The Surrey Transition Team

The Surrey Transition Toolkit.

Overview of the Surrey Transition Team

Structure, Leadership, and Professional Roles within the Transition Team

Strategic Leadership

Assistant Director with Senior and Team Managers set direction and oversee operational performance.

Transition Pathway Leadership

Senior Manager and Therapies Manager coordinate services and therapeutic input for youth transitions.

Operational Management

Assistant Team Managers provide day-to-day leadership and link strategic plans to frontline practice.

Professional Roles

Social Workers, Occupational Therapists, Support Brokers, and Senior Social Care Assistants deliver holistic, person-centered transition support. School Facing Workers-attending school reviews

Legal Framework

Principles, Laws and Regulations

Legislation and Policy

Care Act 2014 Overview

Provides a statutory framework emphasizing wellbeing, prevention, personalisation, and safeguarding in adult social care.

Mental Capacity Act 2005

Establishes principles for supporting individuals unable to make decisions, ensuring decisions are in their best interests.

Equality and Human Rights Acts

Protects against discrimination and upholds dignity, respect, and fundamental human rights across public services.

Disability and Children's Legislation

Autism Act 2009 and Children and Families Act 2014 enhance support for autistic people and promote integrated care for children.

Other Key UK Legislation and Policy

Care Act 2014

Mental Capacity Act 2005

Human Rights Act 1998

Leaving Care Act 2004

Autism Act 2009

Children and Families Act 2014

Valuing People 2001

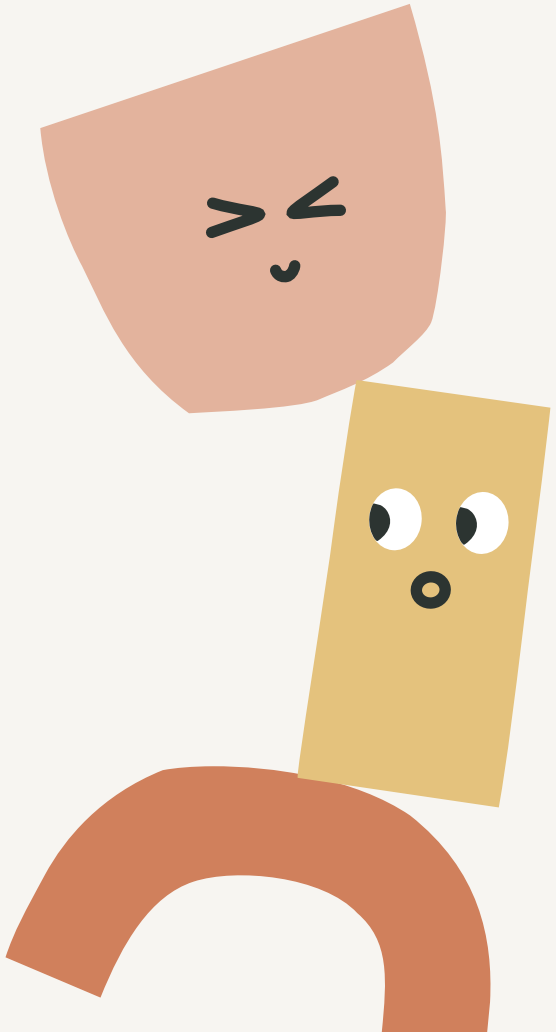
Children's Act 1989/2004

Valuing People Now 2009

OUR PARTNERS

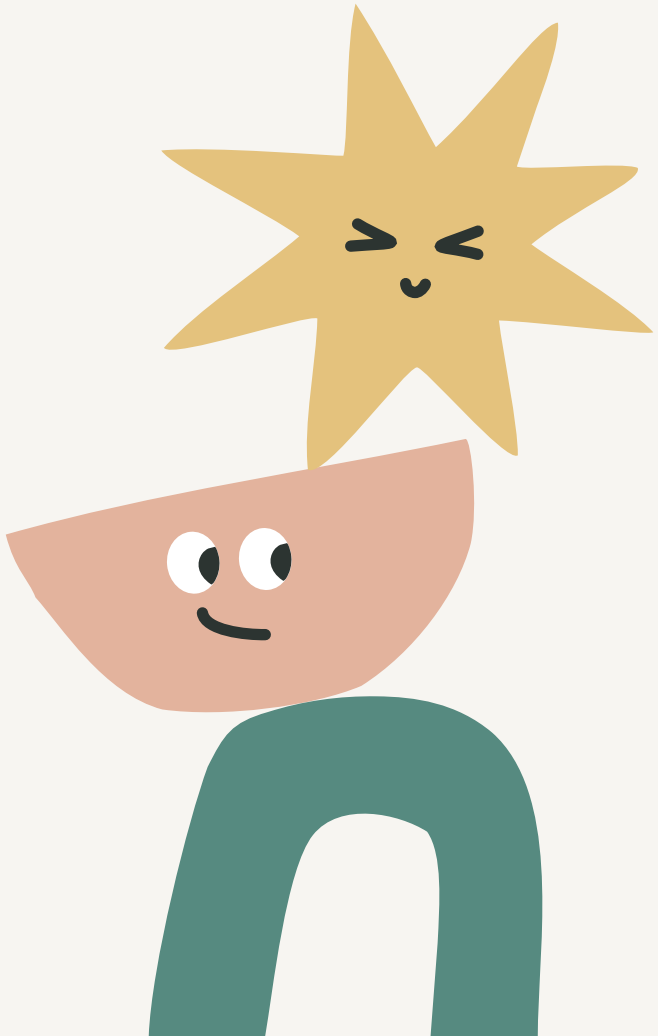
As a Care Act Service, our commissioning responsibility extends to social care provision only. We collaborate with the following partners:

