UK CCN/SAPHNA
Supporting CYP in education settings with SEND

Agenda 16/7/24

- Summary May 24
- Transition
- Open discussion – clinical interventions

Next meeting

Sept 17th 1400-1500hrs

Topic: Safeguarding

Public health pertussis/measles

UK CCN/SAPHNA
Supporting CYP in education settings with SEND

Summary – UKCCNN & SAPHNA- supporting CYP with SEND in education settings – 21/5/2024
12 attendees

- Presentation; Jane Mulcahy and Angie Fudge on Nursing needs & EHCP presentation
- Overview Sussex Tool (Trudy Ward) and understanding the health needs of Children and young people within education settings
- Mapping whole school needs and comparing – number of CYP with Complex and fluctuating health needs, Number of delegated tasks in total within a school setting.
- Frequent and/or intensive periods – when health fluctuates outside day care plan, or requires nursing input as a daily requirement due to changing needs
- Training 2-3 staff members per child – however all school approach can also be taken with multiple CYP with health needs (training programmes)
- Tool also used to input into Education, health and care plans (EHCP) reports (anonymised template shared and discussed)
- Gold standard to work with CCNs to utilise on initial needs/outcome assessment request.
- Currently completed for EHCP annual reports – positive to track the changes in CYP needs over time.

Transition for CYP in education settings

- Wellchild – 8 Principles transition
  - Templates and resources

- NICE guideline [NG213]

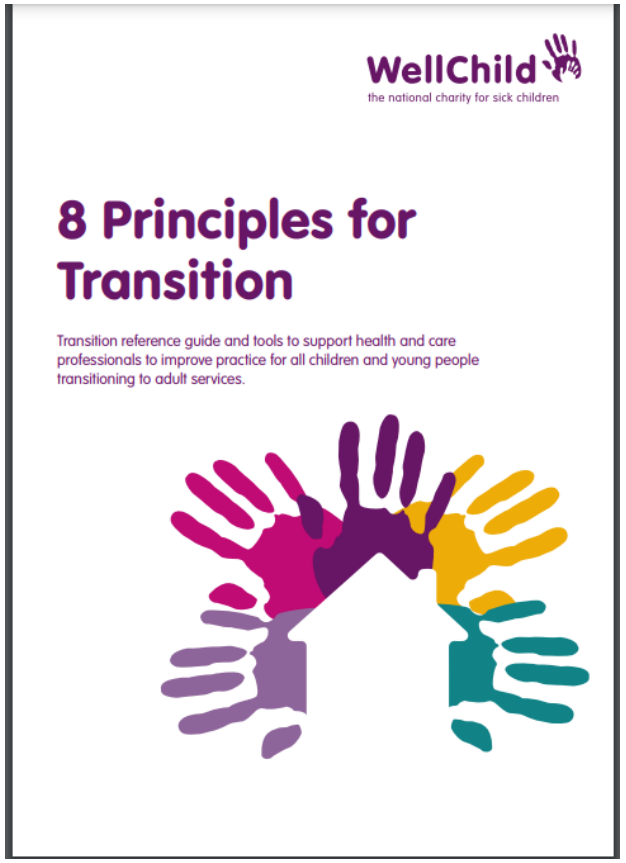
Disabled children and young people up to 25 with severe complex needs: integrated service delivery and organisation across health, social care and education

- Annual health check GP age 14yrs https://www.nhs.uk/conditions/learning-disabilities/annual-health-checks/

- Sussex – year 9 transition pack – reviewed annually as part of EHCP review

8 Principles of Transition - WellChild

https://www.wellchild.org.uk/for-professionals/research-resources/8-principles-for-transition/



8 Principles of Transition - WellChild

https://www.wellchild.org.uk/for-professionals/research-resources/8-principles-for-transition/

