



Transition Planning

In

Derbyshire

**PATHWAYS AND PERSON-CENTRED
APPROACHES**

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An example of a transition plan

Foreword

There are many transitional periods in the life journey, but the changes between childhood, adolescence and adulthood are particularly difficult requiring extra thought, planning and support. It is during this time that the map of future life is shaped, particularly in relation to those members of society who have special needs.

It is important for all concerned to work together to support the young person during this often anxious and confusing transitional period. Together with the young person, statutory, voluntary and independent providers can create a plan and identify the factors required to make it happen. The combined knowledge of the group provides information and guidance to inform the young person of choices available to them. By listening to the young person's aspirations and matching those to the information and resources available, we can enrich the young person's life experiences and help build a solid foundation for adulthood.

Parents often feel additional pressure and anxiety at this time as their son or daughter leaves their school placement. Or maybe they can't identify just the right setting or course and need extra guidance and reassurance.

Partnerships between the young person, their carers, Connexions, the Local Authority, voluntary and independent representatives can only strengthen the planning and organisation required to assist the young person achieve their goals, whether in further education, training, apprenticeship, employment or independent living.

For those with special needs, a greater choice is becoming available through direct payments, individual budgets and other options. It is in everyone's best interests for all the knowledge, aspirations and skills to be brought together through effective transition planning and I encourage those with an involvement in the process in Derbyshire to use this guidance as their reference point.

Margaret Reeve
Derbyshire Autism Services Group and member of the group which has produced this guidance.
February 2011

Introduction

In 2002 Derbyshire published Transition Planning Procedures. This guidance updates those procedures and takes into account changing legislation and policy. It also provides a clear, strategic, multi-agency protocol on how local services should work to meet the needs of a young person with special educational needs and disabilities in their transition to adulthood, thereby ensuring the maximum effectiveness of local support.

Who this document is for

This document has been developed for use by those supporting young people as they move into adult life and, where appropriate, engage with adult services. The young people this document is aimed at are those that will benefit from a multi-agency approach as they move from children's to adult services. The young people may or may not have had a Statement of Special Educational Needs.

This document sets out one basic model, with key principles that should be adopted for all young people with special educational needs and disabilities ("Pathway A"). However, it is recognised that a much smaller number of young people with severe and complex disabilities will require a more co-ordinated and intensive approach ("Pathway B").

Criteria

The young people will be

- ⇒ 14 to 25 years of age
- ⇒ identified as having learning difficulties and /or disabilities
- ⇒ require a multi-agency approach to support the transition process
- ⇒ need support to access universal services
- ⇒ require specialist support into adulthood

and may have a Statement of special educational needs (SEN) or be at School Action Plus (SA+) in relation to the SEN Code of Practice. Where a young person is at **SA+** and fulfils the requirements set out above (see bulleted points), the same transition planning process will apply as for a young person with a Statement of SEN. Please refer to examples in appendix 1.

Young people will require a more intensive and co-ordinated approach to transition (Pathway B) if they have identified severe learning difficulties and/or disabilities (around 1.2% of each cohort). This group of young people will all have either a Statement of Special Educational Needs or very complex health needs. It will include all young people who are eligible for continuing care. Please refer to examples in appendix 1.

Information gathering

This guidance builds upon, and enhances, the statutory SEN transition review process. Where a young person attends school, the school is expected to take the lead in organising the annual review. Where a young person attends college, the college would be expected to lead.

For a young person with a **Statement of SEN**, information will be held, and updated as appropriate, by the school they attend. If a young person is Educated Otherwise than at School, the information will be co-ordinated by the local authority (LA).

However, young people with special educational needs and disabilities are likely to receive services and support from a number of different agencies. Transition reviews should be holistic, and should draw upon key information and assessments held by other agencies. The school or college should seek to identify which agencies are supporting a young person and to share information where appropriate.

Key Workers

A young person will be encouraged from within their circle of support to identify a key worker to support them through the transition process.

A key worker may have different functions in different circumstances, and the role may include some or all of the following functions:

- helping the young person and parent or carer to get good information about their child's strengths and needs and the services and resources available to help them
- helping the young person understand the information provided
- signposting and helping the young person to access all relevant support
- listening to and offering emotional support to the young person
- supporting the young person in organising appointments and with home visits
- encouraging and enabling services to be provided in a joined up way for the young person.