- Schools and Education
- SEND (Preparation for Adulthood agenda)
- Primary Health – Universal Pathways
- Continuing Healthcare (for young people above Local Authority remit)
- Community Mental Health Recovery Service
- Forensic Services
- Community Team for People with Learning Disabilities



OUR PRIORITIES

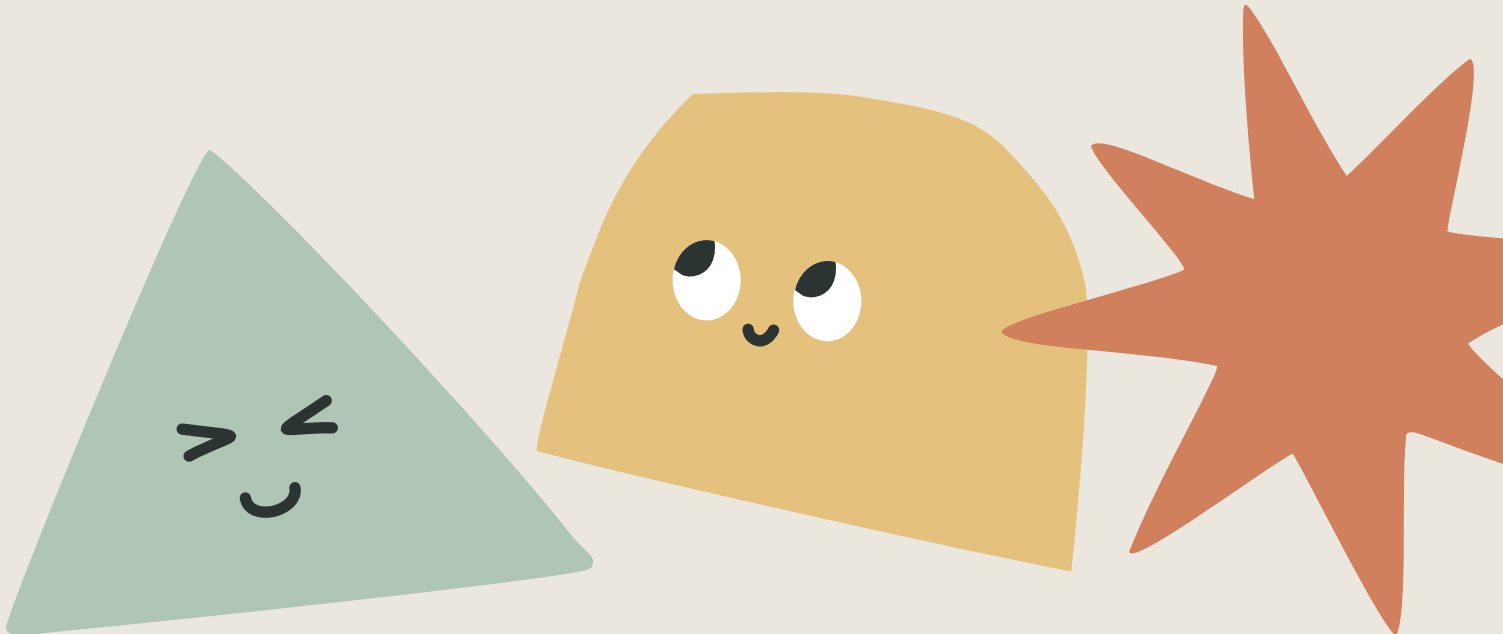
- Early engagement to facilitate smoother transition.
- Partners understanding our role and remit.
- Effective joint working to facilitate proactive planning.
- Early identification of appropriate pathways for young people with social care and/or health needs.
- Safeguarding
- Early commissioning discussions to identify appropriate provision.
- Promotion of supported living for young people over a residential model of support.
- Strategic planning
- Link with Locality Teams and preparation of cases that transfer over at 25.



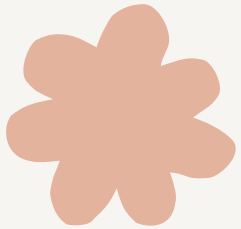
OUR PRIORITIES – CONTINUED

- Lifelong planning - planning beyond EHCP
- Developing Local Offer
- Strengthening relationships with Housing, private and voluntary organisations.