1. Planning – key lead, who needs to be involved (education/hospice/tertiary/GP)

2. Governance –Joint transition care plan/documentation including risk assessments,
audit of process for standards

3. Identification – Who, How, when, capacity YP, training

4. Communication – openness, honesty, managing expectations – tailored to meet the YP needs - passports

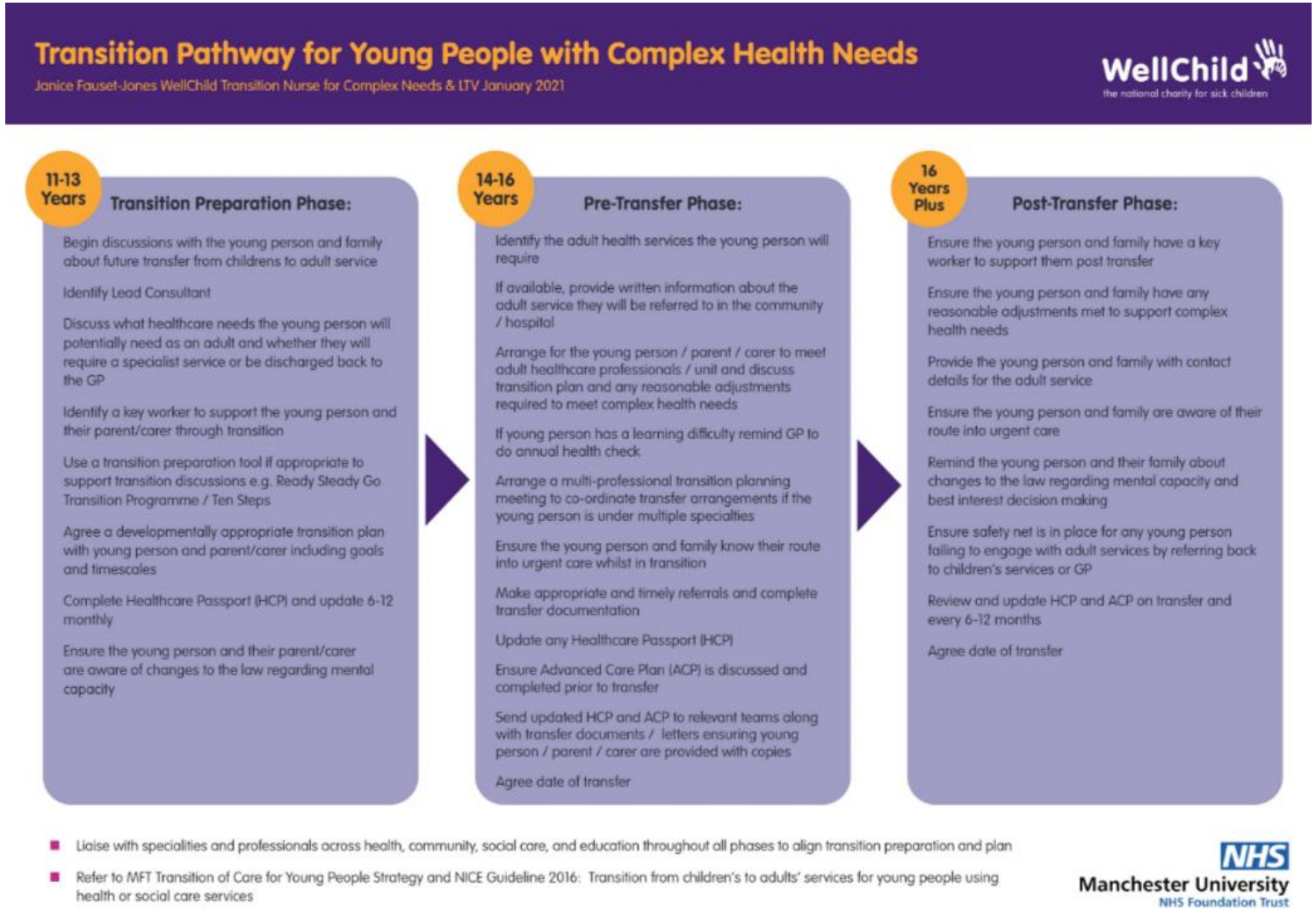
5. Empowerment – YP/Family – what are their wishes, goals? Deputyship

