



Calderdale Transitions Framework for Professionals:

**Supporting Young People into Adulthood
in Health and Social Care**

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1. Introduction

Purpose of the Framework

This Framework sets out a shared understanding of how organisations and professionals across health, social care and education should support young people as they move from children's to adult services.

It is written specifically in relation to young people who are receiving specialist health and/or social care services in childhood who will continue to require a level of support in adulthood.

The Framework is written to assist organisations and professionals involved in delivering or commissioning services across local authorities, the NHS, education providers, and the wider system.

It provides a foundation for integrated, person-centred, and legally informed transition planning and delivery across the system.

It is intended to facilitate cooperation between organisations and to ensure young people and their families are kept well informed of what to expect during the transition process. This will help ensure that the transition into adulthood is smooth and straightforward for the young person and their family as well as the organisations involved.

Why Effective Transition Matters

Poorly managed transitions can result in disengagement, unmet needs, emotional distress, and avoidable crises.

A seamless transition promotes independence, stability, and well-being. It supports young people to achieve their aspirations in areas such as education, employment, relationships, and community participation.

2. Understanding the Transition Journey

Key Challenges

There have been a number of national reports into transitions published, which include:

- From the Pond into the Sea published in 2014 by CQC (on children's transition to adult health services)
- The Inbetweeners Report published in 2023 by NCEPOD (on the transition of children and young people with complex chronic health conditions into adult health services)
- Preparation for adulthood arrangements in local areas: a thematic review published in 2024 by CQC and OFSTED
- On the cliff edge: disabled young people and their journey to adulthood published in 2025 by Kids

These national reports highlight a number of key challenges around transitions, such as:

- Services for children and adults can differ significantly in eligibility, culture, and delivery models.
- Transition can be emotionally and practically difficult for young people and families.
- Planning is often delayed or inconsistent, with fragmented communication between agencies.

These can lead to young people and families having a poor experience during the transition period. They may experience:

- Feeling unprepared for the move to adult services
- Gaps in support when children's services end and adult services have not started
- Lack of information about what adult services exist
- Families and young people feeling excluded from planning

These challenges, if not appropriately addressed, can also result in longer term negative outcomes such as:

- Increased anxiety, loss of confidence, and difficulty accessing education or employment.
- Uncontrolled conditions leading to poor health outcomes on entering adulthood
- Reduced adherence to care and medication
- Increased emergency hospital visits and admissions
- Increased risk of multi-morbidity and potentially death
- Pressure on carer/ family
- Pressure on health system i.e. paediatrics, adult services, GP and ambulance services

- Impact on the emotional health and wellbeing of family who report feeling on 'a cliff edge'
- Negative impact on education, employment and life chances.

Core Concept

Transition is a process, not a single event linked to turning a specific age.

It should begin early, usually starting by age 14 (Year 9). Transition planning should start immediately if the young person enters children's services after the age of 14.

Transitions work involves supporting young people, and their families, as they move from children to adult services. Having a carefully planned and managed transition is crucial for ensuring that young people with ongoing health and/or social care needs receive appropriate and timely support and services as they grow older.

3. Legal and Policy Framework: Statutory Duties and National Guidance

Transition planning and delivery for young people moving into adulthood must comply with several key pieces of legislation, statutory guidance, and national best practice standards. This section consolidates those responsibilities in a detailed and accessible format for professionals across health, social care, and education.

3.1 Children and Families Act 2014

Link to Act: [Children and Families Act 2014](#)

The Children and Families Act 2014 introduced major reforms, particularly in the area of Special Educational Needs and Disabilities (SEND). Part 3 of the Act sets out key duties for local authorities and partners including health.

Key Duties:

- **Early Transition Planning:** Preparing for adulthood should start at the earliest opportunity and the Education Health and Care Plan process, including annual reviews, should include an element of transition planning from Year 9 onwards
- **Joint Commissioning:** Local Authorities and Integrated Care Boards (ICBs) must jointly commission services to meet the needs of children and young people with SEND.
- **Involvement in Decision-Making:** Children, young people, and parents must be given clear and appropriate information and be supported to participate as fully as possible in decision-making processes.
- **Independent Advice and Guidance:** Young people with SEND must have access to impartial careers and options advice.
- **Education, Health and Care Plans (EHCPs) must include a focus on outcomes that prepare for adulthood**, such as:
 - Employment
 - Independent living
 - Community participation
 - Health and well-being

Principles (Section 19):

Link to Section 19: [Children and Families Act 2014](#)

Local authorities, in carrying out their functions under the Act in relation to disabled children and young people and those with special educational needs (SEN), must have regard to:

- the views, wishes and feelings of the child or young person, and the child's parents

- the importance of the child or young person, and the child's parents, participating as fully as possible in decisions, and being provided with the information and support necessary to enable participation in those decisions
- the need to support the child or young person, and the child's parents, in order to facilitate the development of the child or young person and to help them achieve the best possible educational and other outcomes, preparing them effectively for adulthood.