Transition Team Referral Pathway and Transfer Protocol for Children's Services



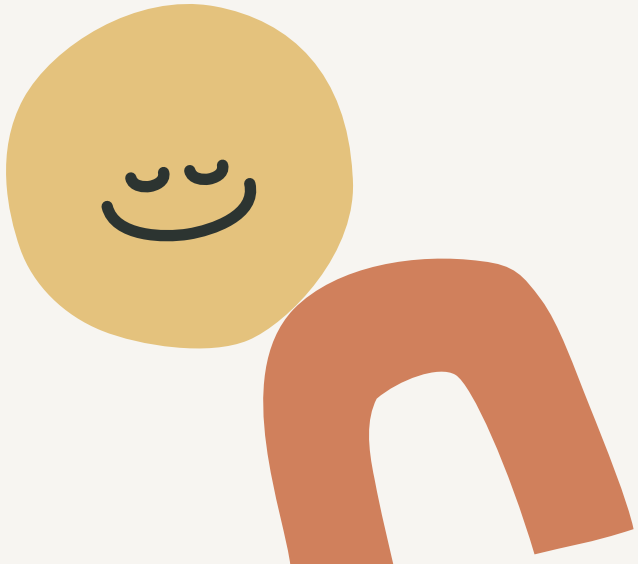
Referrals



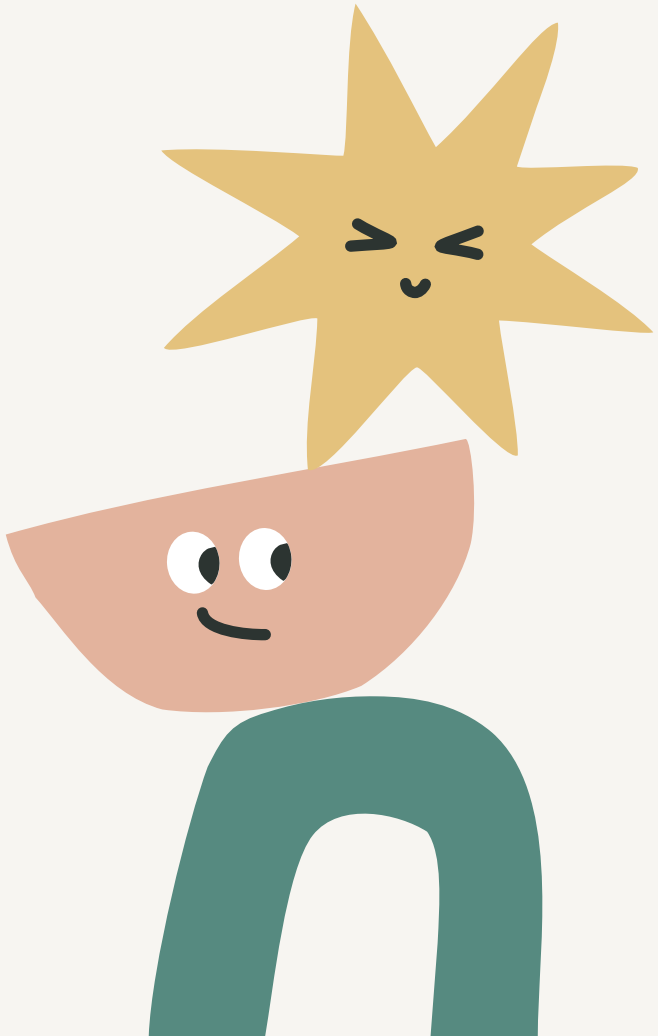
- The Team will accept new referrals where cases are open to:
- Children Services Social Care Teams and Special Educational Needs and Disabilities (SEND) where the young person has a diagnosed primary need of either Learning, physical and/or sensory disability and/or Autism. SEND referrals will be for young people who are actively in education.
- Referrals sitting outside of these criteria, will be referred to the Locality Team where the young person resides or the PLD and Autism Team if this is more appropriate.
- Young people who are not in employment, education or training (NEET) should be redirected to more appropriate ASC pathways or universal services.

Transition Team and Transfer Protocol

- The team will keep clients up to the 1st April of the financial year they turn 25, however, if in settled placements they will transfer to locality teams or the PLD and Autism Team prior to 25.
- The team will accept referrals from the age of 14 but financial responsibility from 18.
- It is an expectation that Children's Services Colleagues will make a referral to the Transition Team at age 14 with the latest referral being received by a young person's 16th birthday to enable the Transition Team to plan around the volume if referrals being received.
- Referrals received after a young person's 16th birthday will be considered late.



Transition Team and Transfer Protocol

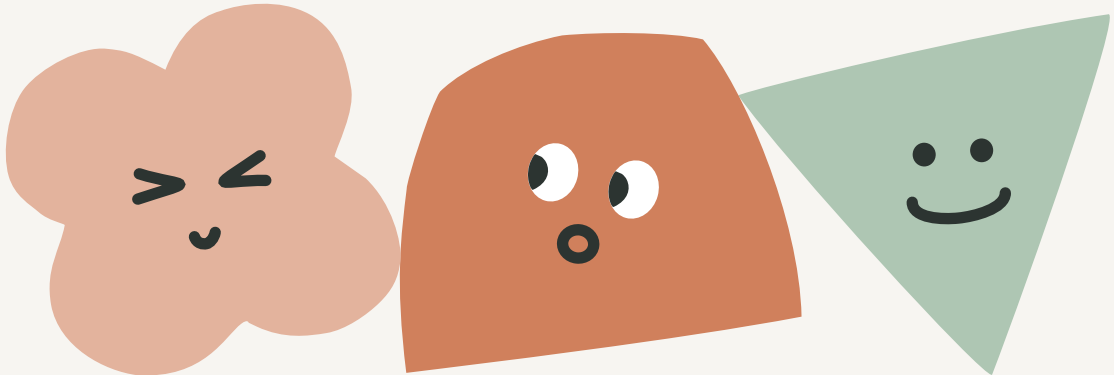


- Children's services colleagues will remain with funding responsibility for late referrals until such a time that ASC has had an opportunity to undertake an eligibility assessment and implement a support plan that has been agreed by the young person and their family/representatives.
- New referrals to ASC for people aged 23 and above, will go directly to locality teams or the PLD and Autism Team, as these clients are not in transition.
- Transition team practitioners must have capacity to attend under 18 reviews from year nine and to assess and support plan for rising 18 cases prior to their 18th birthday

