OCTOBER 12, 2017

Making Life Journeys

YOUNG PEOPLE MAKING LIFE JOURNEYS THAT THEY CHOOSE FOR THEMSELVES; SERVICES SUPPORT THOSE WHO NEED THEM TO FULFIL THEIR LIFE JOURNEYS

IMPROVING TRANSITION FOR YOUNG PEOPLE IN KINGSTON, WHO MAY REQUIRE ADULT HEALTH AND SOCIAL CARE SERVICES

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Version:	Draft v1
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Introduction

During September 2017 Kingston's organisations involved in transition undertook a number of activities to develop a new transition pathway and protocol for young people who may require adult health or social care services.

This report aims to summarise the activities and findings as well as recommendations which should be taken forward in developing a multi organisational transition model. Alongside this report is the first draft pathway that was developed.

Recommendations

Key recommendation and consideration that emerged:

1. Finalise the pathway and consult. Further Engagement with young people on this pathway. Also align with steps that all young people go through.
2. Establish a co-editing group.
3. To integrate the principles and statements into the pathway and protocol. Include the aspect of collaboration and multi-disciplinary working. To be pragmatic some parts of the NICE guidance may be aspirational as it is acknowledged that it will take time to embed however other should be implemented much sooner. Based on the survey and events we should focus on strength based and person- centred approaches.
4. Ensure that the protocol outlines the function and outcome for Names Worker, Checkpoints, Transition Plan and Personal Folder.
5. Set realistic scope for the pathway and which organisation to include.
6. Through a communication strategy:

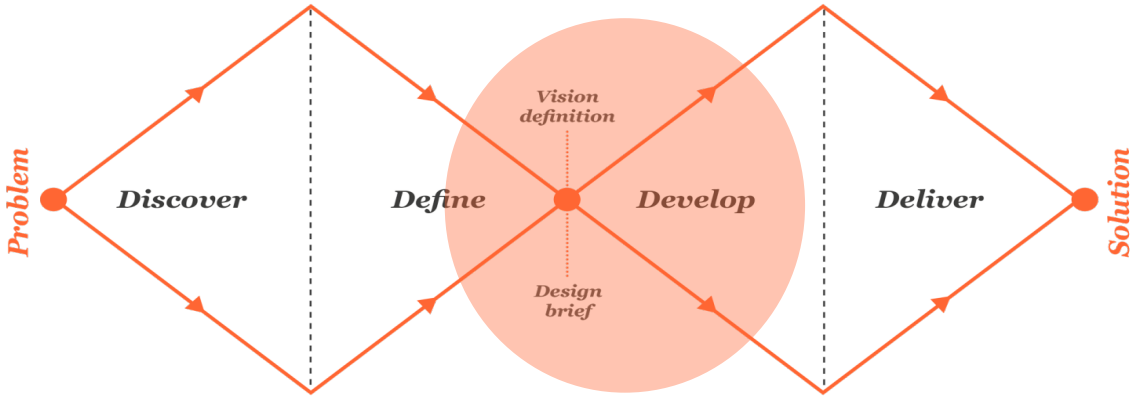
- Actively engage those organisations involved and clarify ratification process for the protocol and to keep them informed of progress
- Explore how touchpoints can support the transition pathway and information for parents and young people.
- Explore Nudge Theory to start taking organisations in the direction that is needed to best meet young people's needs.
- Explore innovative way of bringing the pathway alive as part of the communication strategy

7. Explore Young People keeping a Dream Diary that is updated as they get older and is taken with them as they transition to adulthood.
8. Young People having an individual profile that all organisations can use.
9. Ensure Families/carers are seen as more important in the transition process.
10. Map what data we have (what can be automated) and clarify what is missing/ absolutely essential
11. Joint Data group to be established and to meet in order to progress discussion.
12. Meet with Look After Children team to ensure that this is aligned

Discussion

The report and development of the pathway follows the structure of the 'double diamond' a simple visual map to identify the four stages in a design process (discover, define, develop and deliver) to move from a problem to a solution state. It incorporates outcomes from two workshops, attendance at the 14-19 Partnership Board and an online survey.

Why are we focussing on transition?



Discovery

Through engagement events, as part of developing an All Age Learning Disability Collaboration between Achieving for Children, Royal Borough of Kingston and Your Healthcare it became apparent that there were wider issues around transition that were going beyond learning disability services.

Young people, their parents and staff reported a disconnect between child and adult focussed services. Others reported that there was some silo working rather than person centred care. Whilst some people felt their transition went well, other were less satisfied. Additionally, there were a number of individuals who came to adult social care's attention after their 18th birthday.

An initial desk top review and transition stocktake also identified issues with transition and the current protocol:

- The Protocol is in need of refreshing (as it referred to teams who no longer existed)
- The Protocol is not in line with the NICE Guidance on transition, which were published in 2016 and does not focus on maximising independence and well-being, hence not taking account of Care Act and Children and Family Act Legislation and requirement for transition (see appendix for gap analysis)
- Transition arrangement do not take account of local Joint Strategic Needs Assessment (Autism, Learning Disability, Child Sexual Exploitation and SEND JSNAs RBK)
- A local SEND Review highlighted transition as a priority area (AfC 2017)

- Kingston Hospital indicated that they wanted to focus on Transition
- The Safeguarding Children Board identified transition as a priority area for 2017/18
- Lack of outcomes in terms of identifying and coding young people who may require adult services; lack of consensus on what should happen during transition and roles and responsibilities.
- Had the potential to have cost implication for adult services (as forward planning remained challenging due to lack of understanding of future needs and trends)

Defining

At a recent RBK Councillor session on the demand management programme 'No Stone Unturned', members requested RBK and AfC to revisit transition arrangement. Drawing on work undertaken on Learning Disability it was apparent that we needed to reconfirm organisations commitment to transition and reconcile the three transition pathways that currently exist and ensure that these are aligned and reconciled:

- Multi Agency Transition Protocol for young people with learning difficulties, disabilities, additional needs or mental health issues (Richmond, Kingston and AfC)
- Transition Protocol Child and Adolescent Mental Health Services (CAMHS) to Adult Mental Health Services (South West London and St. Georges)
- Health Transition Pathway

A collaborative approach was needed to develop a multi- agency pathway and protocol that can be owned by the stakeholders involved in transition and ensures that there is a cultural fit with organisation who are involved in transition.