3.2 Special Educational Needs and Disability Code of Practice

Link to Code of Practice: [SEND code of practice: 0 to 25 years - GOV.UK](#)

The Code of Practice explains the duties of local authorities, health bodies, schools and colleges to provide for those with special educational needs under part 3 of the Children and Families Act 2014.

Key elements

- Encourages coordinated planning between health, education, and care services.
- Promotes early identification and inclusive practices.
- Strong focus on preparing for adulthood throughout the EHCP.

3.3 Care Act 2014

Link to Statutory Guidance: [Care and support statutory guidance - GOV.UK](#)

The Care Act 2014 is the main legislation governing adult social care in England. It includes specific provisions for young people and carers approaching adulthood.

Key Duties:

- **Transition Assessment:** The local authority must carry out a transition assessment on a young person, young carer or an adult caring for a young person who is likely to have needs when they or the young person they are caring for turns 18, if the local authority considers there is significant benefit to the individual in doing so
- **Content of Assessment:** The local authority will need to consider the needs of the person, what needs they are likely to have when they or the child they care for turn 18, and the outcomes they want to achieve in life
- **Timing of Assessment:** Must be carried out early enough to ensure continuity of care and avoid a gap in provision
- **Advocacy Duty:** The local authority has a duty to provide advocacy to

people who have substantial difficulty in understanding, using or communicating information if those people do not have an appropriate person to support them and if they are taking part in certain defined processes, e.g. needs assessment, review of care and support plan etc.

Key Principles:

- Transition planning must be person-centred, outcome-focused, and proportionate.
- Services must work together to facilitate smooth transition and avoid duplication.
- Authorities must ensure that support continues during the transition until adult services are in place.

3.4 Mental Capacity Act 2005

Link to Mental Capacity Act Code of Practice: [Mental Capacity Act Code of Practice - GOV.UK](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/362222/Mental-Capacity-Act-Code-of-Practice-2017.pdf)

The Mental Capacity Act (MCA) applies to young people aged 16 and over. It governs how decisions are made on behalf of individuals who lack capacity to decide for themselves.

Most of the Act does not apply to children under the age of 16, with the exception of some functions of the Court of Protection and offences of ill treatment and neglect;

Most of the Act does apply to young people aged 16 – 17, although they cannot make some decisions covered by the Act, such as a Lasting Power of Attorney or some advance treatment decisions. There are additional requirements about consultation with family and carers for young people aged 16 – 17;

The Act applies to young people over the age of 18 (subject to the various restrictions and specific provisions within the Act itself)

Five Key Principles:

- 1: A person must be assumed to have capacity unless it is established that they lack capacity.
- 2: A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success.
- 3: A person is not to be treated as unable to make a decision merely because they make an unwise decision.

4: An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests.

5: Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive

Deprivation of Liberty Safeguards (DoLS):

- These do not apply to individuals under 18.
- For under-18s lacking capacity, consent may fall to someone with parental responsibility, but any significant restrictions may require court authorisation (especially under the Children Act 1989 or inherent jurisdiction of the High Court).

3.5 Children Act 1989 (Transition for Care Leavers)

The Children (Leaving Care) Act, 2000 amended the Children Act, 1989 Link to Legislation : [Children \(Leaving Care\) Act 2000](#)

The statutory guidance originally published in 2010, and since updated outlines the key responsibilities around transitions for those leaving care.

Link to Statutory Guidance: [Children Act 1989: transition to adulthood for care leavers - GOV.UK](#)

Volume 3 Guidance: Planning Transition to Adulthood for Care Leavers

This statutory guidance provides the framework for supporting young people leaving care, including care leavers with disabilities

Key Requirements:

- Agencies must understand each other's roles, responsibilities, and legal duties.
- Multi-agency protocols must be developed locally and cover:
 - Children's and adults' social care
 - Health (mental and physical)
 - Education and training
 - Housing and supported living
 - Employment and benefits advice
 - Youth offending and leisure services
- Strategic planning must be reflected in individual planning:
 - Pathway planning should be integrated with other transition planning frameworks (e.g., EHCPs, PfA pathways).
 - Plans should be reviewed and adapted to meet changing needs and aspirations.