Those young people with severe learning difficulties or disabilities, who require a more intensive and co-ordinated approach (Pathway B), should all have a lead professional during transition. It would be the role of the lead professional to:

- Help the young person think about what is working/not working; their strengths and support needs
- Help the young person think about future goals and ambitions
- Help the young person and family identify what may be possible (a) now and (b) in the future
- Identify the services and resources available to support the family during transition
- Help the young person and their family understand the information which is available
- Encourage and enable a coherent package of support to be provided for the young person
- Write up the Transition Plan and monitor its implementation. They may also lead person-centred planning with the young person and their family

For most young people, their parents or carers are often at the heart of brokering support services and communicating their needs to a range of agencies. They act in a "key worker" role and are the main support to their children. Their views and full participation are therefore essential during transition.

Although it is important to engage with the young person separately from their parents or carers when seeking his or her views and wishes, parents, carers, siblings and other significant people need to be at the heart of the planning process. In order to participate at all levels, parents and carers require information before meetings, access to information on local resources and support from identified professionals.

Principles/Vision

Derbyshire adheres to the following principles and expects all those involved in the transition process to work towards a process which is:

- Person-centred – involving the young person in a meaningful way because their views and aspirations are central to the process
- Holistic – a young person’s aspirations and needs will touch on every aspect of their future lives and hence there must be an holistic approach to planning and providing support
- Supportive – the main purpose of the statutory transition and annual review processes is to support the young person, their parents and the professionals who work with them in the process of making decisions about the next stage of their lives
- Evolutionary – the year 9 review and the leaving school stages are just the first steps in the transition of a young person towards adulthood. They are part of a much longer and gradually evolving process
- Inclusive – schools need to ensure that their careers education and guidance programmes form part of the transition planning process and meet the requirements of all pupils
- Collaborative – effective transition planning requires teaching staff, parents/carers and staff from all agencies to work closely together
- Streamlined – wherever possible person-centred transition planning should encompass and fulfil the requirements for other plans and reviews. From Year 9, it should fulfil the requirement for an annual SEN transition review. It should also fulfil or provide the starting point for other plans and reviews such as a review of the care plan for children in care; a joint health/social care plan for people with a long term condition; annual review of the child in need plan; health action plan and personal/individual budgets support plan

Through the process, consideration must be given to the 5 outcomes of “Help Children Achieve More” which are:

- be healthy
- stay safe
- enjoy and achieve
- make a positive contribution
- achieve economic well-being

Transition Planning

Legislation

All agencies have a responsibility to work together to facilitate the transition process so that it is as smooth as possible for the young person and the family. The legislative requirements are detailed in Government guidance found on the Department for Education and Health websites and detailed information can be found on www.transitionsupportprogramme.org.uk.

The Process

The transition review process must be effectively implemented. Having a review, that leads to a transition plan that clearly sets out the wishes and aspirations of an individual young person as well as the support that they need, is a highly effective tool. The process in itself is meaningless if the actions agreed are not followed up.

The Transition Plan

The transition plan needs to be an active document. It should be person-centred, with the young person at the centre of its development and implementation. The plan should set out the commitment each agency has made, and how and when the support will be delivered. For example it should inform

- curriculum planning to help young person with a range of needs to achieve in school and prepare for choices afterwards
- planning for access to health services beyond those related directly to a young person's disability, for example, contraception, advice on healthy eating etc
- planning for further education
- planning to acquire the skills, services or support that will be needed for adult life.

An example of a Transition Plan based on the 5 outcomes for "Help Children Achieve More" is given at Appendix 2, although person-centred plans can be done in a range of formats. Further resources to support person-centred planning will be developed in 2011-12, along with a template for feedback to inform commissioning.

Organisation and Preparation for the Transition Review

The organisation of and preparation for review meetings should be centred on the young person's needs and how they will be supported to participate fully in the review process. For example, the meeting co-ordinator should find out where and when the young person would like to meet, who they would like to be present and how they would like to communicate their views. For families, the meeting format, style and timing need to be organised so they feel confident about contributing.