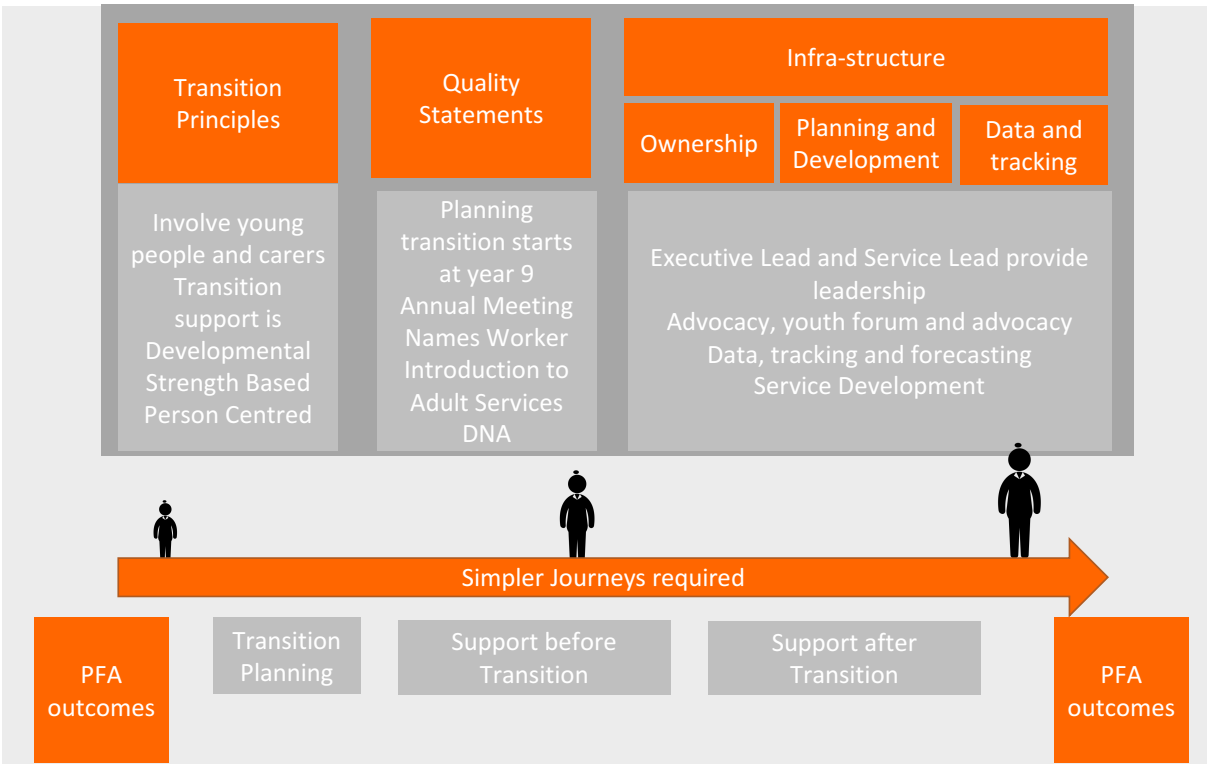
Develop

During the latter part of September 2017, we moved into the development phase by:

- Creating an online survey to test the NICE guidance principles and statements
- Hosted a transition workshop to jointly develop a future pathway
- Attended the 14-19 Partnership Board to engage with schools and colleges commissioned by Achieving for Children
- Held another workshop were the initial pathway was presented, sense checked and iterated.

For the development of the pathway and protocol we used the key building blocks identified in the NICE Guidance.

Pathway and protocol development : The key building blocks



Transition Principles and Quality Statements

Online Survey

An online survey was created in mid-September with nine questions relating to the four overarching principles and five quality statement from the NICE guidance on transition. Participants were asked to rate their importance using a Likert scale:

1 Not Important
2 Somewhat Important
3 Not Sure
4 Important
5 Very Important

A total of 25 Responses from across organisations were collected, this is a small cohort when considering the workforce across organisation and is therefore not statistically significant but should be read as a 'temperature reading'. Participants at the transition pathway workshop also commented on the quality statements and principles. A fuller discussion of the findings is enclosed in appendix one.

Principles and Statements	Weighted	Key comments

	Scoring	
NICE Principle One Involving young people and their parents or carers in service design by co-producing strategies with them asking them if the services helped them to achieve outcomes	4.5	Some participants felt that it was equally important to ensure that there was a joint understanding between services, the young person and their families of availability of resources and to manage expectations.
NICE Principle Two Transition Support is developmental appropriate taking into account the person's maturity, cognitive abilities and psychological status needs in respect to long term conditions, social and personal circumstances, caring responsibilities, communication needs and potential safeguarding issues	4.6	Consideration needs to be given to accessible communication so that the person can make informed decisions.
NICE Principles Three Ensure transition support: is strengths-based and focuses on what is positive and possible for the young person rather than on a pre-determined set of transition options identifies the support available to the young person, which includes but is not limited to their family or carers.	4.76	Some participants highlighted that this should extend to focus on the informal networks that the person can access (Circle of Support) and what they can do before considering community, prevention and paid services
NICE Principles Four Use person-centred approaches to ensure that transition support treats the young person as an equal partner and takes full account of their views and needs involves the young person and their family or carers, primary care practitioners and colleagues in education as appropriate.	4.8	Participants felt that that person-centred approaches are vital and should be embedded within services to understand people's aspirations, what's working well, or not working well
Quality Statement One Young people who will move from children to adults' services start planning their transition with health and social care practitioners by school year 9 (aged 13-14), or immediately if they enter children services after school year 9.	4.3	Some participants highlighted that long term planning needed to be part of transition for young people so to help them shape their future and ensuring the right services are involved at an early stage.
Quality Statement Two Young people who will move from children's to adults' services have an annual meeting to review transition planning.	4.56	There was a mixed response regarding this question, some participant felt it should not be just an annual meeting (with work need to happen throughout the year), others stating that some people may require

		more meetings and others less.
Quality Statement Three Young people who are moving from children's to adult services have a named worker to coordinate care and support before, during and after transfer.	4.48	There was some concern expressed with this function as operational demand and financial constraints may make this difficult for services to take on. Support to families (which are likely to be a more constant feature) is important due to changes in staffing in services.
Quality Statement Four Young people who will move from children's to adult services meet a practitioner from each adult service they will move to before transfer.	3.96	Some people felt that it could be too confusing to meet a number of organisations, instead a named adult worker should act as liaison. Participants felt that it was more important to have a named worker rather than meeting adult facing services.
Other At the workshop, there was an expressed request to include joint, collaborative working as a principle		

All principles and statement were rated important (4) or above, except for Quality Statement Four (meeting adult service practitioners). People felt most strongly about person centred approaches and a strength based approach.