3.6 Children and Social Work Act, 2017

Link to Act: [Children Act 1989: transition to adulthood for care leavers - GOV.UK](#)

The Children and Social Work Act, 2017 strengthens corporate parenting duties, and extends personal advisor support for young people leaving care up to 25 years old.

It also places a requirement on local authorities to assess and meet the ongoing needs of young people leaving care as they transition into adulthood.

3.7 NICE Guidance on Transitions

NG43 – Transition from Children’s to Adults’ Services (2016)

Link to Nice Guideline: [Overview | Transition from children’s to adults’ services for young people using health or social care services | Guidance | NICE](#)

Transition Planning for adulthood should begin from year 9 (age 13 or 14). A meeting should be held annually to include a review of transition planning, or more frequently if needed. The plan outcome should be shared with all those involved in delivering care to the young person.

The young person should be supported to identify a single practitioner – who should act as a 'named worker' – to co- ordinate their transition care and support.

Key principles:

- Involve young people and carers in service design, delivery and evaluation related to transition
- Use person-centred approaches to ensure that transition support meets the needs of individual young people and is developmentally appropriate
- 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
- Check that the young person is registered with a GP.

QS140 – Quality Standard on Transitions

Link to NICE Quality Standard: [Transition from children’s to adults’ services](#)

This includes five key quality statements:

Statement 1: 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 (aged 13 to 14 years), or immediately if they enter children's services after school year 9

Statement 2 Young people who will move from children's to adults' services have

a coordinated transition plan

Statement 3: Young people who will move from children's to adults' services have an annual meeting to include review of transition planning

Statement 4: Young people who are moving from children's to adults' services have a named worker or team to coordinate care and support before, during and after transfer

Statement 5: Young people who are moving from children's to adults' services meet a practitioner from each adults' service they will move to before they transfer.

3.8 Other Relevant Legislation and Guidance

Equality Act 2010

Link to Act: [Equality Act 2010](#)

- Services must make reasonable adjustments for disabled people.
- Promotes inclusive and accessible services.

Health and Social Care Act 2012

Link to Act: [Health and Social Care Act 2012](#)

- Encourages integration of health and care services to improve outcomes and efficiency.
- Reinforces the importance and positive impact of working with people and communities.

4. Safeguarding

Differences in Childrens and Adults Safeguarding Legislation

Safeguarding for those under 18 is governed primarily by the Children Act 1989 and related statutory guidance. Key features include:

- A duty on local authorities to protect children from significant harm.
- A broad focus on welfare and protection, responding to risks such as abuse, neglect, and exploitation.
- Proactive and holistic systems that recognise vulnerability as part of childhood development and prioritise early intervention.

When a young person turns 18, the legal framework in relation to safeguarding changes under the Care Act 2014:

- Adult safeguarding applies only where an individual:
 - Has care and support needs.
 - Is experiencing or at risk of abuse or neglect.
 - Is unable to protect themselves.
- This eligibility-based approach is narrower than child protection thresholds.
- The Care Act is underpinned by six principles:
 - Empowerment, Prevention, Proportionality, Protection, Partnership, Accountability.
- Making Safeguarding Personal - professionals should ensure that safeguarding responses are person-centred and outcome-focused.

Why Transitional Safeguarding Matters

- Many young people face a 'cliff edge' at 18, remaining at risk but falling outside adult safeguarding thresholds.
- Transitional Safeguarding bridges this gap by:
 - Recognising that harm and vulnerability do not stop at 18.
 - Promoting flexible, developmental, and contextual approaches.
 - Encouraging multi-agency cooperation and person-centred planning.

Transitional Safeguarding remains a developing area, but useful introductory information is contained in this Department of Health and Social Care document: [Bridging the gap: Transitional Safeguarding and the role of social work with adults](#).

Safeguarding as Part of Transition to Adult Services

Professionals should ensure that as part of the transition process:

- Any safeguarding risks identified during childhood are understood

- These risks are shared and considered in ongoing work.
- Where risks remain:
 - Recognise and understand them.
 - Mitigate them where possible, in line with Care Act principles of proportionality and prevention.
- Work with the young person to:
 - Agree how risks will be managed.
 - Keep safeguarding responses personalised and outcome focused.