6. Assessment needs – what is required, how is this supported, funded, training, timelines

7. Partnership working – YP, Family and MDT

8. Final transfer and onward journey – transfer days/time to say goodbye

Transition pathway for YP with complex health



Transition Pathway for Young People with Complex Health Needs

Janice Fauset-Jones WellChild Transition Nurse for Complex Needs & LTV January 2021

WellChild
the national charity for sick children

11-13 Years

Transition Preparation Phase:

- Begin discussions with the young person and family about future transfer from childrens to adult service
- Identify Lead Consultant
- Discuss what healthcare needs the young person will potentially need as an adult and whether they will require a specialist service or be discharged back to the GP
- Identify a key worker to support the young person and their parent/carer through transition
- Use a transition preparation tool if appropriate to support transition discussions e.g. Ready Steady Go Transition Programme / Ten Steps
- Agree a developmentally appropriate transition plan with young person and parent/carer including goals and timescales
- Complete Healthcare Passport (HCP) and update 6-12 monthly
- Ensure the young person and their parent/carer are aware of changes to the law regarding mental capacity

14-16 Years

Pre-Transfer Phase:

- Identify the adult health services the young person will require
- If available, provide written information about the adult service they will be referred to in the community / hospital
- Arrange for the young person / parent / carer to meet adult healthcare professionals / unit and discuss transition plan and any reasonable adjustments required to meet complex health needs
- If young person has a learning difficulty remind GP to do annual health check
- Arrange a multi-professional transition planning meeting to co-ordinate transfer arrangements if the young person is under multiple specialties
- Ensure the young person and family know their route into urgent care whilst in transition
- Make appropriate and timely referrals and complete transfer documentation
- Update any Healthcare Passport (HCP)
- Ensure Advanced Care Plan (ACP) is discussed and completed prior to transfer
- Send updated HCP and ACP to relevant teams along with transfer documents / letters ensuring young person / parent / carer are provided with copies
- Agree date of transfer

16 Years Plus

Post-Transfer Phase:

- Ensure the young person and family have a key worker to support them post transfer
- Ensure the young person and family have any reasonable adjustments met to support complex health needs
- Provide the young person and family with contact details for the adult service
- Ensure the young person and family are aware of their route into urgent care
- Remind the young person and their family about changes to the law regarding mental capacity and best interest decision making
- Ensure safety net is in place for any young person failing to engage with adult services by referring back to children's services or GP
- Review and update HCP and ACP on transfer and every 6-12 months
- Agree date of transfer

- Liaise with specialities and professionals across health, community, social care, and education throughout all phases to align transition preparation and plan
- Refer to MFT Transition of Care for Young People Strategy and NICE Guideline 2016: Transition from children's to adults' services for young people using health or social care services

NHS
Manchester University
NHS Foundation Trust

NICE guideline [NG213]

Disabled children and young people up to 25 with severe complex needs: integrated service delivery and organisation across health, social care and education

1.8 Transition from children's to adults' services

These recommendations should be read alongside the special educational needs and disability (SEND) code of practice (chapter 8 and paragraphs 9.151 to 9.152), and supporting legislation.

1.8.1

Local authorities must ensure that preparation for adulthood is covered at education, health and care (EHC) plan reviews from year 9 onwards, in line with the SEND Regulations 2014.

1.8.2

When working with young people, interagency teams should:

- focus on the young person's goals for adulthood, instead of just treating health problems or providing short-term support
- help the young person and their parental deputy to prepare for adult life and maximise their independence.

1.8.3

- Do not assume that young people will have a clear plan for adulthood at the start of transition planning. Help them to understand the different options, and give them and their families enough information to make informed decisions.