Transition Process & Policy

May 2026

To ensure Young People and their families in Salford have a smooth, timely and supported transition into adult life, by working together, setting out clear plans created in a person-centred approach, enabling them to make a difference in their world and to reach their full potential.

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1. What does this policy aim to do

The **Salford Multi-Agency Transition Policy and Process** outlines the expected journey of young people as they transition into adult services. It establishes the collaborative approach required between **Salford Integrated Care Organisation, Salford SEND, Children's Social Care, Health, CAMHS, GMMH, and the ICB Locality** to ensure a seamless transition.

This policy brings together national, regional, and local strategies and procedures to ensure compliance with statutory duties across both children's and adult legislation. By doing so, Salford aims to uphold best practices and deliver high-quality support for young people.

The primary goal of this policy is to offer guidance, support and outline processes to professionals and services to ultimately enhance the quality of experiences and opportunities for young people moving into adulthood.

Young people encounter multiple transitions throughout life, from early years to childhood and eventually adult life. These transitions involve psychological, social, and educational changes influenced by their **environment, family, relationships, and support systems**.

Some young people will follow a **single, service-to-service transition pathway**, where their needs can be met through a straightforward progression from one support service to its adult equivalent. These transitions are typically linear and involve minimal service coordination.

However, other young people, particularly those with more **complex needs**, will transition across **multiple pathways**. This may include involvement with several agencies such as health, education, social care, and housing, requiring a multi-agency response. For these individuals, transition planning must be more robust, coordinated, and personalised, ensuring that all aspects of their care and support are addressed in a timely and seamless manner.

Salford recognises that transitions from childhood to adulthood is a vital transition that is integral to young people's life chances.

2. Salford's Approach to Transitions

Salford's Transitions Policy acknowledges that young people can find transition challenging and want to ensure that the transition young people experience in Salford is positive.
In accordance with NICE Guidelines, the transition process will be based on the following principles:

Planning Early: Transition planning should begin at age 14, ensuring there's sufficient time to discuss future needs, preferences, and services available.

Person-Centred and Family Involvement: Transition should be driven by the needs and aspirations of the individual, involving young people their families and carers in planning and decision-making.

Transition is everyone's responsibility: Planning and support is every professional's responsibility and children's and adult's services will work closely to ensure a smooth and effective transition.

Holistic Assessments: A holistic approach to transition, ensuring that health, social care, education, and emotional needs are all considered and co-ordinated through existing multi-agency meetings to ensure effective communication

Continuity of Care: Aiming to ensure there is minimal interruption in services or care as the young person moves from children's to adult services, or where changes are likely due to legislative or policy reasons this is fully explained to the young person and family in advance.

Preparing for Adulthood Framework: The principles of Preparing for Adulthood will be integrated into all transition pathways.

Flexibility in Transition Planning: Transition planning should remain flexible to accommodate a young person's needs and circumstances where possible.

3. Alignment with Salford's Vision

Salford's Transition Policy aligns with the city's 0-25 Partnership vision, which aspires for "all children and young people to achieve their full potential."

We also recognise that support for staff is key to this vision and we want to help and support professionals give young people the right support and services needed to reach their individual goals.

Recognising the significance of transitions, this policy is a key component in several local strategies, including:

- Salford Thrive Plan | Partners in Salford
- Salford City Council - SEND Strategy 2024 to 2027
- Care Leaver Strategy 2023-26 Salford City Council

3.1 Thrive in Salford

Salford is committed to a strengths-based approach, incorporating the principles of trauma-informed care. While specific models may vary across teams, the THRIVE model has been adopted across Salford.

Thrive in Salford

4. Where will this policy be used

This policy aims to support professionals with collaborative working across all agencies involved in helping young people transition to adult life in Salford. We recognise that this transition can be complex, especially for those with additional needs, therefore, there is information on the Local Offer Website for Salford under Preparing for Adult Life and Transitions. (link here)

This policy has a broad scope and relies on collaboration across multiple agencies.