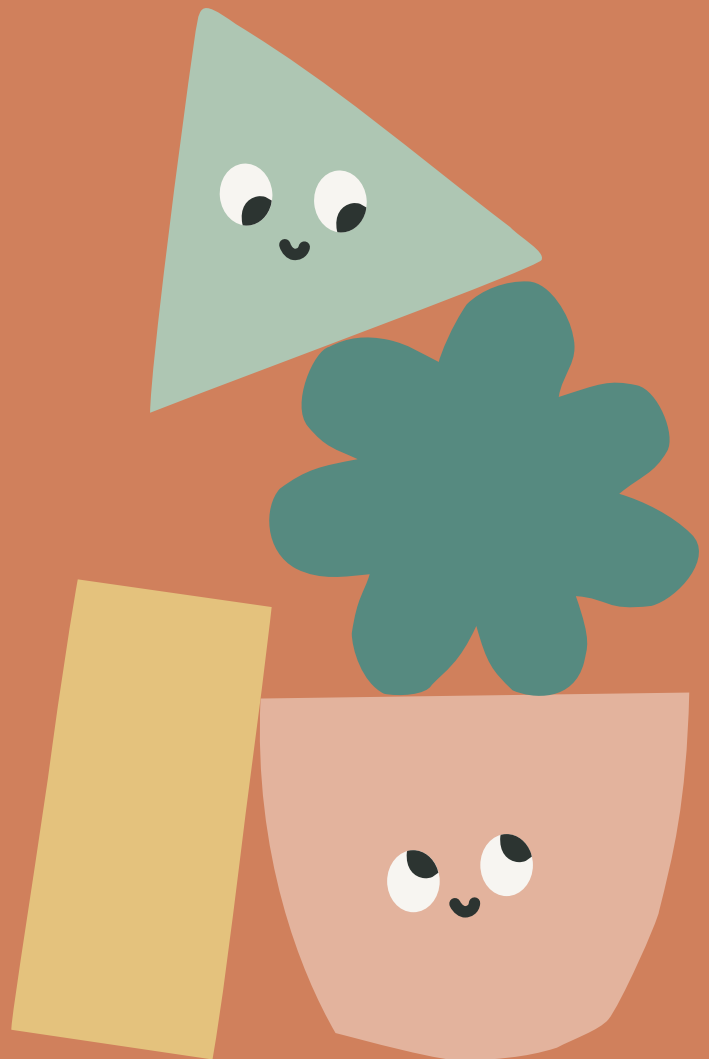
Conditions of Transfer

In addition to the criteria stated above, cases must have:

- Evidence of eligibility assessment for ASC
- Authorised support plan
- Review and/or reassessment not more than one year old.
- Cases will transfer according to age and not case status at 25. This is because it is not always possible for all case issues including behavioural difficulties to be resolved prior to 25.
- Locality teams and the PLD and Autism Team will be advised of rising 25 cases due to transfer to their team from October each year.



Transition to Locality Teams



- Rising 25 cases will transfer to the respective locality teams or the PLD and Autism Team every 1st of April, if they have not already transferred.
- Cases will be transferred to the locality where the person is currently residing or to the PLD and Autism Team if this is the more appropriate pathway .
- Out of county cases will transfer to the locality with geographical responsibility for that area or the PLD and Autism Team .
- For CHC awarded cases, the carers will transfer to the locality team or the PLD and Autism Team, as soon as CHC is awarded, as there is no role for the transition team in supporting transition and developing long-term support plans.
- The Transition Team will support young people previously open to the team, aged 22 and below, who cease to be CHC funded. Young people aged 23 above will be supported by the responsible Locality Team or the PLD and Autism Team

Our Role at Year 9 (+) Reviews

Aim

To aid a smooth Transition into adults' services, regardless of how complex somebody's needs may be.

Provide a strong focus on local, community-based support and provision

We believe that everybody should have the right to live their life in their own community, regardless of their disabilities.

How

We will do this by:

- Identifying local options with network partners
- Working with Commissioners
- Explaining Adult Social Care involvement
- Explaining Legal changes when turning 18
- Offering advice and guidance regarding Preparation for Adulthood outcomes.

Our Message to Parents

Year 9 is a key period for parents to begin to:

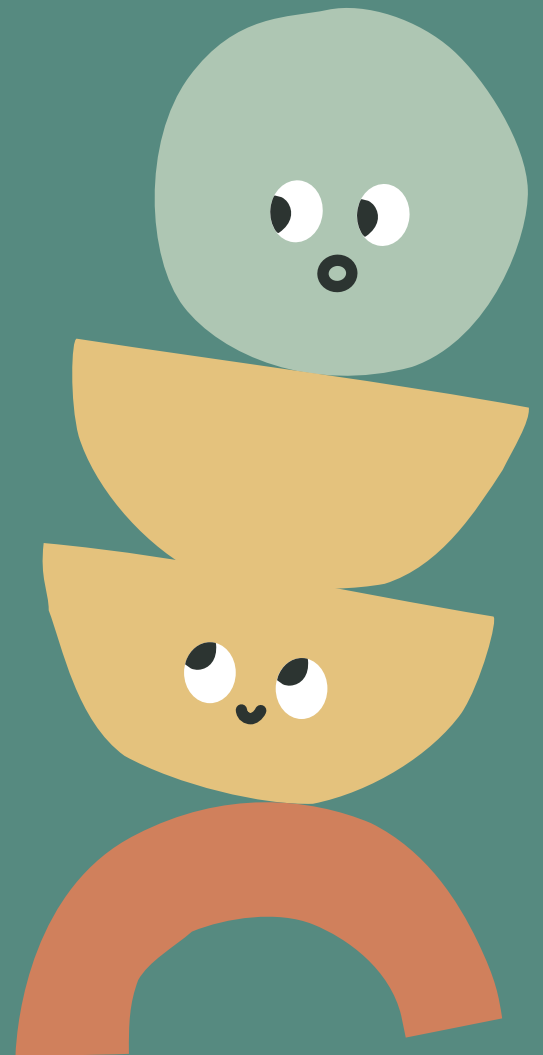
- Ask **ALL** professionals working with their child/ young person what preparation for adulthood planning is happening?
- Ensure that their young person's voice is being heard by those making decisions.
- Year 10 is key period when SEND / EHC planning has to begin- and parental preferences are gathered. Speak to SEND worker and Social worker (if you have one)
- Start thinking about the future and how you imagine it might look like and how your young person might want their future – what college/ what independent living arrangements are going to be needed.