Recommendation:

- To integrate the principles and statements into the pathway and protocol. Include the aspect of collaboration and multi-disciplinary working. To be pragmatic some parts of the NICE guidance may be aspirational as it is acknowledged that it will take time to embed however other should be implemented much sooner. Based on the survey and events we should focus on strength based and person- centred approaches.
- To outline the expected outcomes from the quality standards. For example, a brief Job Description of the Named Worker, description who could take on that role and what information they would need to be able to access. Furthermore, outcomes that would need to be covered at the review meeting should be described.
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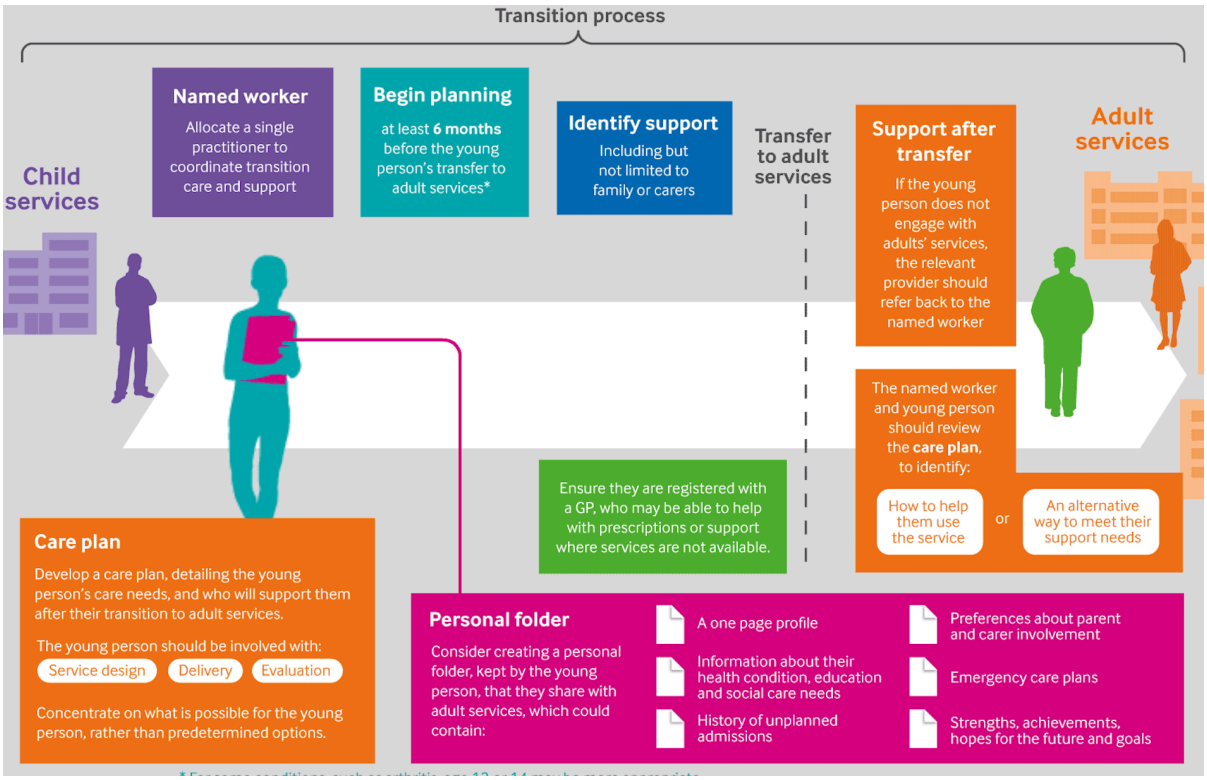
Pathway Workshop

On the 27th September 2017, we held a transition working summit with the aims of:

- Creating an initial transition pathway based on the NICE quality standards and principles

- Held a creative session to look at innovative way of improving transition
- Held a data meeting to assess current and future data and tracking requirements

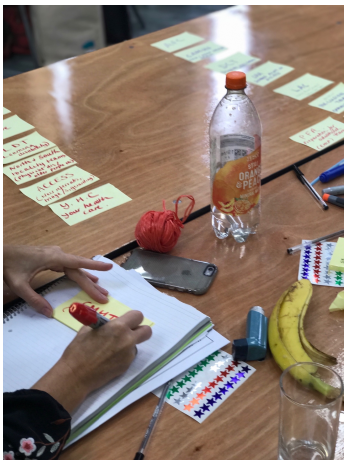


Around 26 people attended the event including individuals from AfC, RBK, Your Healthcare, SEND Family Voices, Voluntary Sector, Colleges and Library Services.

Our method

Pathway mapping is a tool for capturing and presenting key insights into the complex customer interactions that occur across services. In this case transition from children to adult services. At the heart of a pathway map lies the journey of the young person. The activity of mapping builds knowledge and consensus across teams and stakeholders, and the map allows us to create and support better experiences for the young person. One of the challenge was to develop a pathway that was detailed enough but not too detailed.

Three stages were used in designing the pathway:



1.Determine the scope of the pathway

2.Determine the structure of the pathway

3.Group Analysis of the pathway (this was only partially achieved)

Determining the Scope of the pathway

Through displaying the mapping of organisation involved in children, young people and adults highlighted the plethora of services that could play a role in transition.

'Sending Organisations'	**Transition can occur across multiple lines and between different services**	**Receiving Organisations**
Schools and Colleges		Housing and Housing Options
SEND Team		Community Mental Health Services
Preparing for Adulthood		Primary Mental Health Services
Integrated Children with Disability Team Social work		Tolworth Hospital
Integrated Children with Disability Team Community Paediatricians		Kingston Hospital
Your Healthcare		Primary Care Services
Children and Adolescence Mental Health Tier 1-4		Adult Education and Further Education
Looked After Children Team and Leaving Care Team		Adult Social Care (Long Term; Mental Health or Learning Disabilities)
AFC Family Support Team		Community Health Your Healthcare
Focus Healthcare Team		Neurodevelopmental Services Your Healthcare
School Nurses		*Kingston Coordinated Care*
Voluntary Sector		*Wellbeing Service*
SEND Family Voices		Adult Substance Misuse

		Services
Children Continuing Healthcare		Balance Supported Employment Services
		Voluntary Sector
		Carers Network
		Adult Continuing Healthcare
Touchpoints between young people and adults and services: Children Single Point of Access Schools and Colleges Local Offer and other websites Libraries and Community Assets (Leisure) Meeting and Events Contact Centre RBK Single Point of Access St Georges *Single Point of Access KCC* SEND Family Voices Carer Centre Involve Young People Engagement Healthwatch Career Interviews for young people with SEND		

Many of the organisation will be listed on the Local Offer hosted by Achieving for Children. Some such as adult mental health services may not however.