4.1 Core Agencies Involved in Transition:

- **Adult Social Care** (Community Mental Health Teams, Integrated Care Teams, Learning Disability Teams, Transition Support Team, Sensory Team)
- **Children's Social Care** (Children with Disabilities Team, Cared for, Child in Need Team, Early Help, Next Steps Leaving Care Service)
- **Children's and Adult Safeguarding Teams**
- **SEND Team**
- **CAMHS**
- **Children's Health** (Allied Health, Nursing)
- **Continuing Health Care**
- **Adult Health Teams** (District Nurses, Allied Health Professionals, Mental Health)
- **Children's and Adults Commissioning**

To support the transition experience for young people and their families, agencies should collaborate with partners in the following sectors:

4.2 Key Partner Agencies:

- **Education** (Schools, Colleges, Careers, specialist settings and alternative provision)
- **Housing**
- **Community and Voluntary Organisations**
- **Youth Services**
- **Procurement and Market Management**
- **Specialist Support Providers**
- **Health Organisations**
- **Greater Manchester Police**
- **Children's Safeguarding Board**
- **Adult Safeguarding Board**
- **Primary Mental Health Services**

These organisations should be actively involved in both operational implementation and strategic planning to ensure a continuous development and effectiveness of the transition process.

5. Who does this policy cover

This policy covers certain cohorts of young people young people up to their 25th birthday. The policy is specifically about directing services and professionals on how they are expected to work together to ensure a positive experience for young people and their families and should be used in conjunction with the preparing for adulthood strategy.

It includes those with disabilities, special educational needs and disabilities (SEND), mental health conditions, and those in care. Specifically, this policy covers:

1. Young people with an **Education, Health, and Care Plan (EHCP).**
2. Those **without an EHCP** but who require support in planning for adulthood, including individuals with high-functioning autism, social, emotional, and mental health needs, or long-term health conditions.
3. Young people likely to meet the eligibility criteria for adult social care under the **Care Act 2014.**
4. Individuals receiving services under **Section 17 of the Children Act 1989 due to disability.**
5. Young people supported under **The Chronically Sick & Disabled Persons Act 1970.**
6. Those supported under **Section 20 and Section 31 of the Children Act 1989** who have a disability or impairment and are likely to require accommodation and support post-18.
7. Individuals with **Continuing Healthcare (CHC)** needs.
8. **Young people with complex needs,** including learning disabilities, physical disabilities, mental health difficulties, ADHD, ASD, or chronic medical conditions.
9. **Cared for and formerly Cared for young adults** with impairments or disabilities, who are likely to have eligible needs under the Care Act 2014 or be at risk of vulnerability (as per the Salford Vulnerable Adult Policy).
10. **Carers** of young people preparing for adulthood and young carers transitioning to adult services**.**
11. Young people supported under the **Mental Health Act 1983.**
12. Those who have experienced significant trauma that is likely to impact their ability to function in adulthood**.**

6. Legislative Context

The policy stipulates how Salford intends to meet the statutory and best practice requirement for young people transitioning to adult life.

Legislation ensures that young people, especially those with additional needs or disabilities, **have a right to support, care, and education** as they transition into adult life. This legislation underpins the work completed by all agencies across Salford and gives a strong foundation for this policy.

6.1 Legislation

- **Children and Families Act 2014 (Part 3 - SEND reforms)**: Supports young people (14-25) with special educational needs and disabilities (SEND).
- **Care Act 2014 (Part 1 - Sections 58-66)**: Focuses on **prevention and wellbeing** for those needing adult care, covering both individuals and carers.

6.2 Transition assessments under the Care Act 2014

Salford recognises that the Care Act 2014 applies differently to individuals under the age of 18 and those aged 18 and over. Children under 18 are not subject to adult Care Act eligibility criteria, and therefore the threshold for assessment differs.

In line with Section 58 of the Care Act 2014, Salford Adult Social Care will undertake a Care Act assessment in their 17th year if it appears that the child are likely to have care and support needs after the age of 18 and where it is considered to be of significant benefit to the individual. In Salford, our aspiration is to have completed this and made a decision of care act eligibility by 17 years and 6 months in order for adequate time to plan for transition into adult life regardless of the outcome of the assessment to enable positive outcomes for that young person.

Once a young person reaches the age of 18, adult Care Act duties apply and responsibility for providing eligible care and support as identified via the care act assessment and within the care and support plan will become the responsibility of Adult Social Care.

