Transition Pathway for Disabled Children

Transition Pathway: 'Pathways lay out the steps involved in transition and show who is involved 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 comprehensive.'(Getting a Life, Summer 2005 Edition, Council for Disabled Children).

The following document is Hertfordshire's multi-agency guide to Transition Planning. This has been produced as a result of significant collaboration by a number of key agencies: Youth Connexions, Schools, Colleges, Disabled Children's Teams, Children's Services and Health and Community Services.

Where a disabled child is looked after, and would usually be considered for progressing to a Staying Put arrangement with carers, a Shared Lives placement with Hertfordshire Community Services should be explored in order to commence as soon as possible after the 18th birthday.

	YEAR 8	
	• Schools will begin to prepare young person, parents and carers for year 9 by inviting them to information evenings/coffee mornings and by providing appropriate information and guidance. • Schools will begin to prepare young people for year 9 through appropriate programmes of study that will help them form ideas about the future. • School will inform all relevant agencies of future young people that will require input at year 9 transition.	**SCHOOLS**
	YEAR 9 Transition planning will start for Young People with Special Educational Needs and/or Disabilities (SEND) at 14 (year 9)	
14yrs	• Schools will ensure that young person, parents and carers have access to information and guidance regarding transition planning and the Transition Review prior to the year 9 review meeting. This will include passing on information provided by Youth Connexions such as 'Ideas 4 Life' and 'Thinking About the Future.' • Schools will prepare their young people for the Transition Review and ensure they are enabled to contribute as fully as possible to the meeting. Where possible they will prepare a presentation in an appropriate and person centred format which outlines their needs and aspirations for the future. • The school will prepare, circulate a review report and convene a Transition Review meeting and ensure that all relevant people are able to attend. This will include: • The young person • Young person's parent/carer • Relevant teacher (friend, relative and adviser if they wish) • Representation of the funding Local Education Authority, Children's Services (CS) and Youth Connexions	**SCHOOLS**

	Where appropriate: • Representatives of the Health Services • Advocate • Representatives of CS • Other closely involved professionals • Interpreter The Transition Review meeting will be holistic and will consider all aspects of planning for the future. • The school will ensure that the young person is at the centre of the review and that they are enabled to present their own views as far as possible. • The school will also ensure that young person, parents and carers are enabled to express their views and that these are recorded. • Following the Transition Review the School will ensure that a comprehensive and detailed Learning for Living and Work Transition Plan is completed that reflects the needs and aspirations of the Young Person – this together with minutes of the meeting will be circulated to all parties.	
	• Personal Adviser (PA) will ensure Young Person, Parents/Carers receive appropriate Transition information including the ideas4life pack/DVD. • PA will prepare a Report for Transition detailing the Young Person's aspirations, support needs and post school options • PA will attend the Year 9 review as a statutory duty, part of the SEN Code of Practice. • PA will co-ordinate and oversee the delivery of the Learning for Living and Work Transition Plan. • PA will send a copy of the Report for Transition to Children's Services and Transition Team. • PA will offer information clinics to Parents/Carers and young people (mainly SLD schools) jointly with Transition Coordinators where possible and The 'Ideas for Life' DVD and pack will be given by Youth Connexions to the school. • Out County PA will contact out of county schools and Connexions services to ensure attendance at Year 9 review and arrange home visits (if appropriate). • PA will identify young people who may need Specialist College funding Post 16/17/18/19.	**YOUTH CONNEXIONS**
	• Appropriate college staff visit school to meet potential future learners. • Attend Annual Planning meetings. • Attend school open evenings to discuss options and give overview of provision.	**COLLEGES**
	Children in Need: • DCT will attend Year 9 reviews on those young people with the most complex needs and contribute to the Learning for Living and Work Transition Plan. For all other young people the DCT will provide	**DISABLED CHILDREN'S TEAM**

	information for inclusion in the Learning for Living and Work Transition Plan.	

	Health relates to a variety of professionals and teams who may be involved including acute and community consultants, GPs, School Nurses, Community Paediatric Nursing and Continuing care teams, Specialist Nurses, Clinicians within Child and Adolescent Mental Health Services, Therapists – e.g. Physiotherapy etc. this list is not exhaustive. The young person may have only a number of these professionals involved in the management of his/ her health care needs.
	