Recommendation

- Set realistic scope for the pathway and which organisation to include.
- Actively engage those organisations and clarify ratification process.
- To cross reference organisation listed at the event against the Local Offer. Ensure that they are included.
- Explore through development of a communication strategy how touchpoints can support the transition pathway and information for parents and young people.

Determine the structure

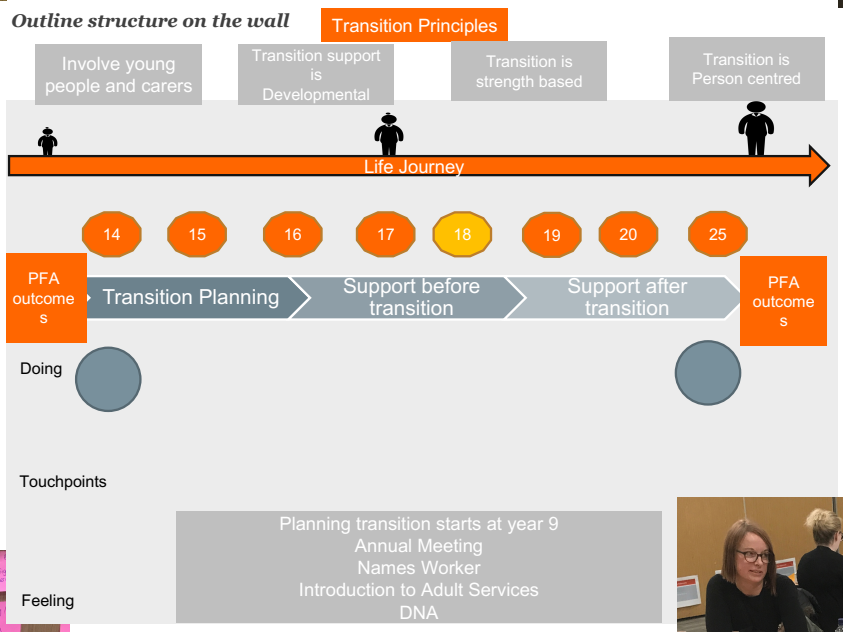
Three groups supported by facilitators chose a particular pathway to focus on:
Therapist Pathway
SEND to Adult Social Care
CAMHS to Adult Mental Health

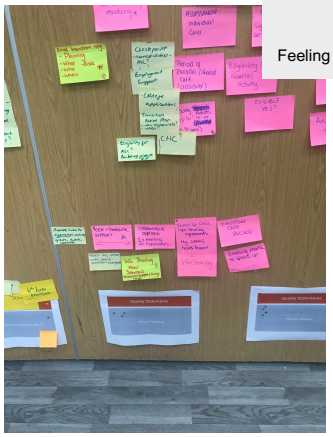
To support the groups, reference material was provided out such as a graphic representation of the current pathway as well as the NICE guidance. These can be found in the appendices. The groups identified the steps required to ensure a smooth transition from children focussed services to adult focussed ones. Groups then presented their pathway to the audience and transferred these to one of the

walls which was structured around the key areas to develop a pathway.

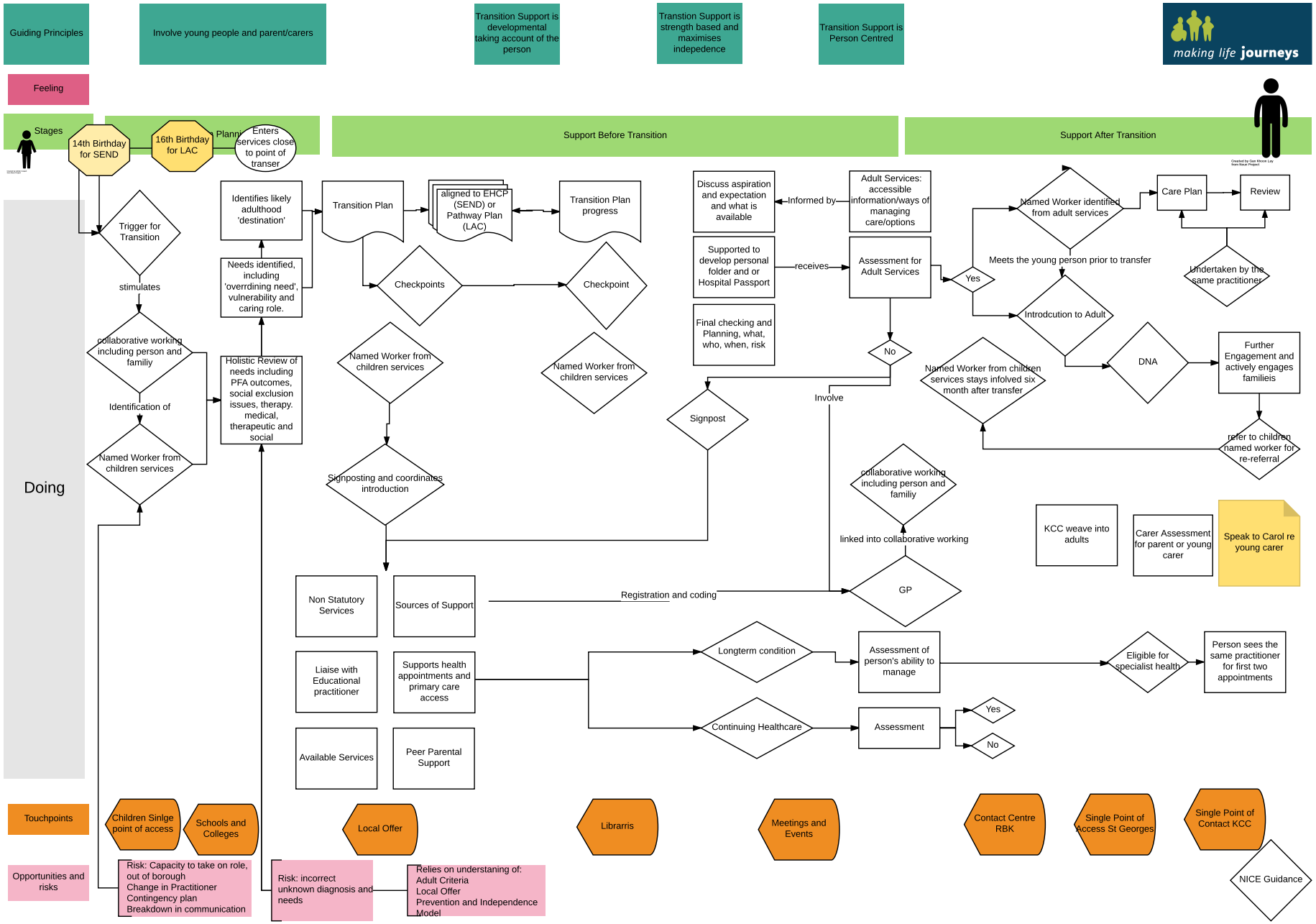
Impressions from mapping session 27th September 2017