5. Calderdale's Key Standards and Core Principles for Transition

Key Standards:

Based on feedback from young people, families, and professionals—and in line with national and local priorities—we have identified these key standards and core principles for Transition. We want all services in Calderdale to adhere to these key standards when supporting young people through transition in order that the young person's and family experience is smooth, predictable and supportive:

1. **Person-centred and trauma-informed planning:** Planning should focus on what matters to the young person and be sensitive to their life experiences.
2. **Joined-up support:** All services should work together to make sure support is connected and clear.
3. **Early and ongoing planning:** Planning should begin early (ideally by the age of 13-14 i.e. Year 9) and continue until the transition is complete.
4. **Right support at the right time:** Young people should get support that meets their needs and helps them reach their goals.
5. **Clear information:** Young people and their families should easily get the information they need to understand their options.
6. **Support for families and carers:** Families and carers also need advice, guidance, and emotional support during transitions

Core Principles:

Additionally, supporting these key standards, in the Calderdale system, transition planning should be guided by the following principles:

- a. Transition is a process, not a single action. Transition begins as early as needed, usually from age 13-14 years, and is completed when the young person concerned is safely and successfully established in adult services.
- b. Transition is something that young people do, not something that is done to them. All processes will be person-centred, developmentally appropriate and enable young people to participate in planning and decision making in the way that is right for that particular young person.

- c. Appropriate support will be offered where needed to enable young people to participate in the ways that are right for them. Options considered will include peer support, coaching, advocacy etc. Partners will use appropriate communication tools to support this participation. Reasonable adjustments should always be considered to reduce health inequalities and ensure young people are able to fully engage with the service offer.
- d. Transition will build on each young person's unique strengths, resilience and aspirations; it focuses on what is positive and possible for the young person rather than on a predetermined set of transition options.
- e. Where it is likely that a care leaver will require continuing support from adult services, a formal referral will be made as early as possible from age 16, so that eligibility for this support is established in time for their 18th birthday. This should be a significant level of support particularly where a young person has accommodation needs.
- f. Young people and their families deserve honesty and respect. Where there are limits to what they can expect to receive, they will know well in advance what those limits are.
- g. Transition planning by all partners will be mindful of the impact on budgets for all organisations, and realistic in its goals.
- h. Transition planning will involve the young person, their family, carers, and relevant practitioners from health, education and social care.
- i. It is important to involve multiple stakeholders, including families, educators, employers, and community organisations, to create a supportive network for youth.

Service managers in both adults' and children's services, across health, social care and education, will proactively identify and plan for young people in their locality with transition support needs.

This structured approach allows young people to build confidence and gradually take on more responsibility for managing their own care.

There are three key stages in the transition profile:

| | | | |
|-------|---------------|--------------|--------------|
| Stage | 1.Preparation | 2.Transition | 3.Adjustment |
|-------|---------------|--------------|--------------|

| Age | 13-17 | 17-19 | 19-25 |
|--------------------------------------|---|---|---|
| What Happens | <ul style="list-style-type: none"> • Preliminary evaluation* • Managing expectations • Developing options • Putting plans in place • Awareness of services • Understanding all needs • Agreeing outcomes, including those related to employment, community inclusion, health and physical /emotional wellbeing and independent living • Deciding on goals • Building resilience • Putting exit strategy in place and starting to deliver • Financial Planning • Mental Health Capacity • Voice of the Young Person | <ul style="list-style-type: none"> • Assessment for adult services • Delivering the exit strategy • Handover sessions • Meeting the new team, if any • Trying out new services and options • Saying goodbye to old relationships • Reviewing the plan for the future • Financial Planning including assessment and ensuring that young people and families are aware of charging in AHSC • Voice of the Young person • Assessment of ability to self- manage confidence and readiness for adult services. | <ul style="list-style-type: none"> • Accessing adult services where relevant • Building new relationships • Building resilience • Reviewing the plan for the future • Financial Planning • Voice of the Young person. |
| Who is most likely to take the lead? | Key worker(children's services including health, education and social care); Young person Family | Key worker (adults or children's services); joint planning where appropriate; Young person Family | Young person; Family Key worker (if there is one) from adults' services |

*The preliminary evaluation (preparation stage) can be informal and a natural part of ongoing assessment and planning. It may include the use of tools e.g. Ready, Steady, Go! It is the point at which professionals, families, parents, carers and most importantly young people start to discuss the overall direction of travel for that young person's move into adulthood. No firm decisions are made or options ruled out, but there is a discussion and documentation of the likely options and outcomes, based on the young person's strengths, ambitions, preferences and resilience.