	• Paediatric Consultants, in both Community and Acute health service, will begin to discuss the need to identify adult health provider with young person and parent/carer and obtain their consent.
	• Healthcare Professionals to participate in Multidisciplinary Team transition planning meetings, Team Around the Child, CLA reviews, Annual SEN Statement reviews, safe guarding, and provide information for inclusion in the Learning for Living and Work Transition Plan as required.
	• School Nurses will commence Health Action Plans.
	• Health will participate in nursing assessments as indicated by changes in young person's health needs, including Parallel Planning for young people with unstable health needs.
	• Health Professional will attend Year 9 review if appropriate.
	• Health professionals will provide health updates / reports that are required of the Year 9 reviews.
	• Healthcare Professional will identify young people with ongoing extra ordinary health needs and, after obtaining consent from young person or parent/carer, make referral to the Health Transition Service.
	• Health Transitional Nurse Coordinator will contact young person / parent/carer to arrange visit and complete nursing assessment to establish eligibility.
	• Referrals to Health Transition Service can also be made from other agencies, e.g. Social Care, Connexions, Voluntary sector, Education
	• Once referral has been accepted, the Health Transitional Nurse Coordinator will
	  ○ liaise with the multi-disciplinary team involved with the young person as part of the ongoing transition planning
	  ○ attend Year 9 reviews for young people on their caseload
	  ○ attend Annual Planning Meetings in each of the Special Schools
	  ○ meet with Adult Continuing Care Department to start to identify young people who may require Adult Continuing Healthcare applications
	  ○ Health Transitional Nurse Coordinator can give information and signpost others regarding health issues, acting in a consultative role with other professionals
		HEALTH

YEAR 10		
15yrs	• Schools will, as in Year 9, convene an Annual Review Meeting and ensure there are contributions from all relevant agencies. • Schools will review the Learning for Living and Work Transition Plan	**SCHOOLS**

	in conjunction with Young Person, parent,/Carers, Personal Adviser and all other relevant professionals/agencies. • Schools will ensure that the Young Person's Statement reflects the needs identified and that relevant programmes of study are put in place. • Schools will arrange appropriate college link course and/or Work Experience placements as required. • Local college assessments will be arranged for those young people leaving at 16yrs.	
	• PA will review the Learning for Living and Work Transition Plan with the Young Person and Parents/Carers and attend Annual Review (if required). • PA will liaise with all parties involved to ensure the Plan is progressed and seeks to address barriers to achieving goals • PA will offer person centred planning group work sessions on Post school options. • PA ensures the Learning for Living Framework is submitted (if appropriate) to the local college for an assessment.	**YOUTH CONNEXIONS**
	• College requests learner profiles for all link students. • College arranges appropriate link courses and tasters. • Appropriate college staff visit school to meet potential future learners. • Attend Annual Planning meetings. • Attend school open evenings to discuss options and give overview of provision. • Learning for Living and Work Framework completed for learners needing additional support and leaving school at 16yrs.	**COLLEGES**
	• DCT will attend reviews on those young people with the most complex needs and contribute to the Learning for Living and Work Transition Plan. For all other young people the DCT will provide information for inclusion in the Learning for Living and Work Transition Plan.	**DISABLED CHILDREN'S TEAM**
	• Healthcare Professional will attend Year 10 review. • Health professionals will provide information for inclusion in the Learning for Living and Work Transition Plan as required. • Healthcare Professionals to participate in Multidisciplinary Team transition planning meetings, Team Around the Child, CLA reviews, Annual SEN Statement reviews, safe guarding, and provide information for inclusion in the Learning for Living and Work Transition Plan as required. • School Nurses will update Health Action Plans. • Health providers in both Community and Acute health service, will discuss the need to identify adult health provider with young person and parent/carer and make referral as appropriate. • The training needs of adult services will be identified and signposting will occur so that these can be addressed and young person's health needs met. • Coordinate and participate in nursing assessments as indicated by	**HEALTH**

	changes in young person's health needs, including Parallel Planning for young people with unstable health needs.
	• Health Transitional Nurse Coordinators will
	  ○ attend Year 10 reviews for young people on their caseload
	  ○ attend Annual Planning Meetings in each of the Special Schools
	  ○ for young people on their caseload, will liaise with the multi-disciplinary team involved with the young person as part of the ongoing transitional planning including identifying training needs of receiving adult service
	  ○ meet with Adult Continuing Care Department to start to identify young people who may require Adult Continuing Healthcare application
	• Health Transitional Nurse Coordinator can give information and signpost regarding health issues, acting in consultative role with other professional.
	• Young people will leave children's acute hospital services on their 16th birthday. Paediatrician will ensure referral process to adult Consultant or GP has been commenced.	