Outline structure on the wall





First Draft Pathway



Group Analysis

As part of the mapping the groups considered quality aspects for a number of steps

Item	Considerations
Named Worker	Who is best placed? Needs to have a meaningful relationship with the young person. Could be Allied Health Professional, Nurse, Social Worker. Potentially a parent? Would need to stay in touch for six months after transfer to adult services (in case there is a DNA) Needs to be a period of shared care between adult and children services
Checkpoints	For those under SEND this is part of the year 9 review and annual review meeting Needs to involve all people involved including parent, the person themselves and or an advocate Rather than an annual meeting it is more important that things are on track. Some may need more meetings other may require fewer.
Maximising Independence	Introduce Circle of Support and strengthen peer support Ensure that people learn to travel independent Employment support is important
Transition Plan	Facilitated through Named Worker, lists what needs to be done and by whom. Linked to EHC Plan, Health Development Plan, CPA or Care Plan.
Personal Folder	One page profile linked to strengths, hopes and aspirations. Aligned to other important document (no duplication but signpost to other plans)

Recommendation

- Reiterate the pathway and consult with participants
- Ensure that the protocol outlines function and outcome for Names Worker, Checkpoints, Transition Plan
- Engagement with young people.

Creative Session

RBK is currently using creative facilitation as a mechanism to introduce step change into its business as usual activities. The idea behind creative facilitation is that rather than solving problems with the logical part of the brain, through facilitation participants are supported to solve problems through lateral thinking. Information about the session are contained in the appendices.

The group was facilitated by Alex Towers and it included a family member, staff from Adult Social Care, AfC and Your Healthcare. Stephan Brusch acted as the problem

owner. Using superheroes, with special abilities participants solved the problem of transition. In this way, the group came up with novel ideas in an imaginary space, which was then translated back into the real world and applied to the problem.

Problem stated: How can I… make sure all organisational cultures use the best practice transition pathway and protocol for young people.

Superheroes Solutions to the Problems:

Dr Strange: Would use mind control to force people to work in the right way for young people and would create illusions so young peoples' dreams could be brought to life

Spiderman: Would use his web to collect all young people in one place to keep them safe

Nova Kane: Would create an endless pot of money so all young people could afford to fulfil their dreams

Captain America: Would convince everyone in all organisations how to work best with young people

HE-Man	**Would burn down organisations that don't work with young people in the right way.**
Wonder Woman	**Would talk to all young people to inspire them to fulfil their dreams. Would also fly them in their plane to help inspire them. Would lasso those people working in organisations who aren't working in the right way to show them the truth and show them how to work with young people.**

Choosing the best fit to the situation we then explored further:

Dr Strange	**Would use mind control to force people to work in the right way for young people and would create illusions so young peoples' dreams could be brought to life**

PARTICULAR ASPECTS OF SOLUTION

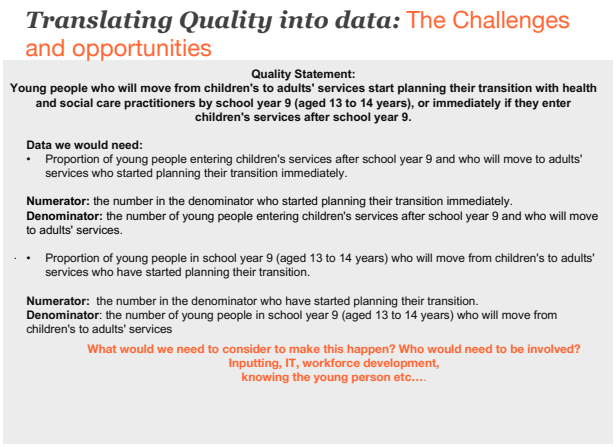
- Helps Young People See Their Dreams
- Convinces People How to Work
- We Need to Find Out Young People's Dreams.

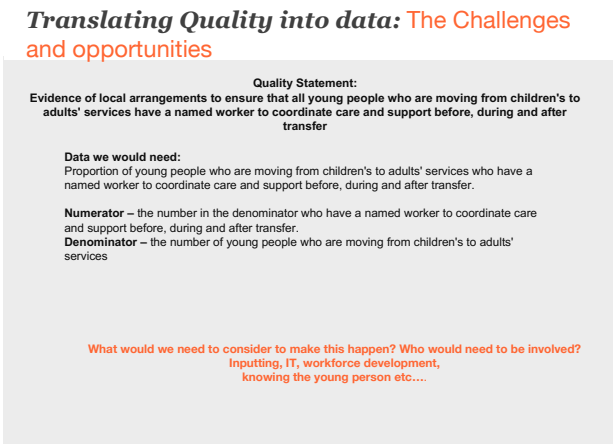
We then used convergence – capturing the novel element and made it useful:

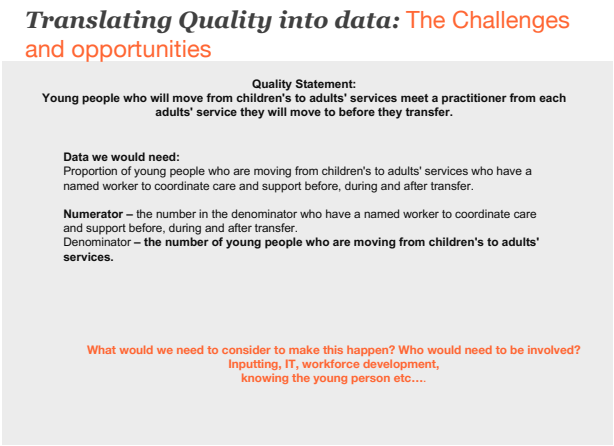
- Explore Nudge Theory to start taking organisations in the direction that is needed to best meet young people's needs. Consider this as part the communication strategy.
- Allowing Young People to keep a Dream Diary that is updated as they get older and is taken with them as they transition to adulthood.
- Young People having an individual profile that all organisations can use.
- The young person being given the expectation and responsibility to own their future
- Families/carers seen as more important in the transition process.