For young people with the most complex needs (Pathway B), the lead professional should visit the family to explain the transition process, give the family a transition information pack and establish how they want transition to work for them.

Person-Centred Approaches in Transition Reviews

Transition reviews need to be carried out in a person-centred way. In using a person centred approach, professionals can support a young person to express what they would like to happen in the future, on their terms. For the purposes of the formal transition review process, this means putting the young person at the centre of the process. They should not only be invited to the meeting but their plans, ambitions and worries should form the focal point of it.

For the transition process to be truly person-centred, a young person must have access to information that helps them understand what happens at transition, how to participate in the planning process, and how to make informed decisions about their future.

There is a set of 5 principles that underpin the person-centred approach:

1. *The person is at the centre*

Person-centred approaches are rooted in the principles of shared power and self-determination. Built into the process of person-centred approaches are a number of specific features designed to shift the locus of power and control towards the person. Simple, practical examples of this are:

- as far as possible the person is consulted throughout the planning process
- the person chooses who to involve in the process
- the person chooses the setting and timings of the meetings.

2. *Family members and friends are partners in planning*

Person-centred approaches take into account the context of a person's family and community. It is therefore not just the person themselves that we seek to share power with, but also their family, friends and other people from the community who the person has invited to become involved. Person-centred approaches start from the assumption that families want to make a positive contribution and have the best interests of the person at heart, even if they understand those best interests differently from other people.

3. *The plan reflects what is important to the person (now or for the future), their capacities, and what support they require.*

In using a person-centred approach we seek to develop a better, shared understanding of the person and their situation. The planning process can be powerful – people's views change, new possibilities emerge, alliances are created, support is recruited, and energy is gathered and focussed. The resulting person-centred plan will describe what is important to the person, their aspirations and the support that they require.

4. *The plan helps build the person's place in the community and helps the community to welcome them. It is not just about services; it reflects what is possible, not just what is available.*

The focus of person-centred approaches is about getting a shared commitment to actions that have a bias towards inclusion. In this context, services are only part of what people

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want and need; planning what services you need comes after planning what sort of a life you want.

- 5. The plan results in ongoing listening, learning and action. Putting the plan into action helps the person to achieve what they want out of life.*

Person-centred approaches are not a one-off event. They are based on the assumption that people have futures, that their aspirations will change and grow with their experiences, and that the pattern of support and services that are agreed now will therefore not work forever. Person-centred approaches are a promise to people based on learning through shared action, about finding creative solutions rather than fitting people into boxes. They are about problem solving and working together over time to create change in the young person's life, in the community and in organisations. To fulfil this promise, it is necessary to reflect on successes and failures, try new things and learn from them and negotiate, and resolve conflict together.

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Pathways

Pathways lay out the steps involved in transition and show who is involved at each stage and what the options may be at each stage. They are useful as they show clearly what the steps are and who has responsibility. They make what is a complicated process look manageable and comprehensible.

PATHWAY A: Transition Planning for all young people with Statements or at School Action Plus who require a multi-agency approach to transition

School Year	Actions	Responsibility	Time Frame
Year 8 12 -13 years	<p>Agree whether multi-agency approach to transition required in Year 8 review</p> <p>Consider/identify key worker</p> <p>Multi-agency meeting to identify all young people with a Statement of SEN or at School Action Plus who require a multi-agency approach to transition</p>	<p>School</p> <p>School/young person</p> <p>Local Authority convenes meeting with input from Health, Social Care, Education, Connexions</p>	July
Year 9 13 -14 years	<p>Information pack sent to young person and parents/carers</p> <p>Person-centred transition planning meeting held. School or key worker writes notes of meeting and develops person-centred plan with actions. Young person/family referred to further sources of information and advice. School responsible for monitoring delivery of plan.</p> <p>Connexions inform College(s) of estimated numbers and levels of needs of young people to access further education provision at year 12.</p>	<p>School</p> <p>School to invite the following if appropriate – taking account of young person's / family's views:</p> <ul style="list-style-type: none"> • Young Person (YP) • Parent/carer • Connexions • Education (LA - SEN) • Educational Psychologist <p>Also if appropriate to the needs of the YP</p> <ul style="list-style-type: none"> • Social Care • Health <p>Should involve minimum necessary number of people</p>	As early in Year 9 as possible
Year 10 14 -15 years	<p>Hold person-centred transition review meeting / update Transition Plan</p>	<p>School to convene and issue invitations (as per Year 9 above). Connexions or key worker to monitor delivery.</p>	Within Year 10