More Messages to Parents

- The young person's rights, voice and preferences should guide decisions once they turn 16
- Health and Social Care have different eligibility criteria but should work together to support young people
- Good planning involves universal, health services, SEND services, Education and voluntary sector support ideally working together and starting early to address the pillars of the Preparation For Adulthood goals.
- Not all children with social care involvement will need Adult social care
- There is a wealth of information on the Local Offer pages..

From Age 17+ – Support Pathway

Guidance and resources for young adult development



Overview of Advice, Assessment, and Ongoing Support

Early Advice and Guidance

Support begins early with advice and information ensuring clarity on services, rights, and responsibilities.

Year 9 SEND Reviews

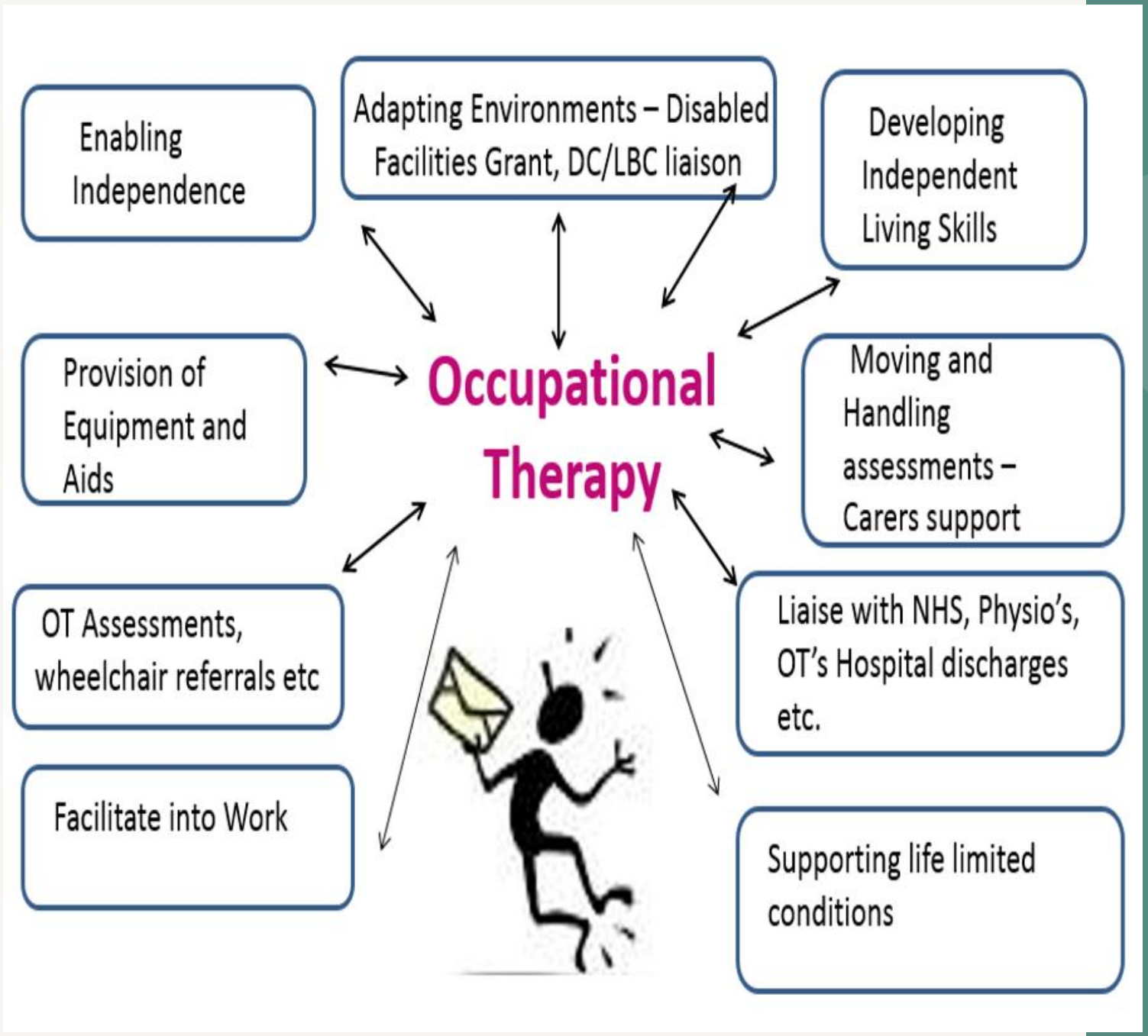
Year 9 reviews help align educational planning with future adult care and independence goals for SEND youth.