	• Will start to gather information on students into Transition database, cross checking information and clarifying involvement of other key services. • Transition Co-ordinators (TC) will provide information sessions to parent forums in the community, at schools and other venues to introduce the transition team and the transition process in conjunction with Youth Connexions. • DCT Worker (Disabled Children's Team),Youth Connexions and Transition Co-ordinators to establish initial eligibility for services from Health and Community Services (HCS) with reference to FAC's. (Fair Access to Care)	**TRANSITION COORDINATOR**
	• Transition Team will begin to prioritise cases for level of involvement needed by TC and plan attendance at forthcoming Year 11 reviews. • At this stage priority for allocation at 16 years of age will be given to those young people who are in receipt of services from DCT and have complex needs.	**TRANSITION TEAM**
YEAR 11		
16yrs	• PA completes the Section 139A assessment if Young Person is leaving school, statutory duty. • PA sends a copy of the S139A to CS, TT and local college(s). • PA attends the Annual Review, statutory duty. • PA submits by March (for Year 11 school leavers) applications for Learning for Living and Work funding (in county) and specialist college funding (out county) to the LLDD Placement Panel. • PA offers Information, Advice and Guidance on post school options and supports applications to college (if appropriate). • PA offers preventative person centred work to ensure young people don't become Not in Education, Employment or Training (NEET) on leaving school. • PA will continue to track young people that become NEET and	**YOUTH CONNEXIONS**

	support them into positive outcomes, e.g. college/training or employment. • PA will liaise closely with all involved parties to ensure the LFLW Transition Plan is progressed seeking to address barriers to achieving goals. • PA will follow the same procedures for Out of County young people and attend the Annual review and refer into the Transition Team as appropriate. • PA will liaise with the Transition Team and other key professionals.	
	• Schools will, as in Year 10, convene an Annual Review Meeting and ensure there are contributions from all relevant agencies. • Schools will where identified invite appropriate representative from post school provision. • Schools will review the Transition Plan/ Learning for Living and Work Framework in conjunction with Young Person, parent/carers, Personal Adviser and all other relevant professionals/agencies. • Schools will prepare the Young Person for 6th form/post 16 ensures that the Young Person's Statement reflects the needs identified and that relevant programmes of study are put in place. • Schools will arrange appropriate college link course and or work experience placements as required. • A transition programme will be developed and all learner needs and resource implications identified. • All useful and relevant information will be forwarded to post school provider.	**SCHOOLS**
	• College staff will arrange appropriate link courses and tasters. • College staff will request learner profiles for all students on college link courses. • Appropriate college staff will visit schools to meet potential future learners. • College staff will attend Annual Planning meetings. • College staff will attend school open evenings to discuss options and give overview of provision. • College staff will arrange an assessment and interview at college • College staff will complete Learning for Living and Work Framework for learners needing additional support and leaving school at 16. • College staff will attend last annual review to discuss transition arrangements. • A Transition Programme will be put into place.	**COLLEGES**
	Children in Need: • DCT will ensure that advice and support is given to family in terms of Benefits and registering for Housing. • DCT will ensure that permission is given for a referral to be made to the Transition Team on the Young Person's 16th birthday. • DCT will ensure Transition Team are given information regarding current services, cost and end date. • DCT will ensure that the latest Core assessment, Chronology and Care Plan/pathway plan accompany the referral to the Transition	**DISABLED CHILDREN'S TEAM**

	Team. • DCT will invite TC to any relevant Child in Need review meetings. (This is where all current needs and services provided to the young person and their family. i.e. short breaks, DP, Play schemes and Home Care will be reviewed). • DCT will attend reviews on those young people with the most complex needs. For all other young people the DCT will provide information for inclusion in the Learning for Living and Work Transition Plan. • For those young people leaving school at 16yrs DCT will with Youth Connexions continue to develop and deliver a Child in Need Plan that supports young person's attendance at college. • DCT will ensure where appropriate Mental Capacity Assessments are completed. CLA Cases: • DCT will refer young people to the Transition Team where it is assessed that the young person has a learning disability. The referral (including information highlighted by the Transition Checklist) will be considered. • Where it is assessed that the young person has a cognitive and/or enduring learning disability, a Transition Co-ordinator will undertake a Needs and Outcomes Assessment to ascertain if the young person meets the HCS - Transition Team - FAC's Services criteria.	
	• Health will provide updates for inclusion in the Learning for Living and Work transition Plan that are required and will attend Year 11 reviews as appropriate. • Healthcare Professionals to participate in Multidisciplinary Team transition planning meetings, Team Around the Child, CLA reviews, Annual SEN Statement reviews, safe guarding, and provide information for inclusion in the Learning for Living and Work Transition Plan as required. • Coordinate and participate in nursing assessments as indicated by changes in young person's health needs, including Parallel Planning for young people with unstable health needs. • School Nurses will update Health Action Plans / Learning for Living and Work Framework Transition Plan (health section). • Acute Paediatric Consultant will discuss the need to identify adult health provider with young person and guardian and ensure referral process to adult Consultant or GP has been completed as young people will leave children's acute hospital services on their 16th birthday. • All Health services involved in the care will identify and discuss the transition process to adult services as relevant to the young person's needs with the young person and their parent/carer. • Health Transitional Nurse Coordinators will o attend Year 11 reviews for young people on their caseload. o attend Annual Planning Meetings in each of the Special Schools o for young people on their caseload, will liaise with the multi-disciplinary team involved with the young person as part of the ongoing transitional planning. o meet with Adult Continuing Care Department to start to identify	**HEALTH**