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School Year	Actions	Responsibility	Time Frame
	<p>Individual young people will also be raised at the Transition Panels organised by the Disabled Children's Teams (Social Care) in the north or south of the county depending on where the young person lives. (If parents don't want a service from social care until their child is 18, CAYA will advise on the importance of assessment & planning pre-18. If parents still don't want an assessment CAYA will add an initial contact record with as much information as possible about the young person within that initial contact for panel and note that parents may request assessment post 18. CAYA will also complete a transition episode for young people aged 16+ at the point of the initial contact and pass it through to the appropriate adult area team.)</p> <p>College staff visit school</p> <p>Young person visits college regularly with school teaching staff</p>	Children's / Adult Care (all teams).	
Year 11 15 – 16 years	<p>Hold person-centred transition review meeting / update Transition Plan. Consider assessment against adult continuing healthcare and adult social care criteria at age 16, if relevant</p> <p>If leaving school notify</p> <ul style="list-style-type: none"> • Children's Social Care • Health <p>Learning Difficulty Assessment – LDA (formally the Section 139a) completed if needed,</p>	<p>School to convene and issue invitations (as per Year 9 above).</p> <p>Connexions</p>	Before the end of March

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School Year	Actions	Responsibility	Time Frame
	building on person-centred planning already done. Compulsory for all young persons in their final year of schooling with a Statement and then any others who meet the requirements (see page 4).		
Year 12 16 – 17 years	<p>Hold person-centred transition review meeting / update Transition Plan.</p> <p>Individual young people will be raised at the Transition Panels convened by social care in the north or south of the county depending on where the young person lives</p> <p>If required Adult Care to attend transition review; assess against adult social care criteria; produce indicative budget by age 17 and begin co-working with appropriate children's worker.</p> <p>LDA completed for those in final year of schooling.</p> <p>College carries out assessment</p> <p>College offers a place</p> <p>Place agreed</p> <p>LA ceases Statement</p>	<p>School/college or key worker with all relevant service staff, the young person and parents/carers</p> <p>Children's / Adult Care. Follow procedures above (see Yr 10) where parents don't want a service from children's social care but may want a service at 18+.</p> <p>Adult Social Care</p> <p>Connexions</p>	<p>October – December</p> <p>March</p>
Year 13 17 -18 years	<p>Hold person-centred transition review meeting / update Transition Plan</p> <p>Prior to leaving school notify</p> <ul style="list-style-type: none"> • Adult Care • Health <p>LDA completed for those in final</p>	<p>School/college or key worker with all relevant service staff, the young person and parents/carers</p> <p>Connexions</p>	

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School Year	Actions	Responsibility	Time Frame
	year of schooling Arrangements for handing over responsibility from children's to adult services agreed	All children's / adult services	
Year 14 18 – 19 years	Hold person-centred transition review meeting / update Transition Plan Prior to leaving school notify <ul style="list-style-type: none"> • Adult Social Care • Health professionals LDA completed for those in their final year of schooling	School or key worker with all relevant service staff, the young person and parents/carers Connexions	

PATHWAY B: Multi-agency transition planning for young people with severe or complex learning difficulties or disabilities

School Year	Actions	Responsibility	Time frame
Year 8 12 -13 years	Young people eligible for this pathway identified at Year 8 review of SEN statement Lead professional identified Multi-agency meeting to identify all young people potentially eligible for the pathway	School School/young person Local Authority convenes meeting – with input from Health, Social Care, Education, Connexions	July
Year 9 13 -14 years	Information pack sent to young person and parents/carers Lead professional meets young person/family to explain transition process and establish preferences. Introduce to advocacy services Person-centred transition planning meeting held. Lead professional or young person/family writes notes of	Lead professional Lead professional School to convene and invite the following if appropriate – taking account of young person's / family's views:	As early in Year 9 as possible

