 - financial arrangement for the future,
 - Their daily management as is appropriate based on the young person's developmental needs (e.g. ordering and collecting medications, equipment, and supplies)
- 3.3.3 The focus for professionals during this Touchpoint relates to a formal referral to the adult team by undertaking an initial screening for CHC at a suitable point after the young person's 16th birthday.
- 3.3.4 The Named Worker (or CYPCC Nurse if appropriate) will formally refer the young person to CHC using the checklist. The Preparing for Adulthood Monitoring List should be updated to record the date the checklist was submitted.



- 3.3.5 The Named Worker / CYPCC Nurse should ensure they have sought the appropriate consent for sharing information with third parties e.g. family / friends / advocates before submitting the CHC Checklist for screening. This will include an assessment of the young person's capacity under the Mental Capacity Act. All nurses working with young people should have the appropriate training to carry out assessments to assess mental capacity.
- 3.3.6 The formal screening should identify whether the young person may potentially be:
- Fully NHS CHC funded
 - Jointed funded between NHS CHC and Local Authority
 - Fully LA funded
 - Not eligible for NHS CHC (universal / specialist / targeted services only)
- 3.3.7 There is no 'expiry' time on received checklists, but CYPCC Nurse should ensure that checklists are updated with any significant changes to the young person's health need.
- 3.3.8 The timeframe for 28 days between checklist and DST does not apply to those under the age of 18 and assessments need to be carried out only in a timely fashion to support the commissioning of on-going care whether CHC eligible or not.
- 3.3.9 The CYPCC and CHC teams will start working more closely together from this point. A representative from CHC team will be invited to join the CYPCC Nurse at the young person's annual assessment. The young person's named Social Worker (or an appropriate representative from the 0-25 Together Team) should also join this assessment to ensure assessment process is holistic and multi-agency.
- 3.3.10 At the end of this Touchpoint, young people and their families will again be encouraged to feedback on the mid-point their transition journey, to highlight what they think is progressing well, any changes and improvements they would like to see in the next touchpoint, and to get a sense of their understanding regarding transition.

3.4 **Touchpoint 3: Age 17 – Assessment and Care Planning**

- 3.4.1 By this Touchpoint, the Transition Support Plan has a greater focus on the young person's legal status as an adult and providers question prompts and things to consider as these changes approach. The young person should begin to consider what their package of care in adulthood may look like.
- 3.4.2 Joint assessment (full assessment using CHC National Framework DST) with CHC taking the lead should take place around the young person's 17th birthday. This should include all relevant professionals from children's and adult's teams, to gather all necessary information regarding the young person's needs.



- 3.4.3 If the young person is eligible for CHC funding, it is the CHC team's responsibility to determine the appropriate level of funding and equipment needs as identified in the assessment. Any package of care that is identified by means of the CHC assessment process before a young person reaches adulthood will come into effect on their 18th birthday, subject to any change in their needs and any existing tripartite funding arrangements agreed at Multi-Agency Panel (MAP) would usually be funded between CHC and Education.
- 3.4.4 Once the DST has been ratified and the package of care agreed, the CHC team will work with the young person and their family in developing their care plan which will be in place on their 18th birthday. The CYPCC Nurse should contribute to the development of the care plans to ensure all clinical needs are met.
- 3.4.5 During this Touchpoint, the CYPCC team will refer the young person to the District Nursing service and provide a list of equipment / medical consumables which the young person requires, copying the CHC team. At this stage, if the young person is eligible, the CHC team will begin to organise the changeover of equipment and work with the family to establish a routine for ordering disposable equipment.
- 3.4.6 Where a young person is not in receipt of a CYPCC package of care, and it is believed that they may be eligible for CHC, the young person's lead health professional or social worker will be signposted to the CHC Team. All referrals will go directly to the CHC Team from 17 years. To ensure that the legal responsibilities for child and adult services are discharged appropriately, transition plans will set out clearly who is responsible and why.

3.5 **Touchpoint 4: Age 18 – Transfer of Care**

- 3.5.1 One month before the young person's 18th birthday, the CHC team should be ready to introduce their care package. A full handover meeting involving the young person, their family, the CYPCC team and CHC team should take place to ensure there are no outstanding actions remaining in the transition plan.
- 3.5.2 Transfer of care happens on the young person's 18th birthday.
- 3.5.3 After transfer of care has been completed, young people and their families will again be encouraged to feedback on their transition journey, to highlight what they think is went well, any changes and improvements they would recommend regarding transition.