	young people who may require Adult Continuing Healthcare application. • Health Transitional Nurse Coordinator can give information and signpost regarding health issues, acting as consultative role with other professionals.	
	• DCT SW/Youth Connexions and Transition Co-ordinators to continue to establish initial eligibility for service from Health and Community Services (HCS) with reference to FAC's. • If agreed that FAC's met then with Young Person and Parents/Carers permission Youth Connexions will complete a referral into the Transition Team on the young person's 16th birthday. • Transition Team will begin to prioritise cases for level of involvement needed by TC and plan attendance at forthcoming Year 11 reviews. • At this stage priority for allocation at 16yrs of age will be given to those young people who are in receipt of services from DCT and/or have complex needs. • TT (Transition Team) will inform Schools and partner agencies of allocated TC. • TC will attend all Year 11 reviews on those cases which are open to DCT to introduce the TT service to young person and Parent/Carers. • TC will give Young People, Parents and Carers - Team leaflet, Carers Article, FAC's leaflet, Charging Policy leaflet. • The role of the TC will be to introduce, guide and inform the process towards planning the HCS self-directed support model, which will begin in earnest at Year 12. • TC will ensure particular focus on relevant sections of the Learning for Living and Work Framework and ensure sufficient information is available to complete the HCS Needs Assessment Questionnaire. • Where case has allocated DCT worker TC's now have an advisory/oversight role on the transition planning elements only. • The TC will liaise with the Social Work Case Manager in the DCT. • TC will undertake HCS FAC's eligibility check and inform DCT. • Liaise with Youth Connexions PA and identify each workers role/responsibility. • To formally make links with each Young Person and their family/Carers with particular emphasis on offering HCS (Health & Community Services) Carer's assessments. • Gather information about current level of services being provided and detail of funding and end dates.	**TRANSITION TEAM**
	• Signposting and information giving regarding health issues and adult services, acting in a consultative role with other professionals. • Liaise with Special School Nurses, Community Paediatricians and other Children's services. • Liaise with Primary Care Trust Transitional Coordinators about their input with young people on their caseload and any future Transition Team Nursing needs. • Participate in presentations to young people, parents and carers about health aspect of Transition planning in conjunction with Youth Connexions.	**TRANSITION TEAM /NURSE/ HEALTH CARE ASSISTANT**
YEAR 12		

17yrs	• PA will attend the Annual Review and update the Report for Transition. • PA or Broker will co-ordinate the Learning for Living and Work Assessment if required with the local college to ensure timely and effective transition planning in place. • PA will identify post school options based on the Young Persons aspirations and assessed needs. • PA will follow up on Out of County young people and attend the review. • The Youth Connexions Personal Adviser will liaise with the TT allocated worker and other key professionals.	**YOUTH CONNEXIONS**
	• Schools will, as in Year 11, convene an Annual Review Meeting and ensure there are contributions from all relevant agencies. • Schools will review the LFLW Transition Plan in conjunction with young person, parent/carers, personal adviser and all other relevant professionals/agencies. • Schools will ensure that the young person's Statement reflects the needs identified and that relevant programmes of study are put in place. • Schools will arrange appropriate college link course and or Work experience placements as required. • A transition programme will be developed and all learner needs and resource implications will be identified.	**SCHOOLS**
	SLD: • College staff will arrange appropriate link courses and tasters. • College staff will request learner profiles for all students on college link courses. • Appropriate college staff will visit schools to meet potential future learners. • College staff will attend Annual Planning meetings. • College staff will attend school open evenings to discuss options and give overview of provision. • College staff will arrange an assessment and interview at college. • College staff will complete Learning for Living and Work Framework for learners needing additional support and leaving school at 16. • College staff will attend last annual review to discuss transition arrangements. • A Transition programme will be put into place. **MLD/ BESD/Mainstream:** • Learner enters programme. • College Staff will assess their learners through the 6 week induction period. • Appropriate agencies will be informed of any major concerns and any services needed. • College staff will conduct a First Term Review for all learners funded	**COLLEGES**