School Year	Actions	Responsibility	Time frame
	<p>meeting and develops person-centred plan with actions.</p> <p>Lead professional monitors delivery of actions set out in plan and starts to refer to further sources of information and advice.</p> <p>Adult services alerted / GP sent information if very complex needs/high cost</p> <p>Liaison with CAYA /Health commissioners to confirm any new resource commitments</p> <p>Connexions inform College(s) of estimated numbers and levels of needs of young people to access further education provision at year 12.</p>	<ul style="list-style-type: none"> • Young Person (YP) • Parent/carer • Lead professional • Connexions • Education (LA - SEN) • Educational Psychologist <p>Also if appropriate to the needs of the YP</p> <ul style="list-style-type: none"> • Social Care • Health <p>Should be minimum necessary number of people</p> <p>Named Health transition lead from specialist health service provider to be engaged from Yr 9 to ensure robust multi agency working and contribute to planning of services needed in adulthood, though may not necessarily attend meeting. Health transition lead to liaise with all key health professionals</p>	
<p>Year 10</p> <p>14 -15 years</p>	<p>Hold person-centred transition review meeting / update Transition Plan</p> <p>Individual young people will also be raised at the Transition Panels organised by the Disabled Children's Teams (Social Care) in the north or south of the county depending on where the young person lives. (If parents don't want a service from social care until their child is 18, CAYA will advise on the importance of assessment & planning pre-18. If parents still don't want an assessment CAYA will add an initial contact record with as much information as possible about the young person within that initial contact for panel and</p>	<p>School to convene and issue invitations (as per Year 9 above). Lead professional responsible for monitoring delivery of plan.</p> <p>Children's / Adult Care (all teams).</p>	<p>Within Year 10</p>

School Year	Actions	Responsibility	Time frame
	<p>note that parents may request assessment post 18. CAYA will also complete a transition episode for young people aged 16+ at the point of the initial contact and pass it through to the appropriate adult area team.)</p> <p>College staff visit school</p> <p>Young person visits college regularly with school teaching staff</p>		
<p>Year 11</p> <p>15 – 16 years</p>	<p>Hold person-centred transition review meeting / update Transition Plan.</p> <p>Referral for adult continuing healthcare assessment and assessment against adult social care criteria at age 16, if necessary</p> <p>Arrange benefits check</p> <p>If leaving school notify</p> <ul style="list-style-type: none"> • Children’s Social Care • Health <p>Identify who the young person’s lead professional will be when they leave school.</p>	<p>School to convene and issue invitations (as per Year 9 above). Adult services attend reviews from Yr 11 onwards for most complex cases. GP or nominated rep also invited to attend review from Yr 11 where relevant and sent notes/action plan as routine for information. Health transition lead aware and involved in Health Action Planning.</p> <p>Lead Professional refers to adult service(s) as appropriate, following annual review.</p> <p>Lead Professional</p> <p>Lead Professional</p>	<p>Before the end of March</p>

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School Year	Actions	Responsibility	Time frame
	Learning Difficulty Assessment – LDA (formally the Section 139a) completed if needed, building on person-centred planning already done. Compulsory for all young persons in their final year of schooling with a Statement and then any others who meet the requirements (see page 4).	Connexions	
Year 12 16 – 17 years	<p>Hold person-centred transition review meeting / update Transition Plan. Important that opportunities within Derbyshire are identified as preferred option with a clear understanding of what care and support could be available, as well as opportunities for out-of-authority placements. Where out-of-authority education placements are agreed there should be consideration of shared funding where placement partially meets health and social care needs</p> <p>Allocation of additional resources to be agreed with Adult health & social care commissioners (and Adult Finance notified)</p> <p>Health transition lead to co-ordinate all health care planning pathways to adult health care services. GP to receive updated Health Action plan and outline of funding model.</p> <p>Offer Direct Payments in own right if appropriate & in line with assessed need</p> <p>Identify key worker(s) in each adult service and overall lead.</p>	<p>School to convene and issue invitations, as per Yr 11 above.</p> <p>Lead professional / Adult Social Care/Health</p> <p>Health transition lead</p> <p>Children’s Social Care</p> <p>Adult services</p>	<p>Age 16</p> <p>Age 16</p>