Adult Social Care Assessment

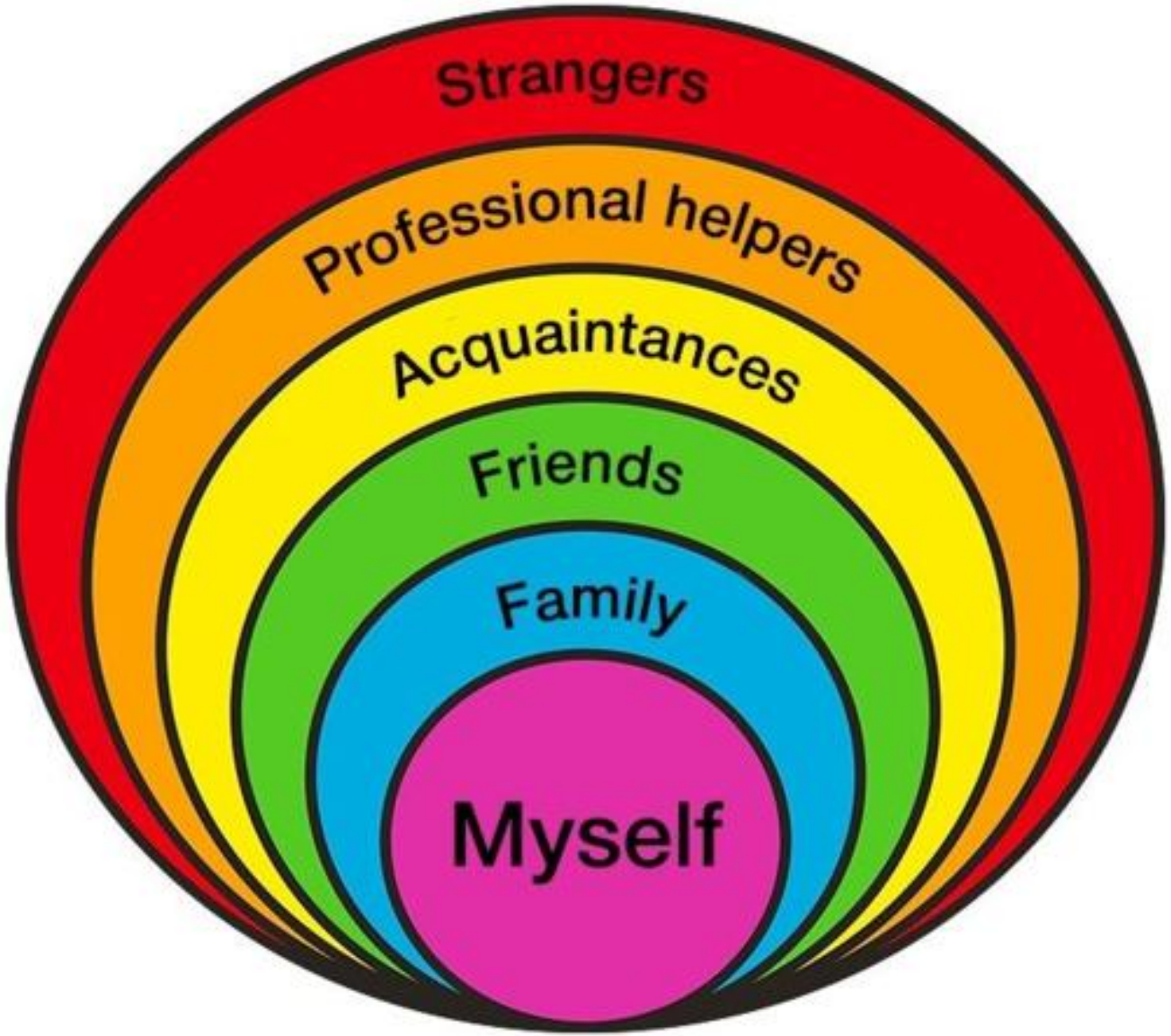
Assessment identifies needs, eligibility, and financial contributions to form the basis of ongoing support.

Personalised Support and Reviews

Personalised plans focus on independence and life goals, with regular reviews ensuring responsiveness.



Occupational Therapy a Key Element of the Team



Strengths Based Focus

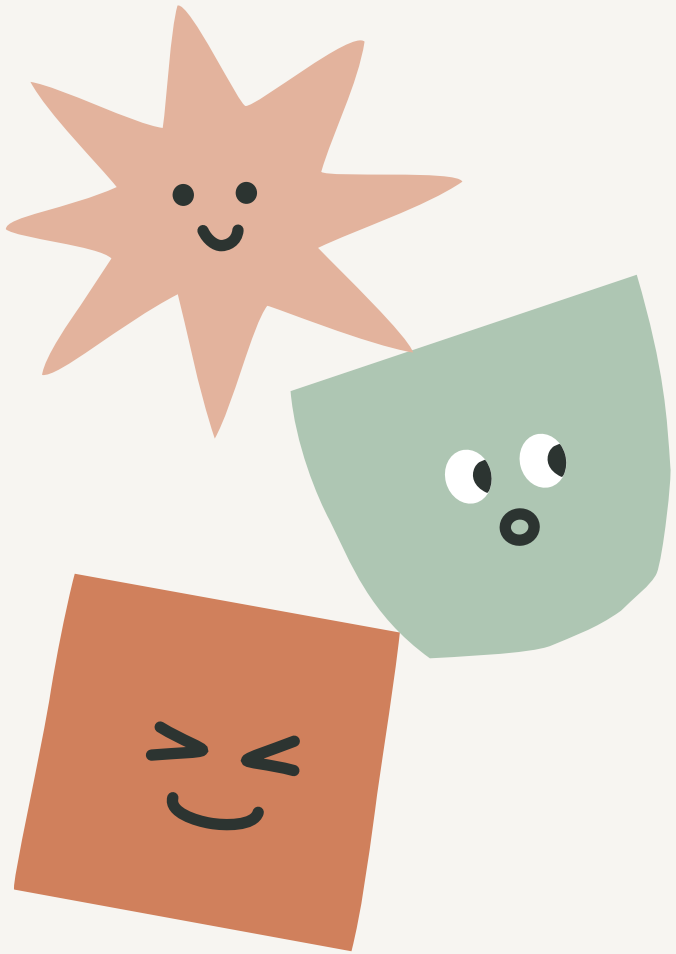
14–18 Link Service

- Non-case-holding, proportionate model
- Tiered approach: universal, targeted, priority
- Focus on high-risk and complex transitions
- Light-touch support for wider cohort

What the Link Service Will Do

- Supports early planning from age 14
- Provides system navigation for families
- Links children's and adult services
- Offers advice, guidance and signposting