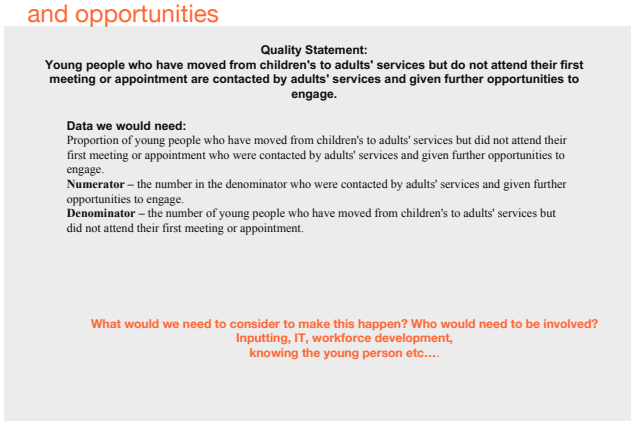
Data Session

We brought together data and performance staff from AfC and Adult Social Care to explore if we could develop underpinning data for the quality statements as well as ensuring better information, data and tracking in order to forecast future trends. Suggested data (numerator and denominator were provided for each quality statement).









The current tracker:

The Data on all 14-18 year olds is currently held by the SEND team.
There is a risk in that we may be missing some young people, for example those in the CAMHS team/ service who may not have a statement of educational need. Equally those who may have a physical health problem not impacting on education.

There are issues with data sharing and consent in terms of this. Previously there have been difficulties experienced when requesting data from CAMHS.

There was discussion about 'main presenting need', and if we could include secondary/ tertiary needs? But would this help to identify who may come through to Adults Services? AfC will send a list of definitions.

One solution put forward was to use person's NHS number to track children and young people through the various services and systems. NHS number however is not always currently recorded and there are further issues regarding data sharing and governance. GP info should be recorded so can be provided.

Finance (Children's) could provide current costings. There is capacity in the system for this but possible resource needed. Similarly, situation for adults' finance information.

Data about residential school placements could be automated. 'Additional health involvement' is not currently available. Some information on the tracker would require a Lead team/ worker to manually input.

Quality Statements

- AfC and ASC contract with Liquid Logic which may be an opportunity to integrate. However, SEND cohort not currently in spec for Liquid Logic.
- Can we bring SEND info in to ICS with aim of all using one system

Recommendations

- Map what data we have (what can be automated) and clarify what is missing/ absolutely essential
- Joint Data group to be establish and to meet in order to progress discussion.
- AfC to provide a list of definition for tracking purposes.

14- 19 Partnership Board

Stephan Brusch presented at the Partnership Board which is attended by Schools and Colleges commissioned in Kingston and Richmond. The draft Transition Pathway and Protocol was handed out and the Board was asked to consider a number of questions

Key Discussion Points:

Is there agreement what is being discussed at annual reviews to support transition?

No consensus of what is being discussed. General prompts would be useful. There is currently no connection to Adult Social Care

What happens to pupils without SEND or EHCP but who may require adult services? Pupils with mental health problems or physical disabilities?

Numbers for these cohorts are low but often require intense support, for example, from paediatric care to adult services.

Do school and colleges take on the Named Worker Role?

Schools work with the young person in coordinating between college, GP, nurses and social workers but are not named worker as such. Though it is acknowledged that schools often know the person best.

Schools were worried that there are no accountability measures in place should an external coordinator be put in the Named Worker Role. There has to be the structure in place for the coordinator linking in with the school.

Are schools supported by adult services about the local (adult) offer and care act requirements?

Participants stated that they have little access to information to adult services and what the offer and eligibility criteria are.

What is participation like at the Annual Reviews? Do people from children and adult services attend?

Schools responded that there are currently no representatives from adult services attending Annual Reviews. Schools are also unclear about what adult services are available, for example, support for young carers in finding out how to access specific support during transition.

Recommendation:

- A representative from the 14-19 Partnership Board to join the editorial group to ensure that the educational system is represented.
- Stephan to keep the Partnership Board informed of development

29th September 2017 Workshop

A smaller two-hour workshop was held for those individuals who were unable to attend the previous full day event. The pathway was handed out and participants had the opportunity to comment on the steps and add comments.

Key discussion points:

Useful to have a pathway depicted on one page
Need to align with what all children want at that stage, but acknowledging that some young people may need additional help
Align with the 'Ready Steady Go' programme that is used in Hospital to support transition.
Clarify the scope of organisations involved
Outline the quality aspect of transition plan, review and named worker role
Ensure that housing is integrated into the transition pathway
Strengthen Parents in their role
Focus on aspiration, resilience and well being
Acknowledge that some people may not access adult services (with capacity to choose not to)
Explore how to utilise social media or other tools to bring the pathway alive

Recommendation:

- Update the Pathway to incorporate comments
- Explore innovative way of bringing the pathway alive as part of the communication strategy
- Meet with Look After Children team to ensure that this is aligned

Final Comments

Given the ambition to ensure that the protocol takes account of many young people with varying needs across a number of organisations and services it is important to ensure that there is ownership and ratification by the relevant committees. As such a multi- agency editorial group will be established to ensure that there is cultural fit with the various organisations and services.

In principle is has been agreed that the SEND Partnership Board will have strategic oversight and ownership of the protocol and pathway and its implementation.

Throughout the document we used the 'making life journeys' logo and it is suggested that this will be utilised when we are talking about transition. This is so that people sign up to the vision of what we are trying to achieve.

The protocol and pathway by itself is not likely to improve the life chances of young people. It needs to be aligned to future commissioning and service reconfiguration to ensure that there is much more seamless and person-centred care. Kingston Coordinated Care (whilst not mentioned within this report) focusses on joint working for adults and will provide great learning how to ensure that this is equally applicable to young people going forwards.

We need to consider strong implementation and engagement through various channel to change behaviour across a number of organisations. This will require time and leadership.