School Year	Actions	Responsibility	Time frame
	Individual Benefits Maximisation	Key worker (Adult Care)	
	Adult Social Care begin co-working and explore actively accommodation, support, care, funding options (etc) which support the YP's choices	Key worker (Adult Care)	At 16 ½
	Carer's assessment carried out if needed (for carer of young person) and copied to GP	Key worker (Adult Care)	At 16 ½
	Adult Social Care to identify likely support plan and indicative budget by 17 th birthday.	Key worker (Adult Care)	By 17
	Eligibility for adult continuing health care confirmed by 17 th birthday (if relevant).	Key worker (Health)	By 17
	Refer to Brokerage – to identify potential Adult Social Care service providers. Adult support package planned	Key worker (Adult Care)	At 17
	Adult Social Care and health service support package finalised/confirmed	Adult Social Care / Health	By 17 ½
Year 13 17-18 years	Hold person-centred transition review meeting / update Transition Plan. Formal hand over from children's to adult services at 18 – adult support package implemented	School or college (if young person attending) otherwise Lead Professional jointly with adult key worker All services. Health transition lead to co-ordinate care planning with wider specialist health care colleagues	At age 18
Year 14 18-19 years	Hold person-centred transition review meeting / update Transition Plan. GP invited to attend annual review meetings and reports sent to GP routinely. Benefits Maximisation	Adult Key Worker	

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School Year	Actions	Responsibility	Time frame
Age 20-21	Hold person-centred transition review meeting / update Transition Plan. Review need for ongoing Connexions services and After Care.	Adult Key Worker	
Age 21-22	Hold person-centred transition review meeting / update Transition Plan.	Adult Key Worker	
Age 22-23	Hold person-centred transition review meeting / update Transition Plan.	Adult Key Worker	
Age 24-25	Hold person-centred transition review meeting / update Transition Plan.	Adult Key Worker Connexions and After Care advisors cease involvement.	
Age 25+	End of transition period		

Roles and responsibilities

Young Person	Parents/Carers	Schools	Health	Connexions	CAYA (Multi-Agency Teams; Children's Social Care; Education)	Adult Care
<p>Take an active part in the transition process</p> <p>Carefully consider the options for continuing in education, training or work</p> <p>Identify the support needed and how it can be appropriately delivered</p> <p>Support the completion of the Assessment of learning Needs – LDA</p> <p>Complete identified actions</p>	<p>Attend all review meetings</p> <p>Listen to your young person's stated choices</p> <p>Provide support so informed choices can be made</p> <p>Actively seek information to support the process</p> <p>Identify future objectives and follow these through</p> <p>Support the completion of the LDA</p>	<p>Deliver a Person Centred Planning approach for young person</p> <p>Actively involve the young person in all transition arrangements</p> <p>Arrange transition review in Year 9</p> <p>Identify all persons who should be supporting the young person and invite to the meeting</p> <p>Review the Transition Plan year on year identifying any changes</p>	<p>Collate and share with other agencies data relating to young people in Year 8 who are likely to require multi-agency planning</p> <p>Discuss with young person and carer their health needs and transition options</p> <p>Attend or provide a report for the Transition Planning meeting</p> <p>Prepare and review the Health Action Plan</p>	<p>Attend review meeting in Year 9 and attend subsequent review meetings where appropriate</p> <p>Co-ordinate the delivery of the transition plan unless there is an agreed lead professional from another service overseeing this</p> <p>Transfer information to future providers to ensure young person receives necessary support or specialist help</p>	<p>Work closely with the Adult workers, Connexions and Health to support young people who need support through transition to adult services</p> <p>Where appropriate, may take on lead professional role for young people they are working with</p> <p>Complete transition episode at age 16 for all young people likely to transfer to Adult Care</p> <p>Create an initial</p>	<p>Engage with Children's Social Care and other agencies, to understand the likely future needs of young people in transition</p> <p>Identify named workers for young people likely to transfer to adult services at age 14, and individual case managers at 16</p>