	through LFLW. • College staff will ensure that an Annual learner review is conducted which includes Youth Connexions PA, LFLW Broker, and Social Worker as appropriate. • The review will consider the appropriateness of current provision including opportunities to transfer to other courses and/or progression to mainstream if appropriate. • College staff will ensure that all learners have an appropriate exit/moving on strategy which will include progression to employment where appropriate.	
	TYS Cases • TYS will refer young people to the Transition Team where it is assessed that the young person has a cognitive and/or enduring learning disability. The referral (including information highlighted by the Transition Checklist) will be considered by the TT.	**TYS**
	• Health will provide health updates / reports that are required and will attend Year 12 reviews as appropriate. • Healthcare Professionals to participate in Multidisciplinary Team transition planning meetings, Team Around the Child, CLA reviews, Annual SEN Statement reviews, safe guarding, and provide information for inclusion in the Learning for Living and Work Transition Plan as required. • Coordinate and participate in nursing assessments as indicated by changes in young person's health needs, including Parallel Planning for young people with unstable health needs. • School Nurses will update Health Action Plans / Learning for Living and Work Framework (health section). • All health providers will discuss the need to identify a relevant adult health provider with young person and parent /carer and ensure that the referral process has commenced. • Training needs within receiving adult service is identified to enable them to address this need. • Health Transitional Nurse Coordinators will o attend Annual Planning Meetings in each of the Special Schools o for young people on their caseload, attend Year 12 review, liaise with the multi-disciplinary team involved with the young person as part of the ongoing transitional planning, including identifying training needs of receiving adult services so that they are able to meet the health needs and assisting in completion of risk assessments / care plan. o for young people on their caseload, will assist others or complete Adult Continuing Healthcare Checklist and Full Assessment application if indicated. o meet with Adult Continuing Care Department to start to identify young people who may require Adult Continuing Healthcare application. • Health Transitional Nurse Coordinator can give information and signpost regarding health issues, acting as consultative role with other professionals.	**HEALTH**

	• The point at which the TC's and/or the Transition Team pick up any other students will be negotiated and prioritised according to need under FAC. This relates to those young people who may be on School Action, School Action + or open to Youth Offending Team/TYS and other vulnerable young people who are not receiving a service from DCT. • Once allocated the worker from the TT will ensure particular focus on relevant sections of the Learning for Living and Work Framework to ensure sufficient information is available to review/complete the HCS Universal Assessment. • Allocated worker from the Team will attend Year 12 Review. • It will be the allocated workers responsibility to ensure along with other agencies that there is a detailed transition plan which places the Young Person at the centre. • This plan will include and evidence the wishes and aspirations of the young person in terms of their future regarding employment, leisure, housing and Health. • Universal Assessment to be reviewed/completed which gives an indicative amount. This is the maximum amount identified that is available to meet the young person's future needs. • Support planning will now begin. This is a process of turning the transition plan into reality. It involves helping the young person to identify what support they would need, exploring the options available and the costs, plus supporting them with making decisions and choices in conjunction with Parents/Carers, Youth Connexions, DCT, other Children's Services Teams, Schools and Colleges where appropriate.	**TRANSITION TEAM**
	CLA CASES: • The Transition Team will begin a HCS Universal Assessment on all children looked after aged 17+ allocated to TYS teams where it is judged that the young person is likely to meet the HCS -Transition Team FAC's of critical and substantial need on reaching the age 18. • Where it is assessed that a young person does meet the FAC's criteria, the Transition Team will maintain a 'watching brief' between the completion of the assessment and the point the case transfers to the Transition Team. This will involve attending significant statutory review meetings and professionals/planning meetings where major changes/decisions need to be made. • The Transition Team should ensure that the Care Plan and Pathway Plan identify the work required to enable a smooth transition to Health and Community Services. The Care and Pathway Plan should incorporate the Transition (LFLW) and Support Plan. • Case and financial responsibility transfers to the Transition Team from CS when the young person's SEND ceases, generally, this occurs between the 19th and 20th birthday, or, on the 18th birthday if the SEND ceases prior to the 18th birthday.	**TRANSITION TEAM**
	• Liaise with Special School Nurses, Community Paediatricians and other Children's services to ensure discharge summaries are available on discharge from these services and that appropriate adult	**TRANSITION TEAM /NURSE/ HEALTH CARE**