Appendices

Appendix Organisation Participating in Development of Protocol and Pathway

Organisation involved in development		
Sector	**Organisation**	**Team**
Children Services	AFC	SEND
Adult Social Service	RBK	Learning Disability
Adult Social Service	RBK	Mental Health
Adult Social Service	RBK	Business Analyst
Children Services	AFC	Business Analyst
Children Services	AFC	Integrated Service for Children with Disability
Children Services	AFC	Looked After Children Team / Leaving Care Team
Children Services	AFC	14-19 Service
Community Mental Health	Adult Primary Care Mental Health	Candi
Housing	RBK	Housing Team
Parent and Carer	SEND Family Voice	SEND Family Voice
Kingston Hospital	Kingston NHS Hospital Trust	Paediatric unit
Safeguarding	Safeguarding Adults Board	Safeguarding Team
Leisure	RBK	Sport and Leisure Team
Voluntary Sector	Balance	Employment Service
Children Services	AfC	Local Offer
Participation	RBK	Involve
Participation	AfC	Integrated Service for Children with Disability
Education	RBK	Kingston Adult Education Children Services
Commissioning	RBK/CCG	All Age LD Commissioning
Children Services	Your Healthcare	Children SALT
Children Services	Your Healthcare	School Health
Children Services	Your Healthcare	Head of Children and Family Services
Children Services	Kingston Hospital	Paediatric Unit
Children Services	AfC	Community Paediatrician
Health	Your Healthcare	Neurodevelopmental Services
Voluntary Sector	KCIL	
Library	RBK	Kingston Library Service
Substance Misuse Commissioning	RBK	Substance Misuse Commissioning and Service Development Officer
Education	Schools and Colleges	Various Schools as part of 14-19 Partnership Board
Children Services	AfC	Executive team
Adult Social Service	RBK	Executive team
Public Health	RBK	Mental Health Lead

Appendix NICE Guidance Gap Analysis

Transition from children to adults' services for young people using health or social care services QS140 -Transition from children to adult services	
Implication for provider	**Evidence in Protocol (y/no)**
Overarching principles: Involvement developmental appropriate using person centred approaches	Statement on involvement but lack of mentioning of person centred approaches and developmental approach
Health and social care service managers in children's and adults' services should work together in an integrated way to ensure a smooth and gradual transition for young people. This work could involve, for example, developing: • a joint mission statement or vision for transition • jointly agreed and shared transition protocols, information-sharing protocols and approaches to practice.	Mission statement mentioned and Governance outlined Some key partners are missing (CCGs, Mental Health Trust, Your Healthcare)
Service managers in both adults' and children's services, across health, social care and education, should proactively identify and plan for young people in their locality with transition support needs.	Mentions tracker meeting, would benefit from a more strategic approach (e.g. it states what organisations are doing already rather than what proactively is being done)
Every service involved in supporting a young person should take responsibility for sharing safeguarding information with other organisations, in line with local information-sharing and confidentiality policies.	Safeguarding mentioned but not aligned to information sharing protocols
Check that the young person is registered with a GP. Consider ensuring the young person has a named GP.	No mentioning of GP registration
Ensure transition support is developmentally appropriate, taking into account the person's: • maturity • cognitive abilities • psychological status • needs in respect of long-term conditions • social and personal circumstances • caring responsibilities • communication needs.	Not explicitly
Young people who will move from children's to adults' services start planning their transition with health and social care practitioners by school year 9 (13-14) or immediately if they enter children services after school year 9	Work flow does not state that planning for transition is starting (only mentions tracking)
Start transition early for young people in out of authority placements	Not mentioned
Hold annual meeting to review transition planning, or more frequently if needed. Outcomes are shared (meeting involve all practitioner including GP, the person, family carer) it informs transition plan	Many annual reviews mentioned (EHCP for example) not clear if this is identified as a transition planning meeting. No mentioning of outcomes being shared or informing transition plan. What happens for people who transition but do not have EHCP
Young people who are moving from children to adult's services have a named worker to coordinate care and	No mentioning of named worker

support before, during and after transfer (specific responsibilities outlined in NICE guidance)	
Ensure transition support: • is strengths-based and focuses on what is positive and possible for the young person rather than on a pre-determined set of transition options • identifies the support available to the young person, which includes but is not limited to their family or carers.	Somehow mentioned
Involve young people and their carers in service design, delivery and evaluation related to transition	Not explicit but maybe should be in strategy or policy if there is one.
Building independence how to develop and sustain leisure and recreational networks information and signposting contact with peer support	Some mentioning but no links in protocol to Local Offer or other resources. unclear how this will happen
Involving parents and carers recognising young person preference regarding involvement taking into consideration MCA	No mentioning of MCA or preference around involvement
Support before transfer practitioner from relevant adult services meet the young person before they transfer contingency plan in place it the named worker leaves the position personal folder to share with adult services (has own quality standards)	Not mentioned
Information should be given to young people and their families about what to expect accessible describe the transition process describe support before and after transfer describe where they can get advice about benefits	Not mentioned
Policies and procedures are in place to ensure that there is a common understanding and clear pathway	Pathway in place. Unclear if there are policies in place and or other pathways.
Support after transfer Young people who have moved from children to adults' services but do not attend their first meeting or appointment are contacted by adult's services and give further opportunity to engage If young person does not engage with adult services the relevant provider should refer back to the named worker with clear guidance on re-referral this should trigger review of person-centred plan	Not mentioned
Ensure the young person sees the same healthcare practitioner in adults' services for the first two attendance after transfer	Not mentioned
Ensure the young person sees the same social worker throughout assessment and planning process until the first review of their care and support has been completed	Not mentioned
Ownership Each health and social care organisation in children and adult should nominate: a senior executive to be accountable for developing and publishing transition strategy, policy one senior manager to be accountable for implementing transition strategy and policy	No evidence of strategy or policy No evidence of CCGs (Richmond and Kingston), Southwest London and ST George 'Mental Health Trust and Your Healthcare endorsement of strategy

NICE Principle One

Involving young people and their parents or carers in service design by co-producing strategies with them asking them if the services helped them to achieve outcomes

Result: The weighted average was 4.5 with 17 participants rating this as very important.

Some participants felt that it was equally important to ensure that there was a joint understanding between services, the young person and their families of availability of resources and to manage expectations.

NICE Principle Two

Transition Support is developmental appropriate taking into account the person's maturity, cognitive abilities and psychological status needs in respect to long term conditions, social and personal circumstances, caring responsibilities, communication needs and potential safeguarding issues.

Result: The weighted average was 4.6 with 17 participants rating this as very important.

Some participants expressed concern about the 'mental age' of an individual versus the actual age. Others felt that as well as taking account of the developmental need consideration needed to be given to communication so that the person can make informed decisions.

NICE Principles Three

Ensure transition support: is strengths-based and focuses on what is positive and possible for the young person rather than on a pre-determined set of transition options identifies the support available to the young person, which includes but is not limited to their family or carers.

Result: The weighted average was 4.76 with 19 participants rating this as very important. Some participants highlighted that this should extend to focus on the informal networks that the person can access (Circle of Support) and what they can do before considering community, prevention and paid services. Other highlighted that there is a gap in adolescent services for young people with disabilities.