		<p>Where appropriate may take on lead professional role</p>	<p>Ensure that Adult Health Services are alerted by Year 10, if appropriate</p> <p>Where appropriate, may take on lead professional role</p> <p>Appoint health transition lead to co-ordinate transition between health services/lead on health action planning</p>	<p>Where appropriate, Connexions PA may be lead professional role for young people with severe or complex needs</p>	<p>contact record for young people whose parents choose not to receive a service from Children's Social Care, but indicate that they may request assessment post 18. Complete the transition episode and pass it through to the appropriate adult area team of the young person at time of initial contact</p>	
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Young Person	Parents/Carers	Schools	Health	Connexions	CAYA (Multi-Agency Teams; Children's Social Care; Education)	Adult Care
	<p>Seek the support of Parent Partnership Service or Voluntary sector if required</p> <p>Complete identified actions</p>	<p>Work with Connexions to support young person who needs multi-agency support for transition in to adulthood</p> <p>Support the completion of the LDA</p> <p>Work with local colleges to support the transition to further education</p>	<p>Refer to Young Adult Clinic, if appropriate, or to other appropriate specialist services</p> <p>Ensure that Primary Care Team is kept informed.</p> <p>Support the completion of the LDA</p> <p>Facilitate transfer of information to future providers and services</p> <p>Complete identified actions</p> <p>Promote Parent Partnership Service and Voluntary Sector</p>	<p>Assist young person and parents/carers to identify appropriate post 16 provision</p> <p>Provide information advice and guidance and support to explore and access provision.</p> <p>Ensure an LDA is completed in the final year of schooling and shared appropriately</p>	<p>Contribute to further assessment</p> <p>Liaise with young person, parent/carers and anyone else supporting the young person</p>	<p>Liaise with Children & Younger Adults about any young person who is the subject of serious concern as identified by safeguarding procedures</p> <p>Ensure assessments of need are carried out before the young person's 17th birthday</p> <p>Ensure robust procedures are in place for the transfer of responsibility from Children and Younger Adults to Adult Care</p>

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			support for parents/carers			Contribute to the completion of the LDA, if appropriate
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Young Person	Parents/Carers	Schools	Health	Connexions	CAYA (Multi-Agency Teams; Children's Social Care; Education)	Adults Care
		<p>Establish a timetable of work experience</p> <p>Complete identified actions</p> <p>Promote Parent Partnership Services and Voluntary Sector support for parents/carers</p>	<p>Assess against adult continuing healthcare criteria at age 16, where relevant</p>	<p>Support the young person in new learning environment</p> <p>Arrange appropriate handover to adult services as young person moves out of Connexions age group</p> <p>Complete identified actions</p> <p>Promote Parent Partnership Service and Voluntary Sector support for</p>	<p>Co-ordinate arrangements for young person educated otherwise than at school or electively home educated</p> <p>Hold discussions about the needs of the young person at the Transition Panels convened by social care (via the Disabled Children's Service) in the north or south of the county depending on where the young person lives.</p>	<p>Complete identified actions</p> <p>Facilitate transfer of information to future providers and services</p> <p>Joint working with Children's Social Care from age 17</p> <p>May take on 'lead professional' role across adult services for young people with</p>

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				parents	Complete identified actions Promote Parent Partnership Service and Voluntary Sector support for parents/carers	highly complex needs
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Appendix 1

Transition for young people with additional needs without a Statement of SEN

Examples to aid good practice

A young person with additional needs may require the same level of transition planning as a pupil with a Statement of special educational needs. These are examples of young people where the school should consider involving agencies in planning from year 9.

Learning disability

The young person has a learning disability. School staff have met her needs at School Action Plus. However she requires a high level of adult support. She cannot manage school routines e.g. lunchtime independently. She has received support with personal care. Curriculum access is achieved through placement in the learning support unit and a high level of differentiation. She has experienced increasing difficulty socially and academically through Key Stage 3. Her barriers to learning include communication difficulties, language processing difficulties and poor levels of understanding and awareness. She is expected to need support from adult services.

Mental health needs

The young person has mental health needs manifesting themselves in behavioural management issues in school. He is accessing school support systems. Positive Support, Behaviour Support, counselling. He requires supervision for safety. A Multi Element Plan (MEP) is in place. A referral has been made to Child and Adolescent Mental Health Services. His needs may be resolved during Key Stage 4.