6.3 The Mental Capacity Act 2005

The Mental Capacity Act (MCA) 2005 applies to young people from the age of 16. It operates on the fundamental principle that everyone has the capacity to make decisions unless proven otherwise. Young people should be supported in maximising their capacity to make informed choices about their lives. If a young person lacks capacity, decisions must be made in their best interests, taking into account what they would likely choose, even if their exact wishes cannot always be followed. Importantly, making an unwise decision does not equate to lacking capacity. Supporting young people in understanding their rights and responsibilities is crucial in fostering their decision-making skills.

6.4 Salford transition principles

This legislation is the foundation for Salford transition principles:

Key Legislation & national guidance considered:

- The Children's Act 1989
- The Mental Health Act 1983
- The Mental Capacity Act 2005
- The Leaving Care Act 2000
- The Human Rights Act 1998
- The Health and Social Care Act 2012
- The Equality Act 2010

Key strategies & guidance

- SEND Code of practice 0 – 25
- Salford SEND Strategy
- Preparing for Adult Life Policy
- Building Independence through planning for transition: a quick guide for practitioners supporting young people (NICE guidance)
- Transition from Children's to Adult Services for young people using health or social care services. (NICE Guideline 43)

- Strengths based social work practice framework
- Transforming care
- Preparing for Adult life

Salford acknowledges that young people with additional needs will require different levels of support depending on:

- Abilities/ difficulties
- Natural support
- Personal circumstance

This has led Salford to develop an overarching **Preparing for Adult Life policy** which is based on enabling young people to develop the skills and independence required for adult life.

7. Preparing for Adult Life

Preparation for Adult Life (PfA) Preparation for Adult Life Policy is entwined with the Transition process. It is the processes and practices aimed at helping CYP with SEND transition smoothly from childhood into adult life. The goal is to ensure that they are equipped with the skills, knowledge and confidence to lead fulfilling, independent lives; like our Transitions Policy.

We have included the Pillars here as PfA is closely linked to Transitions, however, PfA covers all age ranges up to 25; Transitions covers the time we begin preparing young people for Transition to Adult Services.

Independent Living. Young people have choice, control and freedom over their lives and the support they have, their accommodation and living arrangements, including supported living. Helping young people to get the skills to live as independently as they want to.

Being as healthy as possible. Including positive physical and mental health and emotional wellbeing. Information tools and support which allows young people to keep themselves healthy, manage their health conditions where possible and know how to ask for help from professionals when needed.

Participating in society. Having friends and supportive relationships, participating in, and contributing to, the local community. Being included in activities that other young people can go to, in places that feel safe and easy to get to. Involving young people in planning and reviewing leisure services and activities.

Further education and/or employment. Supporting young people to get the qualifications, skills and experience that they need so that they can achieve their goals which might include moving onto further or higher education, volunteering, or getting a job. Helping employers and those that support us to understand how they can support young people in reaching their goals.

8. Pathways

There are seven distinct transition pathways in Salford that young people may follow as they move into adult life. While many young people will transition through just one of these pathways, others may experience multiple transitions across different areas of their lives.

For those navigating more than one pathway, the journey can be more complex and may require additional support. In these cases, the role of professionals is especially important. By working collaboratively and maintaining a person-centred approach, professionals can help ensure that transitions are well-coordinated, reducing stress and promoting better outcomes for young people.

Pathway 1 – Salford Generic Transition to Adult Social Care:

The Transition Team – Adult Social Care

There should be one access point for all young people into ASC. ASC are implementing a new practice model which follows a 3 step approach of step 1: advice and info step2: short term support up to 6 weeks (from age 16) and step 3: care act assessment which determines eligibility for ASC by 17 years and 6 months

The Transition Team, part of Adult Social Care, manages the move from Children's to Adults' services for young people, ensuring smooth transitions and appropriate support under the Care Act 2014.

Referral Criteria and Involvement

Referrals are accepted for young people aged 14 to 25 in specific circumstances. These include those referred by Children's Services or those with an Education, Health and Care Plan (EHCP) requiring a Care Act assessment. The team may also become involved if a young person previously had significant involvement with Children's Services, is not in education but had an EHCP, or is the subject of a safeguarding referral.

Referral Sources and Process

Referrals can come from the young person themselves, their family or carers, or professionals working in health, education, housing, and voluntary sectors. Referrals go through the Adult Social Care Contact Team or the Salford Adults Portal. Professionals must complete a Transition Team Referral Form.