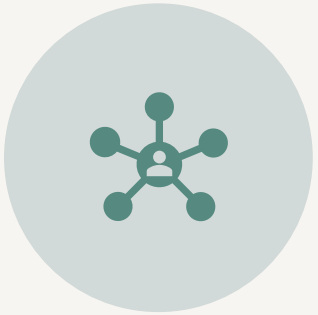
Core Areas of Focus



- Early Identification and Planning
- Coordination and System Navigation
- Transitional Safeguarding
- Information, Advice and Signposting

What the Link Service Does NOT Do

•DOES NOT HOLD STATUTORY CASE RESPONSIBILITY



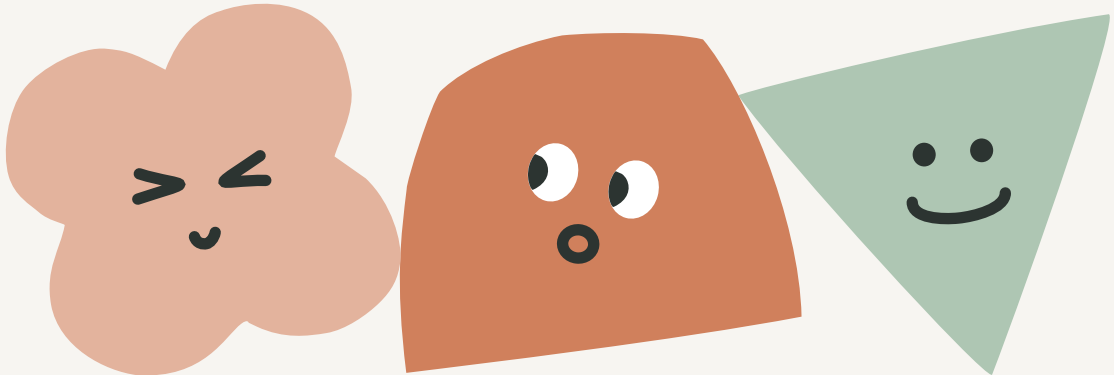
•DOES NOT REPLACE SOCIAL WORK OR SEND ROLES

•DOES NOT LEAD EHCP OR CARE ACT PLANS

•DOES NOT RESOLVE SYSTEMIC FUNDING ISSUES

How the Link Service Operates

- Non-case-holding model
- Tiered and proportionate approach
- Targeted support for complex cases
- Light-touch support for wider cohort

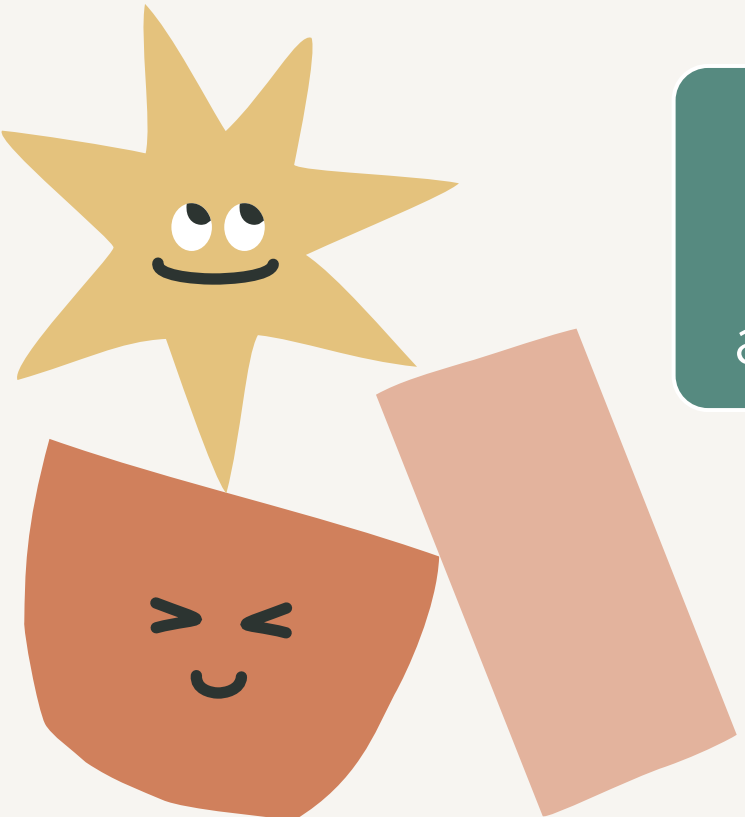


Children's Services retain case responsibility

SEND retains EHCP ownership

ASC retains adult care planning

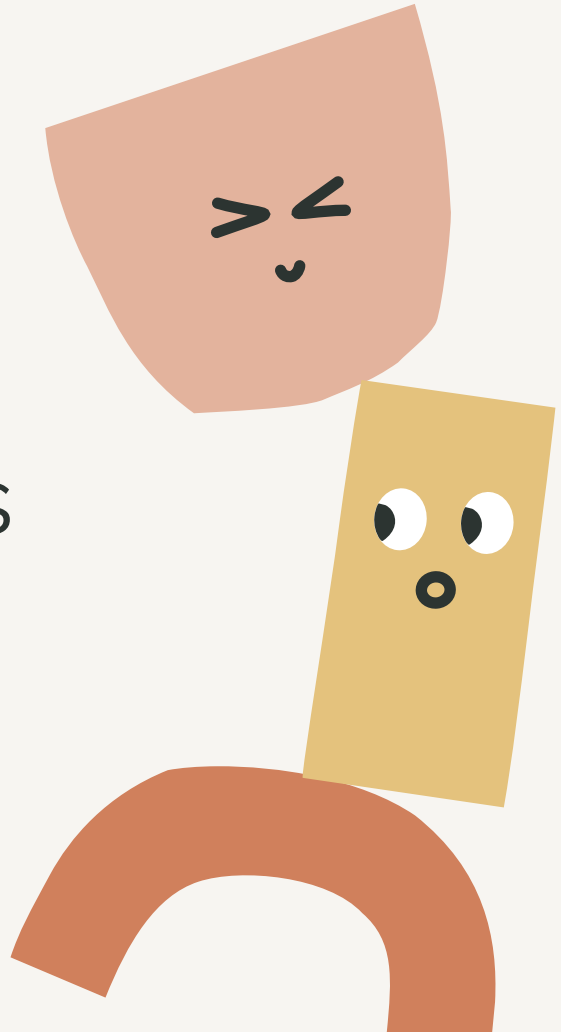
Link Service supports coordination and navigation