	services are identified and referrals made. • Ensure referrals are made to SLDS services as appropriate for young people with LD. • For young people on our caseload, ensure that from age 17 ½ that a letter is sent to GP with Young Person's consent to introduce their needs and transition team if required. This should trigger eligibility for DES Annual Health Check at 18. • 'My Purple Folder' is offered as young person approaches 18. • Ensure Transition Portfolio of 'My Purple Health Book' is started by relevant professionals. • Signposting and information giving regarding health issues, acting in a consultative role with other professionals. • Assist others with and/or carry out checklist for Continuing Health Care to identify need for full assessment. • Assist others with or complete Continuing Health Care paperwork if checklist identifies need for full assessment. This may need to be completed prior to 18th birthday. • Attend relevant meetings/reviews and/or ensure there is a health input in development of the Transition Plan. • Discuss young people with extra ordinary health care needs in Multi Agency Referral Meeting with view to allocation to Transition Team Nurses. • Ensure that all planning and assessments have the Young Person at the centre and that there is evidence of their wishes and aspirations.	**ASSISTANT**
YEAR 13		
18yrs	• PA will attend Annual Review if required. • PA or Broker will co-ordinate the college assessment where appropriate. • PA/Broker will update the LFLW Transition Plan as appropriate. • PA will support the Young Person to apply for Higher Education and liaise with social worker (if relevant) over care needs and direct payments. • PA will liaise with the TT allocated worker and other key professionals.	**YOUTH CONNEXIONS**
	• Schools will, as in Year 11, convene an Annual Review Meeting and ensure there are contributions from all relevant agencies. • Schools will, where identified invite appropriate representative from post school provision. • Schools will review the LFLW Transition Plan in conjunction with Young Person, parent/carers, Personal Adviser and all other relevant professionals/agencies. • Schools will ensure that the Young Persons Statement reflects the needs identified and that relevant programmes of study are put in place. • Schools will help ensure that all local college assessments take place and are completed a year in advance of leaving school. • Schools will arrange appropriate college link course and or Work experience placements as required.	**SCHOOL**

	• A transition programme will be developed and delivered and all learner needs and resource implications will be identified. • All useful and relevant information will be forwarded to post school provider.	
	SLD: • College Staff will arrange appropriate link courses and tasters. • College Staff will request learner profiles for all students on college link courses. • Appropriate college staff will visit schools to meet potential future learners. • College staff will attend Annual Planning meetings. • College staff will attend school open evenings to discuss options and give overview of provision. • College staff will arrange an assessment and interview at college. • College staff will complete Learning for Living and work Frameworks for learners needing additional support and leaving school at 19. • College staff will attend last annual review to discuss transition. • A Transition programme put into place. **MLD/ BESD/Mainstream** • College staff will ensure that an Annual learner review is conducted which includes Young Person, Parents/Carers, Youth Connexions PA, LFLW Broker, and Social Worker as appropriate. • Appropriate agencies will be informed of any major concerns and any services needed. • The review will consider the appropriateness of current provision including opportunities to transfer to other courses and/or progression to mainstream if appropriate. • College staff will ensure that all learners have an appropriate exit/moving on strategy which will include progression to employment where appropriate.	**COLLEGES**
	DCT Cases: • DCT will continue to ensure particular focus/completion of relevant sections of the Learning for Living and Work Framework. • DCT will ensure Transition Team is given information regarding current services, cost and ceasing date. • DCT will formally notify young person, Parents and Carers of the end of CS involvement as appropriate.	**DISABLED CHILDRENS TEAM**
	TYS Cases: • TYS will ensure particular focus/completion of relevant sections of the Learning for Living and Work Framework. • TYS will ensure Transition Team is given information regarding current services, cost and ceasing date. • Young people who were previously looked after and meet the criteria for the leaving care service will have a Pathway Plan maintained by a	**TYS**

	personal adviser in the leaving care service. Depending on the circumstances of the care leaver, and the level of disability, the leaving care personal adviser input will range from just maintaining the Pathway Plan and providing the leaving care finance input, through to being directly involved with the young person.	