Initial Screening and Monitoring

At referral, if additional information is needed, the young person may be discussed at the Transition Hub. Young people with complex needs should be identified to the Transition Team from age 14. They are added to the Transition Tracker, and a decision is made about the level of ongoing support. For those with a learning disability, support begins with the Transition Team and is later transferred to the Learning Disabilities Team, usually by age 17.

Step 1: Advice and information 14-16 yrs

Step 2: short term support up to six weeks to prevent, reduce the need for specialist social care support 16-17 years

Step 3: care act assessment to be completed before 17 years and 6 month which determines eligibility for ASC

Assessment and Planning

Once allocated, the worker aims to complete an assessment before the young person reaches 17.5 years old. Early referrals help ensure there is time to plan adequately. Children's Services remain responsible until the young person turns 18, or longer if necessary (for example education for children with SEND).

Following assessment, if Care Act eligibility is determined, the Transition Team creates a care and support plan which may or may not be funded from adult social care if care act outcomes can be met within community resources. Once the young person has a clear plan, their support will be handed over to the adult social care who is most relevant.

Additional Functions of the Transition Team

The team also supports Preparing for Adult Life planning sessions, attends key meetings (such as EHCP reviews and care planning) where appropriate, undertakes safeguarding enquiries, carries out Mental Capacity Act assessments, applies to the Court of Protection, and determines ordinary residence.

The Transition Hub

Held every four weeks, the Transition Hub is a multi-agency forum chaired by the Transition Team. It helps plan for young people aged 16 to 25 and includes representatives from Adult Social Care, CAMHS, AMHS, health, education, and Children's Services. The Hub encourages coordinated planning, updates tracking systems, and ensures decisions are recorded and shared with relevant services.

The Transition Tracker

The Transition Tracker helps monitor progress through the transition process. It keeps track of workflows, supports coordination, and generates reports when needed. It is updated regularly after screenings, referrals, and once the team's involvement ends.

Referral to the Transition Team (Adult Social Care):

- **Referral Form:** Complete the **Transition Team Referral Form** via the Salford Adults Portal: Salford Adults Portal
- **Phone:** 0161 206 0604 (Adult Social Care Contact Team)

Pathway 2 – Young People Leaving Care (Next Steps Team):

Pathway 2 is closely linked with Pathway 1, and there is joint working across both. Young people involved in both pathways are co-worked by professionals from each pathway to ensure coordinated support.

Salford response and approach to supporting people who are cared for and have additional needs as set out in the Care Act 2014, Leaving Care Act 2000 & The Children Act 1989 guidance and regulations: Volume 3: Planning transition to adulthood for care leavers (2010).

Commitment to Community Parenting

Salford aims to offer the same level of care and opportunity to our cared for children and care leavers as any parent would provide. This includes high-quality placements, education, healthcare, and age-appropriate support for developing independence.

Next Steps service support young people aged 16–25 who are eligible for leaving care services with a dedicated worker (a qualified social worker for those under 18). The service supports young people by helping them into further education, employment or training and securing suitable accommodation. Where necessary, they work with adult social care and health services to provide additional support, particularly for care leavers with learning difficulties or mental health needs.

Objectives

- Uphold the Care Leaver Charter.
- Support each young person's education, training, and employment.
- Promote healthy physical and emotional lifestyles.
- Help secure and sustain suitable accommodation.
- Foster positive family and social relationships.
- Promote financial independence and money management.
- Provide an allocated worker for tailored support.

Community Parenting Responsibilities

Community parenting is a shared responsibility across the Council and partners. The Community Parenting Board:

- Reviews data on cared for children and care leavers.
- Considers updates on national and local policy.
- Engages directly with young people and listens to their views (including through the Fight For Change council).
- Monitors progress against the Care Leaver Pledge.
- Acts decisively to address service shortcomings.

Legal Framework

- **Children (Leaving Care) Act 2000**: Sets the duty to prepare young people for leaving care and provide aftercare support.
- **Children and Young Persons Act 2008 / Care Leavers' (England) Regulations 2010**: Require pathway planning, IRO reviews for transitions, and the provision of education bursaries.
- **Children and Social Work Act 2017**: Extends support to all care leavers up to age 25 and mandates publication of the local offer.

Definitions

- **Eligible Young Persons**: Aged 16–17, still in care, and looked after for at least 13 weeks since age 14.
- **Relevant Young Persons**: Aged 16–17, no longer in care but meet the same care history criteria.
- **Former Relevant Young Persons**: Aged 18–25, previously eligible/relevant. Services may continue until age 25 depending on need.