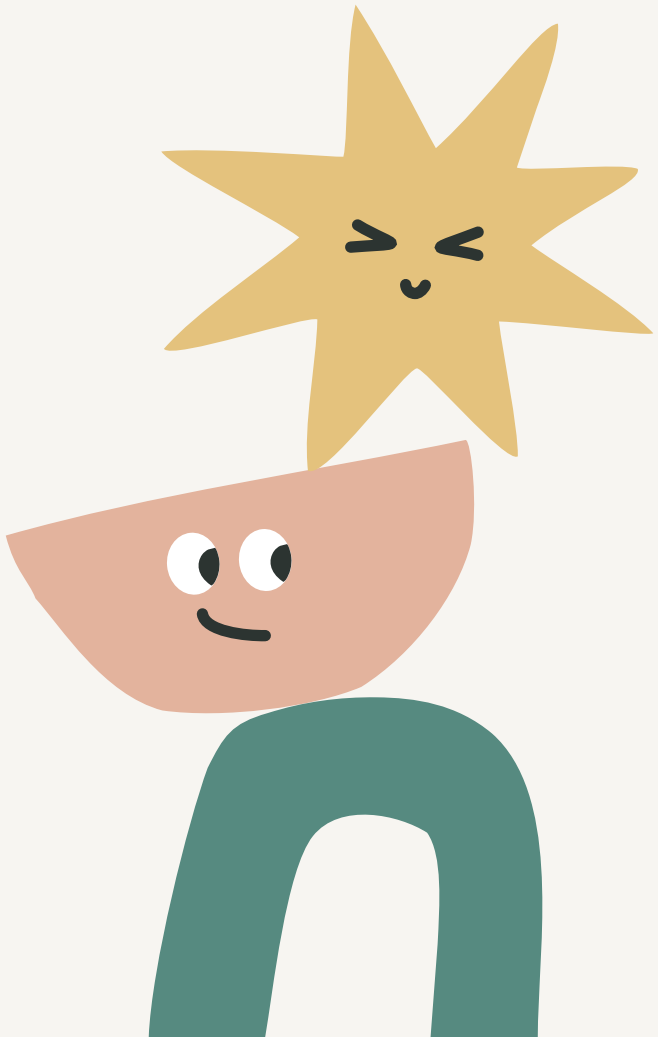
How It Fits in the System

Value of the Service

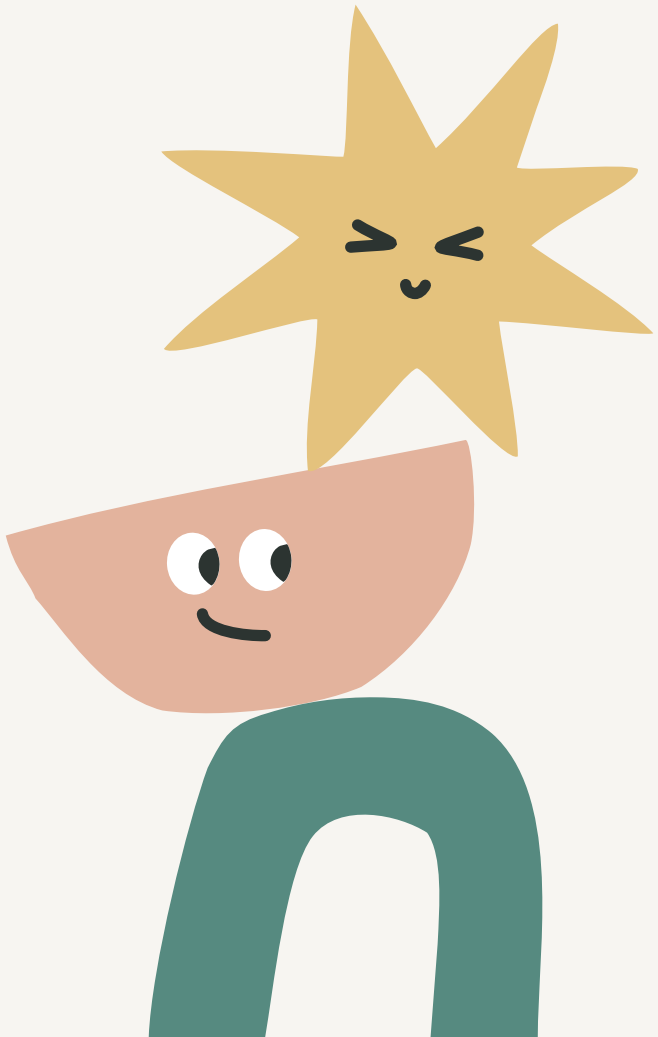
- Earlier and more consistent planning
- Improved navigation for families
- Better coordination between services
- Reduced risk of crisis at transition



Summary



- Targeted, proportionate coordination function
- Improves how the system works
- Supports but does not replace existing services
- Focused on better outcomes for young people



Areas for discussion

- How would this model work in your local authority
- How do your teams social care teams work with 14- to 18-year-olds
- Can you see any limitations of a Link Service