	• Health will provide updates for inclusion in the Learning for Living and Work Transition Plan that are required and will attend Year 13 reviews as appropriate.
	• Healthcare Professionals to participate in Multidisciplinary Team transition planning meetings, Team Around the Child, CLA reviews, Annual SEN Statement reviews, safe guarding, and provide information for inclusion in the Learning for Living and Work Transition Plan as required.
	• Coordinate and participate in nursing assessments as indicated by changes in young person's health needs, including Parallel Planning for young people with unstable health needs.
	• Healthcare Professionals will assist with reports as required for Adult Continuing Healthcare applications.
	• Healthcare Professionals will participate in SAFA, MCA, DOLS and Mental Capacity Assessments as needed.
	• Liaise with Transition Team Nurses / Health Care Assistants.
	• School Nurses will update Health Action Plans / Learning for Living and Work Framework (health section).
	• Medical Practitioner / Consultant will discuss the need to identify adult health provider with young person and guardian and ensure referral process has been commenced if this has not already happened.
	• Community Paediatrician's will cease involvement with young people when they leave school. Paediatrician will ensure referral process to adult Consultant or GP has been completed.
	• Children's Community Nurses will ensure receiving adult community nurses e.g. District Nurses have comprehensive handover including opportunities for joint visiting and training prior to handover.
	• Health Transitional Nurse Coordinators will
	  ○ attend Year 13 reviews for young people on their caseload.
	  ○ attend Annual Planning Meetings in each of the Special Schools.
	  ○ for young people on their caseload, will liaise with the multi-disciplinary team involved with the young person as part of the ongoing transitional planning, including identifying training needs of the receiving adult service so that they are able to meet the health needs and assisting in completion of risk assessments / care plan.
	  ○ for young people on their caseload, will assist others or coordinate the Adult Continuing Healthcare Checklist and Full Assessment application if indicated.
	  ○ meet with Adult Continuing Care Department to start to identify young people who may require Adult Continuing Healthcare application.
	• Health Transitional Nurse Coordinator can give information and signpost regarding health issues, acting as consultative role with other professionals.
	• Young people receiving respite at Nascot Lawn will be unable to access this when they leave school. Liaison with adult respite staff
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	will occur to support the management of the young person's needs, including the opportunity to 'shadow' in Nascot Lawn.	
	• Allocated worker from the Team will attend Year 13 Review. • Continue to contribute and develop/finalise transition plan. • Update Universal Assessment where appropriate to produce an Indicative Budget. • Review/create the HCS Care and Support Plan and amend where necessary working alongside Young Person, Parents/Carers, Youth Connexions, TYS, Schools and Colleges and Providers as appropriate. • Commission HCS services where appropriate ensuring a smooth handover of support from Children's services to HCS. Particular care must be taken around the commissioning of any services to ensure the young person does not experience a break in support between financial transfers. For example Direct Payments, short breaks, residential care.	**TRANSITION TEAM**
	CLA Cases: • Where it is assessed that a CLA meets the HCS –Transition Team FAC's criteria – the Transition Team will maintain a 'watching brief' between the end of the assessment and the point the case transfers to the Transition Team at the end of school year 13. This will involve attending significant statutory review meetings and professionals/planning meetings where major changes/decisions need to be made. • The Transition Team should ensure Pathway Plans for CLA and Care Leavers identify the work required to enable a smooth transition to Health and Community Services. The Pathway Plan should incorporate the Transition (LFLW) and Support Plan. • Case and financial responsibility transfers to the Transitions Team from CS when the young person's SEND Statement ceases, generally this occurs between the 19th and 20th birthday. Where the SEND Statement ceases prior to the young person's 18th birthday, case responsibility transfers on the 18th birthday.	**TRANSITION TEAM**
	• Liaise with Youth Connexions, DCT, Providers, Schools and Colleges re: health needs. • Consultative role with TT worker to ensure any services commissioned are able to meet health needs. • Work as allocated worker for young people with extra ordinary health needs as agreed in Multi Agency Referral Meeting. Assess their nursing needs, write care plans and risk assessments in conjunction with other professionals. Ensure care services communicate with each other and social care and arrange Core Team Meetings as necessary. • Carry out nursing tasks such as; medication monitoring, attending Psychiatry Clinics, ABC/behavioural monitoring, implementing social stories, health facilitation, health promotion and education,	**TRANSITION TEAM NURSE/HEALTH CARE ASSISTANT**