3.6 **Touchpoint 5: Age 18+ - Follow up and Review**

- 3.6.1 Three months after the transfer of care, the care package will be reviewed for appropriateness by the CHC team. The CYPCC Nurse known to the young person and their family should attend the review meeting to provide any relevant clinical support and advice.
- 3.6.2 After this follow up meeting the CYPCC team will inform relevant stakeholders of successful transition to CHC, and the young person has been discharged from the CYPCC caseload.



- 3.6.3 If the care package is no longer meeting the needs of the young person or if the young person's needs appear to have reduced – then their eligibility may be reviewed, and a full assessment may be undertaken.

4 My Healthcare Passport

- 4.1 A young person should be encouraged and supported in utilising and filling out the “My Healthcare Passport” document (Appendix 4). It contains important health information about them, which can be used by health professionals to make sure that they access effective support. It will also help prepare them for the transition into adulthood.
- 4.2 Hertfordshire County Council 0-25 Together Team has a Preparing for a Healthy Adulthood Guide (Appendix 5) to help parents, carers and professionals prepare a young person for the transition into adulthood and adult services. All information and further videos are available on the [SEND Local Offer](#). For adults over 18 years with a learning disability, Hertfordshire County Council Adult Disability Service has developed the Purple Folder to help record and share health information. Further information about My Purple Folder can be found on [Hertfordshire County Council Adult social services Learning Disabilities](#).

5 Non eligible

- 5.1 If during any Touchpoints a young person is determined by CHC team not to be eligible for a package of care, then they and their family should be advised of their non-eligibility and of their right to appeal following the local complaints policy process (Appendix 6).
- 5.2 The CYPCC team should continue to participate in the transition process, to ensure an appropriate transfer of responsibilities, including supporting social care with the transition and/or referring to universal services for ongoing support.

6 Delays

- 6.1 Should there be any unforeseen delays in the CHC team introducing a new package, the CYPCC and adults' teams will work together to ensure the care for the young person is not disrupted. This may include the children's team continuing to fund the package of care after the young person's 18th birthday for a short period of time until the adult's care funding is in place.

7 Education

- 7.1 The Children and Families Act (2014) requires a young person accessing education to have an Education, Health and Care Plan up until the age of 25 years where they have continuing learning needs and outcomes requiring more support than is available through special educational needs support.
- 7.2 This requires partner agencies to acknowledge their continued responsibility for the extended transition period and require funding streams to continue.



- 7.3 Where a young person has an EHCP for special educational needs in addition to a Continuing Care plan, this may continue up to age 25; the transitional period will provide an opportunity for aligning a review of that EHCP, and the assessment for CHC.

8 Section 117

- 8.1 Young people who have previously been detained in hospital for treatment under Section 3 (s3) of the Mental Health Act are entitled to aftercare under Section 117 (s117) of the Mental Health Act. This is a requirement on Integrated Care Boards (ICBs) and Local Authorities (LA) to provide or arrange for the provision. The commissioning of mental health aftercare services is a statutory joint responsibility between LAs and ICBs.
- 8.2 If a young person is in receipt of s117 aftercare services and those services are appropriately meeting the needs of the young person, then a CHC assessment is not required. Transition from Child and Adolescent Mental Health Services (CAMHS) to Adult Mental Health Services is led by a Social Worker completing a Care Act assessment.
- 8.3 If a young person has care needs that are outside the responsibilities of s117 i.e., a care need resulting from a physical condition rather than mental health diagnosis and as such is in receipt of a Continuing Care package of support, then a CHC assessment may be required, and the same transition pathway should be followed.
- 8.4 If a young person is eligible for CHC or Funded Nursing Care (FNC) due to physical needs, the provision of s117 aftercare needs should be considered in partnership with the relevant mental health teams. This should result in a joint funded care provision to ensure all care needs are met.

9 Out of Area Placement

- 9.1 Where a young person receives support via a placement outside the ICB's boundaries, it is important that, at an early stage in the transition planning process, there is clear agreement between NHS Commissioners as to who the responsible commissioner presently is, and whether this could potentially change in accordance with NHS England's 'who Pays? Determining responsibility for NHS payments to providers' (2020).
- 9.2 All parties with current or future responsibilities should be actively represented in the transition planning process. A dispute or lack of clarity over commissioner responsibilities must not result in a lack of provision or risk an individual's placement. Due consideration must be given by the ICB and LA where a child is 'looked after' by the LA, to ensure appropriate placement and funding responsibilities.
- 9.3 Guidance and information regarding the management of disputes can be sought from the Interagency Dispute Resolution policy (Appendix 7).