Pathway Planning & Transition

Planning for independence by the Next Steps team begins early and is integrated into the care planning process. A Pathway Plan, based on a detailed needs assessment by age 16, outlines the support needed and is reviewed regularly. It covers:

- Personal support and contact.
- Education, training, and employment plans.
- Accommodation and independent living skills.
- Health and mental health needs.
- Financial support and contingency arrangements.

The young person's views are central to the plan, which is shared with them. While under 18 and cared for, the pathway plan is reviewed by the Independent Reviewing Officer. If in non-regulated accommodation, reviews occur at 28 days, then at 3-month intervals, and every 6 months thereafter.

Relevant & Former Relevant Reviews

To ensure appropriate support continues, a Relevant and Former Relevant Review is offered to care leavers, chaired by a dedicated officer with access to the Pathway Plan. Care leavers are encouraged to attend and may chair their own review. These meetings focus on welfare, accommodation, community access, and progress. Reviews are arranged within 28 days of any placement move for relevant young people.

Pathway 3 – Mental Health Transition Pathway

Salford's Approach to Supporting Transitions from CAMHS to Adult Mental Health Services
A collaboration between GMMH, MFT, and Salford Care Organisation

Coordinated Transition Support

Every young person transitioning from CAMHS to Young Adult or Adult Mental Health Services (Y/AMHS) should have a named practitioner to coordinate support. Ideally, this is someone they already know and trust, such as a nurse, GP, youth worker, or education/social care professional.

The practitioner serves as a central point of contact, supporting service navigation, coordinating care, and linking the young person to relevant services – including community and peer-led support. They also help with GP engagement and provide guidance on independence, education, employment, housing, and wellbeing.

Families and carers should be involved as appropriate, and support for disabled young people should be tailored in collaboration with education services.

Core Principles of Transition

- Planning should start early, especially for young people placed out of area.
- Focus on developmental readiness, not just age.
- Support autonomy and prepare young people to manage their own care.
- Ensure they know what to expect and how to access support – even if they don't meet adult service criteria.

Managing the Transition Process

Each young person should have a personalised transition plan, co-produced and regularly reviewed. It may include:

- Key health/social care info
- Goals and aspirations
- Emergency plans
- Community and peer support options

Support should continue for at least six months before and after transfer. Handover should be clear and well-structured, especially when practitioners are from children's services.

The young person should be offered:

- A chance to meet adult service providers
- Peer support or mentoring

- Private opportunities to raise concerns
- GP involvement in planning

Service Responsibilities

CAMHS and adult services must provide:

- Clear, early information (at least three months prior)
- Introductions to adult teams
- Support with practical aspects like benefits and budgeting

Adult services should ensure:

- Continuity (e.g. same worker initially)
- Follow-up if the young person disengages
- Safeguarding and family involvement if needed

Transition Timeline

- Ages 16–17: Begin discussions; use tools like *Ready Steady Go*, *i-THRIVE*
- Age 17: Create and review the plan (e.g. *My CAMHS Moving On*)
- Age 17.5: Finalise the plan and complete handover, with ongoing support as needed

Pathway 4 – Transitional Safeguarding:

The key principles of a transitional safeguarding approach are that it is:

- **Evidence-informed**;
- **Contextual** - moving beyond a young person/adult and their family, and considering the wider systems, contexts and spaces in which a young person/adult experiences harm and safety issues; including sexual exploitation outside of the family, radicalisation, county lines and domestic abuse;
- **Developmental** - understanding the distinct developmental needs and strengths of this life stage and creating services and pathways that reflect the individualised nature of transition to adulthood. It encourages greater fluidity between children and adult safeguarding processes and requires an active effort to align systems to create a smoother more holistic offer for people being supported;
- **Relational** - being person-centred;
- **Participative**; and
- **That it attends to issues of equalities, diversity and inclusion**.

This pathway sets out how Salford will support young people aged 18 and over who are vulnerable but do not meet the threshold for adult services, and how we will identify and support those at risk of harm or abuse.

In Salford, the referral process for transitional safeguarding in supporting young people moving from children's to adult services is coordinated through two primary pathways, depending on the individual's age and specific needs.