NICE Principles Four

Use person-centred approaches to ensure that transition support treats the young person as an equal partner and takes full account of their views and needs involves the young person and their family or carers, primary care practitioners and colleagues in education as appropriate. Supports the young person to make

decisions and build their confidence to direct their own care and support over time fully involves the young person in terms of the way it is planned, implemented and reviewed. Addresses all relevant outcomes including those related to: education and employment, community inclusion, health and wellbeing, including emotional health, independent living and housing options. Involves agreeing goals with the young person.

Result: The weighted average was 4.8 with 20 individuals stating that this was very important. Participants felt that that person-centred approaches are vital and should be embedded within services to understand people's aspirations, what's working well, or not working well. This supports understanding the needs as well as building resilience within families.

Quality Statement One

Young people who will move from children to adult services start planning their transition with health and social care practitioners by school year 9 (aged 13-14), or immediately if they enter children services after school year 9.

Result: The weighted average was 4.3 with 11individuals stating that this was very important. Some participants highlighted that long term planning needed to be part of transition for young people so to help them shape their future and ensuring the right services are involved at an early stage.

Quality Statement Two

Young people who will move from children's to adult services have an annual meeting to review transition planning.

Result: The weighted average was 4.56 with 16 individuals stating that this was very important. There was a mixed response regarding this question, some participant felt it should not be an annual meeting (with work need to happen throughout the year), others stating that some people may require more meetings and others less, for some young people this could be aligned to EHCP meeting or Team Around the Child. One person highlighted that from 17th Birthday it would be important to have adult representation.

Quality Statement Three

Young people who are moving from children's to adult services have a named worker to coordinate care and support before, during and after transfer.

Result: The weighted average was 4.48 with 15 individuals stating that this was very important. There was some concern expressed with this function as operational demand and financial constraints may make this difficult for services to take on. Support to families (which are likely to be more constant) is important due to changes in services. Other comments related to the named worker role in advocating for the young person.

Quality Statement Four

Young people who will move from children's to adult services meet a practitioner from each adult service they will move to before transfer.

Result: The weighted average was 3.96 and only 10 people felt that this was very important. Some people felt that it could be too confusing to meet a number of organisations, instead a named adult worker should act as liaison. Participants felt that it was more important to have a named worker rather than meeting adult facing services. Some highlighted the lack of service provision in adults such as for ADHAD or Autism.

Quality Statement Five

Young people who have moved from children's to adults' services but do not attend their first meeting or appointment are contacted by adults' services and given further opportunities to engage.

Result: The weighted average was 4.71. Some participants highlighted that some organisation were already proactive around DNAs. Factors such as MCA and consent and capacity also needed to be weight up. Other contacts to engage through other sectors (such as voluntary sector) could be enhanced. Learning the lessons why people did not attend was also important for future.

1. Ideal group size – 4-6 including the Problem Owner plus the facilitator.
2. The divergent process is then:
a. Hand out the Superheroes cards/descriptions – one each, and do not let people choose which one!
b. Each to read and digest their allocated superhero. Let them know that they will be brainstorming
as if they are the superhero – using some or all of the superhero capabilities.
c. Invite each to read out their superhero details. Let the energy start to flow!
d. Stress that the brainstormed ideas MUST solve the problem, and MUST use one or more of the superhero talents – ensuring that whatever is shared is indeed an "Intermediate Impossible".
e. Also stress that people can pinch other's talents, or invent ones of their own ... there are no rules about who can do what!
f. The brainstorm then commences. Try and get at least one intermediate impossible from each superhero. There will be a tendency for people to play safe – and you, as facilitator, need to encourage more outrageous thinking. None of this is real. The more provocative the idea, the better in terms of creativity at the next stage. Feel free to take an idea and develop it before writing it down e.g. "so you will kill all staff that oppose the change .... but how will you kill them, and when, and in front of who?". Push the detail – as the creative magic lies within this.
g. As already stated, attempt to get at least one great intermediate impossible per superhero.
Timescale: approx 15 mins
3. Then the convergent process:
a. Review all of the intermediate impossibles, and ask the team to identify the one or two (three max) stand-out candidate ideas – the ones that would definitely solve the problem, but that are also outrageously impossible. If people are able to "see where this one will go", then avoid it. Remember, we are trying to make the familiar unfamiliar.
b. Pick one of these candidates and write it on a fresh flipchart/whiteboard. Forget all else, but do remind people of the Problem as Understood.
c. Now the creative work really starts! Ask the question – why does this intermediate impossible solve the problem? What are the attributes of the idea that would fix the problem, and why? What is the "magic" within the idea – and how can it be expressed in more generic terms? It is this magic that must be retailed through the convergent process.
d. Beware: the temptation is for people to converge too quickly – to jump directly from an intermediate impossible to a "safe" idea. The facilitator must be aware of this, and try to hold back the convergence – spending time exploring the "magic" within the idea.
e. Gently allow judgment to come back on the table, but at all times keep the "magic". This is the origin of the creative outcome.
f. Aim for one concept to emerge from each intermediate impossible. As you converge, refer back to the problem owner to get a steer on what is exciting them, and what is not. Use them to navigate you through to a novel and useful concept – not necessarily a fully-fledged, fully defined, idea with i's dotted and t's crossed. You are looking to provide the problem owner with a fresh perspective. Aim to offer the problem owner 1 or 2 concepts only – then time to stop.

Appendix Resource List

At a glance 39: Challenging behaviour: a guide for family carers on getting the right support for teenagers
Building the Right Support (ADASS and NHS England 2015)
Care Act 2014: transition from children's to adults' services – key resources
Child and Adolescent Mental Health Services Transformation Strategy 2013-2020 (RBK and Kingston CCG)
From the Pond into the Sea (CQC 2014)

Joint Strategic Needs Assessment: Child Sexual Exploitation (RBK 2017)

Joint Strategic Needs Assessment: Children and Young People: Special Educational Needs and Disabilities (RBK 2017)
Joint Strategic Needs Assessment: Learning Disabilities (RBK 2016)
Joint Strategic Needs Assessment: Autism (RBK 2015)
Looked-after children and young people (NICE 2010)
Mental health service transitions for young people (Social Care Institute for Excellence)
Model Specification for Transitions from Child and Adolescent Mental Health Services (NHS England 2015)
SEND Education Review (AfC 2017)
Transition from children's to adults' services for young people using health or social care (NICE 2016)
Transition to Adult Care: Ready Steady Go (Southampton Children's Hospital)
TRANSITION PROTOCOL CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS) TO ADULT MENTAL HEALTH SERVICES (South West London and St. Georges 2015)