Sensory/physical impairment

The young person has a hearing impairment. She has required adjustments to the school environment to ensure curriculum/social access e.g. sound field system, hearing loops. School staff and pupils are deaf aware. She has had access to some specialist equipment. She has had additional adult support and differentiation for some lessons. She has accessed Deaf Club. She may require additional support to facilitate independence in adulthood and community inclusion, including help from voluntary agencies.

Autism

The young person has autism. He is of average academic ability. His difficulties with social interaction, communication and dealing with change have been managed at School Action Plus. He has had access to a 'safe haven' at break times. He has been monitored for being at risk of being bullied. School staff have worked on social skills. He has required preparation for any changes in timetabling. He has had a key worker.

Medical

The young person has diabetes. She does not manage her condition. She does not take her insulin or manage her diet. She shows acting out behaviours such as refusal and withdrawal. Parents have not attended meetings in school. School Health is involved.

Out of School Tuition

The young person is on the school roll and is receiving Out of School Tuition (OOST). He has a diagnosis of Asperger Syndrome and is finding school very stressful, showing challenging behaviour at home. The Consultant Psychiatrist has recommended OOST on the grounds that he is not emotionally fit to attend school. He requires joint monitoring by the school and the Local Authority through the OOST Service.

Where a young person has been permanently excluded from school, the Local Authority's Behaviour Support Service Multi Agency Support Team (MAST) will be responsible for considering which other services should be involved in transition planning from Year 9.

Where the young person is electively home educated (EHE), the EHE consultant will be responsible for considering which other services should be involved in planning transition from Year 9.

Examples of young people with severe or complex needs, who would be eligible for Pathway B:

The young person has severe autism, learning difficulties and displays challenging behaviour. He can usually communicate his basic needs to familiar people with prompting and support. He is likely to need ongoing, intense multi-agency involvement to maintain his health, keep safe and achieve structure in his life.

The young person has complex health needs and meets the children's continuing healthcare criteria. She is a wheelchair user, and is fed through a gastrostomy tube. She takes medication for a fluctuating, unstable condition that requires weekly management by a qualified nurse.

Record below all the issues and needs which will be part of the transition process, what action will be taken and who will do this. At the next review of this plan the “What happened?” section can be filled in. Outcomes may be recorded as: achieved, ongoing, next priority or no longer relevant.

My health	Issues I need to think about	What we decided needed to be done	Who is taking action?	When will the action be completed?	What happened?
Physical health – eg relating to diet, exercise, weight, smoking, medicines, health action/care plans, chronic care issues and therapies.					
Sexual health – eg relating to puberty or sexual activity					
Emotional health and well being – eg relating to current mental health needs, emotional problems, bereavement issues and/or emotional maturity and making a positive adjustment to					

disability					
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Keeping me safe	Issues I need to think about	What we decided needed to be done	Who is taking action?	When will the action be completed?	What happened?
Staying safe in the physical environment – eg relating to inclusion and accessibility/specialised equipment and preventing accidents					
Staying safe in the social environment – eg relating to bullying in school and the wider community – safe from exploitation and abusive relationships					
Staying safe in the social environment – eg relating to communication difficulties and other people having the knowledge and skills to understand young person's means of communication					

How I can have fun and achieve	Issues I need to think about	What we decided needed to be done	Who is taking action?	When will the action be completed?	What happened?
Socialising and having friends –					
Education and learning eg relating to attendance, exam concessions, KS4 options and how these will help in adult life					
Self care skills					
Life skills					
Self esteem					

How I can make a positive contribution	Issues I need to think about	What we decided needed to be done	Who is taking action?	When will the action be completed?	What happened?
Being part of the local community eg involvement in local youth clubs					
Being part of school community eg involvement in school council					
Independence skills					

My Economic Well Being -	Issues I need to think about	What we decided needed to be done	Who is taking action?	When will the action be completed?	What happened?
Money – eg offer of a full benefits check					
Employment opportunities and support –					
Transport issues – - eg preparation for independent travel					

My family and the people around me	Issues I need to think about	What we decided needed to be done	Who is taking action?	When will the action be completed?	What happened?
Physical well being of family eg relating to moving and handling and /or high care or nursing needs					
Emotional well being of family eg dealing with services and/ or adjustments for young person's condition					
Practical and financial resources eg relating to housing, equipment, support or financial resources to meet "extra" costs					