Safeguarding Considerations and Earlier Intervention

It is recognised that safeguarding concerns often emerge before the age of 18, and waiting until age 17.5 to begin transition planning can be too late to prevent harm. From a safeguarding adults perspective; where prevention is a guiding principle, early identification of risk is essential. For example, in adult services, financial abuse frequently acts as a gateway to other types of harm. As such, early assessment of a young person's capacity to manage their finances and understanding what support they may need to stay safe is a key preventative measure. These plans can take time to establish, making early detection and planning crucial.

For Young People Under 18

Contact the Bridge Partnership:

- **Phone:** 0161 603 4500 (Monday to Friday, 8:30 AM – 4:30 PM)
- **Online Referral:** Children's Portalsafeguardingadults.salford.gov.uk+14Salford City Council+14Salford City Council+14safeguardingadults.salford.gov.uk+6Salford City Council+6Salford City Council+6

The Bridge Partnership is Salford's multi-agency hub for concerns regarding the welfare or safety of children. Referrals should be made via the online portal. In urgent situations outside of standard hours, contact the Emergency Duty Team at 0161 794 8888. Salford City Council+11Salford City Council+11Salford City Council+11safeguardingchildren.salford.gov.uk+9Salford Directory+9Salford City Council+9

For Young People Aged 14–25 with Complex Needs (refer back to Pathway 1) - Transitional Safeguarding

Pathway 5 – Transitioning from Children's Health Teams to Adult Health Teams

Pathway 5 outlines how all health professionals will assist young people in preparing for the move to adult health services.

Age 14: Preparing for Adult Life discussion

- All health professionals must include a **Preparing for Adult Life (PfA)** discussion as part of the annual review with the young person and their family. This should be guided by the four PfA outcomes:
    1. Employment
    2. Independent Living
    3. Community Inclusion
    4. Health
- The focus should be on supporting the young person to gradually **increase their involvement in managing their own health needs**, in line with their capacity and abilities.

Aged 16: Preparing for Adult Life Transition Planning Questionnaire

Health professionals must ensure a **Preparing for Adult Life Transition Planning Questionnaire** is completed to:

- Identify ongoing health or social care needs.
- Determine if support from adult services will be required.

- Young people and families should be **signposted to appropriate information, resources, and services** to support their transition.

Care Coordination

- If the young person's needs can be met by a **single service**, that service is responsible for:
    - Incorporating PfA and transition outcomes into the young person's **care plan**.
    - **Referring to the relevant adult service** before the planned Transfer of Care date, ensuring a smooth transition.
    - **Annual review of the care plan**.
- If the young person:
    - Has **needs across multiple services**, or
    - Is known to **more than one children's health service**, then they must be referred to the **Health Preparing for Adult Life (PfA) Monitoring Meeting** for coordinated transition planning.

Multi-Agency Engagement

- Relevant health representatives must attend **Year 9, Year 11, and Year 13 EHCP Annual Reviews** (or equivalent multi-agency transition planning meetings) to:
    - Contribute to PfA discussions.
    - Co-develop **joint outcomes** and plans.

Transfer of Care

- Each children's health service must:
    - Include PfA and transition outcomes in the care plan.
    - Refer to the appropriate **adult health service** (e.g., specialist service, district nursing, or GP) prior to the Transfer of Care.

    - Recognise that transfer timelines will vary depending on **individual service commissioning arrangements**.
- All services should aim for a **planned transition**, involving:
    - The young person and their family.
    - Wherever possible, an **introduction to the adult health team** before the transition takes place.

Health Preparing for Adult Life Monitoring Meeting

Purpose

Held quarterly, this meeting facilitates multi-disciplinary planning for young people with ongoing health needs transitioning to adulthood.

Responsibilities

- Children's Health Services should identify **all young people aged 14+** on their caseloads who are likely to require ongoing health support in adult life.
- These young people should be added to a **dedicated health transition database** (currently under development).
- If there is an ongoing social care need post-18 then a referral to the Transitions Team will be submitted via the Contact Centre (Pathway 1).
    - Understand and apply the appropriate **social care pathways and MDT decision-making routes**.
    - Ensure **health representation** at relevant MDT meetings.

Functions of the Meeting

- Multi-disciplinary team (MDT) decision-making for:
    - Allocating the young person to the appropriate transition pathway.
    - Ensuring completion of the **Health PfA Transition Planning Questionnaire**.
    - Supporting teams with knowledge of transition pathways.
    - **Monitoring progress** through transition pathways, including identifying those with high needs or at risk of poor outcomes.