These key stages will be reflected in all services working with young people during transition engaging in:

- **Early Identification** (by Year 9): All services proactively identify young people who may require transition support.
- **Holistic Assessments:** Covering education, health, care, emotional well-being, employment, safeguarding and independent living.
- **Transition Plans:** Reviewed annually (or more frequently if needed), aligned with EHCPs where applicable.
- **Multi-Agency Coordination:** Shared planning, joint meetings, and clear handover protocols.
- **Information Sharing:** Informed by the Calderdale Information Sharing Protocol, reducing repetition and ensuring accuracy.

Services are expected to develop operational protocols which outline how they will align with these key elements and ensure adherence to the principles.

6. Roles and Responsibilities

Young People and Families

- Central to all planning and decision-making.
- Should receive clear, accessible information and be supported to participate.

Children's Services Practitioners (Health and Social Care)

- Initiate early planning, ensuring young people and families have the information they need and are supported to be involved
- Coordinate assessments and input to EHCPs.
- Link with adult services to ensure information is passed on and is clearly understood, including review/ update of plans e.g. Individual Health Care Plan (IHCP) where appropriate.

Adult Services Teams (Health and Social Care)

- Engage early to assess eligibility and support needs.
- Prepare to receive young people smoothly.
- Ensure young people and families have the information they need with regards their move to adult services.
- Ensure continuity and integration of support.

Transition Coordinators/ Named Worker or team (in line with NICE NG43 Guidance)

- Provide continuity throughout the transition.
- Coordinate professionals and track progress against plans.

Education Providers

- Support development of life skills and aspirations.
- Contribute to multi-agency planning meetings.
- Plan and co-ordinate annual review meetings where appropriate, ensuring young people, families and relevant practitioners are involved.

7. Quality and Improvement

It is important to establish clear metrics for assessing the effectiveness of transition programs and intervention, ensuring that they meet the desired outcomes for young people.

Organisations planning Transition pathways may wish to consider the following approaches to support quality assurance and improvement:

Case File Audits

Regularly review a sample of transition cases across services to audit themselves against this framework, including:

- Timeliness of planning (e.g., was planning initiated by age 14?)
- Involvement of young people and families
- Clarity of handover and communication between services
- Use of multi-agency reviews to assess the effectiveness of joint working

Feedback Mechanisms from Young People and Families

Collect structured feedback before, during, and after transition to understand lived experiences. Ensure that any feedback informs service improvement. For example use:

- Surveys
- Interviews or focus groups
- Feedback forms built into transition reviews.

Follow the Rules of Engagement as agreed in Calderdale's Children and Young People's Voice and Influence Strategy (VoCalderdale) including the '**doing with us, not to us**' approach.

Multi-Agency Transition Review Panels

Set up periodic panels to:

- Review complex or high-risk transitions
- Monitor adherence to the framework and strategy
- Identify cross-agency learning and system issues
This promotes accountability and continuous improvement.

Performance Metrics and Dashboards

Develop key indicators to monitor transition quality, such as:

- % of young people with a completed transition plan by a set age
- Attendance at joint planning meetings

- Service engagement 6 months post-transition
- % of young people and families reporting a good transition experience
- Regularly report and share findings across teams.

Supervision and Reflective Practice

Embed transition planning into professional supervision sessions. Encourage:

- Reflective discussions on complex cases
- Use of learning from audits and feedback
- Cross-service shadowing or joint training

Joint Training and Shadowing:

Promote a multi-agency approach to build understanding and collaboration, including colleagues across West Yorkshire.

Competency Frameworks

Defining what “good” looks like in transition support roles and across the workforce.

Ensure job descriptions and roles and responsibilities are clear and inclusive of supporting transition.

Learning from Practice

Using case studies and local examples to share learning and innovation at relevant opportunities.

Ensure feedback, including review of the young person and family journey, influences change where appropriate.

8. Conclusion and Commitments

Partners across the health and social care system commit to:

- Starting transition planning early in Year 9 and continuing supporting people into adulthood through to age 25.
- Empowering young people and families to co-produce their transition journeys.
- Working jointly and transparently across children and adult services and sectors.
- Monitoring and improving transition processes to ensure all young people are supported to thrive in adulthood.