Referral for NHS Continuing Healthcare (CHC)

A referral to NHS Greater Manchester (GM) for CHC assessment should be made when a young person has **significant health needs** that may indicate a **primary health need**.

This applies to young people who:

- Received Children and Young People's Continuing Care (CYPCC),
- Were supported via Children's Social Care,
- Were cared for by family but now need formal support to achieve independence.

Assessment Process in Salford

- **Registered Nurses** from the NHS Funded Care Team assess eligibility for both CYPCC and adult CHC.
- Young people eligible for CYPCC are assigned a **Case Manager** who:
    - Supports the transition to adult CHC,
    - Explains CHC criteria and assessment process,
    - Clarifies that CYPCC eligibility does **not guarantee** adult CHC eligibility.

Referral Pathways

- Young people **not** in CYPCC but who may need adult CHC should be referred to the **Adult Social Care Contact Team**.
- The timing of assessment is agreed between relevant professionals.

Transition Timeline

- **Age 14**: Refer to Adult Social Care Contact Team to flag potential CHC needs.
- **Age 16½**: Make a formal referral to agree roles and responsibilities.
- **Age 17**: Begin CHC screening using the **adult CHC Checklist**, with consent or best interest discussions.

Eligibility Decision

- If the young person "screens in," a **full multidisciplinary assessment** is carried out.
- NHS GM uses the **National Framework** to make eligibility decisions.
- Although the framework sets a 28-day decision target, this may take longer during transition.

Outcome and Appeals

- The outcome is provided **in writing** to the young person or their representative.
- If found **not eligible**, a **review** can be requested in line with the National Framework

  National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care - July 2022 (Revised) - corrected May 2023

Pathway 6 – EHCP Pathway

From Year 9 onwards EHCP annual reviews will incorporate Preparing for Adult Life (PfA) outcomes and forward planning. PfA outcomes can be considered at annual reviews for any age but must be included from Year 9 onwards. For each year thereafter the PfA outcomes should be reviewed.

- Young people and families should have opportunity to prepare for the review beforehand.
- All organisations involved with the young person should be invited to the review and given at least 2 week's notice.
- Attention should be paid to post 16 education and training and the steps that are required to ensure a smooth transition.
- All reviews should establish holistic SMART outcomes which are based on the four pillars of PfA – Independent Living, Good Health, Education and Employment and Friends, Relationships and Community.

Best Practise in Salford – Year by Year Guidance

All reviews from year 9 onwards

- There must be a focus on Preparing for Adult Life
- The discussions must centre on the young person
- The young person's aspirations and what they want to achieve must be explored
- Outcomes should be ambitious and show how they will enable young people to make progress towards their aspirations
- Young people should have the support they need to fully participate in this planning and decision making

Year 9

The review will primarily discuss how the young person is progressing in education but will also look at their health and care needs and make sure they have all the support they need. In the Year 9 review the young person and all involved will start to look at and discuss what support is needed to prepare for adulthood, particularly for each of the 4 PfA outcomes.

Post-16 education options will be talked about as well as discussions about possible Adult Health and Care involvement in the future. Discussions will also take place around longer-term areas such as independent living and transition from paediatric health services to adult health services.

Year 10

At the Year 10 review firmer plans around what will be needed when the young person turns 16 will be discussed. This will usually consider what specific support the young person needs for post-16 education.

Year 11

In the final review before a young person leaves school (or transitions to their school 6th form) the focus will be around the young person making applications for post 16 or employment/ training and specific details around the support needed to achieve this. If the young person is likely to need support from Adult Social Care, there will be someone in attendance who can discuss what support could look like from a Social Care perspective. A Local Authority Caseworker should be invited to ensure all appropriate advice is provided and explain how the EHCP will be amended as the young person changes from school to post 16 education.

Year 12 and beyond

All reviews will continue each year, with a firmer focus on future plans, be that education, employment/ training, Social Care or Health support needed. The Local Authority SEN Team will continue to be involved whilst the young person is in education or training. As always, the voice of the young person is most important and their views, aspirations and ambitions will be central to all decisions and plans.

What happens at 25?

If a young person's EHC Plan is still in place when they reach age 25, it will then cease.

Pathway 7 – Vulnerable Young People Housing Pathway and vulnerable young people at risk of homelessness

Responding to 16–17-Year-Olds Presenting as Homeless or at Risk

Initial Action
Any 16–17-year-old who presents as homeless or at risk must be referred immediately to Children's Services and Housing Options for a joint assessment. Safeguarding considerations take precedence.

Joint assessment outcomes will fit into the following categories:

- *Not homeless* – Preventative work initiated, mediation to family where suitable and return to family home if safe
- *Homeless accepting Section 20* - Accommodation and support provided under Section 20, Children Act 1989. A social worker is allocated.
- *Homeless refuses Section 20* – Continue to offer safe accommodation under S17 Child in Need status

Supported Accommodation for Young People in Salford
Salford commissions a range of supported accommodation options for young people aged 16 to 25. Due to high demand, immediate vacancies are not always available. In such cases, young people may need to be placed in alternative accommodation, which could be located either within or outside of Salford.

When requesting accommodation, it is important to consider any other transitional pathways the young person may be engaged in, to ensure continuity of support and appropriate planning.

In exceptional circumstances B&B placements are used, limited to two working days, and must include supervision and a plan to move to suitable accommodation.

Responding to Care Leavers at risk of homelessness

Please see: JOINT HOUSING PROTOCOL FOR CARE LEAVERS and discuss with Next Steps Service for further information.

Recording and Accountability

All referrals and joint assessments must be recorded on the young person's Liquid Logic record
Any transition planning meetings across any of the pathways should consider housing risks and stability.

Responding to young People aged 18+ who are at risk of homelessness

Duty to Refer

Under the Homelessness Reduction Act 2017, all staff in specified public services must refer young adults they believe to be homeless or at risk of homelessness within 56 days.
This referral is even more important if a young person is vulnerable.

Who does the public duty to refer relate to?
Public services are defined as:

- Health services – including accident and emergency, in-patient and all mental health services
- Social care services
- Children's services
- Prisons (public and contracted out)
- Youth offender institutions and youth offending teams
- Secure training centres (public and contracted out) and colleges
- Probation services (community rehabilitation companies and national probation service)
- Jobcentre Plus

How do I refer someone who is threatened with or is homeless in Salford?

Check with the applicant if they already have a case officer within Salford Housing Options Point. Please do not use the Duty to Refer form where people already have a case officer. If you wish to discuss a case, you should contact the Officer by email. Please bear in mind that the service is extremely busy and staff may not be able to respond immediately. If your query is urgent or you need to find out who the named case officer is, please email housing.advicecentre@salford.gov.uk

If there is no open case, please get the individual's consent to refer them and then complete the referral form below. It is crucial to refer people as early as possible so that we intervene at the earliest opportunity to prevent and/ or resolve homelessness.

Duty to refer form GMCA Housing Assistance Referral Portal

If the individual is homeless immediately at the point of referral they should be directed to attend the

Housing Options Service at Salford Civic Centre, Swinton, M27 5DA.

A triage assessment will be carried out and where the applicant is homeless that day, a same day assessment will be offered. Please do not direct people to the office unless you are satisfied that they are immediately homeless to avoid them being asked to come back another day. In such circumstances, use the Duty to Refer form.
This form should be used to refer people to Salford City Council. Other local authorities will have different methods for submitting these referrals – please check the advice provided by each local authority on how to submit referrals to other districts.

The individual can request to be referred to any local authority of their choice. However, if they are homeless and do not have a local connection, they may be referred to the authority where they do have a local connection.

9. Information Sharing & Consent

Effective transition planning relies on timely and appropriate information sharing between children's and adult services, as well as with relevant health, education, and support agencies. Information must be shared in line with the UK General Data Protection Regulation (GDPR) and the Data Protection Act 2018, ensuring that it is necessary, proportionate, and relevant to the young person's care and support needs. Wherever possible, information should be shared with the young person's informed consent.

From the age of 16, young people are presumed to have capacity to make decisions about how their information is shared, and their views must be respected. Where a young person lacks capacity, decisions must be made in their best interests under the Mental Capacity Act 2005. All professionals involved in the transition process must be clear about their responsibilities in handling information and should ensure that young people and their families understand how their data will be used to support a smooth and coordinated transition into adulthood.

10. Review date

12 months from publication