	coordination of health input and liaison with GPs and other health professionals. • Ensure Adult health services have received and acted upon referrals. • Participate in relevant assessments as needed. Liaise with GP to ensure Young Person receives appropriate support to access primary and secondary care services. Young Person should also receive Annual Health Check (as per surgery sign up). • Ensure referrals are made to Specialist Learning Disability Services / mainstream services as appropriate and provide support to attend appointments as necessary. • 'My Purple Folder' is completed and updated as required by young person, parents, carers or relevant professional. Health Action Plan started with clear aims and responsible persons identified. • Attend relevant meetings and/or ensure there is a health input in development of the LFLW Transition Plan. • Ensure that all planning and assessments have the Young Person at the centre and that there is evidence of their wishes and aspirations.	
YEAR 14 /15 AND BEYOND		
19yrs	• PA will attend final review in school. • PA completes the Section 139A assessment, statutory duty • PA sends a copy of the S139A to CS, HCS - TT and local college(s). • PA or Broker will co-ordinate the Learning for Living and Work Framework/Assessment with the local college to ensure timely and effective transition planning in place • PA submits by March applications for Learning for Living and Work funding (in county) and specialist college funding (out county) to the LLDD Placement Panel. • PA will ensure that transition plans and Section 139A Assessments for young people attending Out of County placements are in place. • PA will discuss with Young Person, Young Person, Carers/Carers and TT arrangements for continuing support of the Young Person on leaving school. • PA will liaise with the TT allocated worker and other key professionals.	**YOUTH CONNEXIONS**
	• Schools will convene a final Annual Review/Transition meeting and ensure there are contributions from all relevant agencies. • Schools will invite appropriate representative from post school provision. • Schools will review the Transition Plan/ Learning for Living and Work Framework in conjunction with Young Person, parent/Carers, Personal Adviser and all other relevant professionals/agencies. • Schools will ensure that the Young Persons STATEMENT reflects the needs identified and that relevant programmes of study are put in place. • Schools in conjunction with Youth Connexions PA will ensure that all local college assessments take place and are completed a year in advance of leaving school. • A transition programme will be developed and all learner needs and resource implications identified and communicated to all relevant	**SCHOOL**

	agencies. • Schools will ensure that all relevant parties understand the next steps involved as the Young Person and their family prepares to leave school. • All useful and relevant information will be forwarded to post school provider.	
	SLD • College Staff will arrange appropriate link courses and tasters. • College Staff will request learner profiles for all students on college link courses. • Appropriate college staff will visit schools to meet potential future learners. • College staff will attend Annual Planning meetings. • College staff will attend school open evenings to discuss options and give overview of provision. • College staff will arrange an assessment and interview at college. • College staff will complete Learning for Living and Work Framework for learners needing additional support and leaving school at 19. • College staff will attend last annual review to discuss transition. • A Transition programme will be delivered. **<u>In Year 15 SLD Learners Enter Programme</u>** • College will assess learner during the 6 week induction. • College staff will conduct a First Term Review for all LFLW learners. • College staff will ensure that an Annual learner review includes Young Person, Carers/Parents, Youth Connexions PA, LFLW Broker, and Social Worker as appropriate. • The review will consider the appropriateness of current provision including opportunities to transfer to other courses and/or progression to mainstream if appropriate. • College staff will ensure that all learners have an appropriate exit/moving on strategy. **MLD/ BESD/Mainstream** • College staff will ensure that an Annual learner review is conducted which includes Young People, Parents/Carers, Youth Connexions PA, LFLW Broker, and Social Worker as appropriate. • Appropriate agencies will be informed of any major concerns and any services needed. • The review will consider the appropriateness of current provision including opportunities to transfer to other courses and/or progression to mainstream if appropriate. • College staff will ensure that all learners have an appropriate exit/moving on strategy which will include progression to employment where appropriate.	**COLLEGES**
	Children in Need: • DCT will continue to ensure particular focus/completion of relevant	**DISABLED CHILDRENS TEAM**

	sections of the Learning for Living and Work Framework where appropriate. • DCT will ensure Transition Team are given information regarding current services, funding and ceasing date. • DCT will formally notify young person, Parents and Carers of the end of CS involvement as appropriate.	
	• Most young people will be accessing universal health services at this time. • There will be a small cohort of young people who will be still in receipt of ongoing support from the Heath Transition Service. For young people on their caseload, the Health Transitional Nurse Coordinator will continue to offer support until they are one year post successful transition or until they are 21 years old, including support to the adult health providers and notification of discharge from Health Transition Service will be given to the young person and the multidisciplinary team involved • The Health Transitional Nurse Coordinator will: o Ongoing liaison with Transition Team Nurses / Health Care Assistants, working collaboratively with them and multidisciplinary teams o Arrange and participate in Core Group meetings as required o Coordinate and participate in nursing assessments as indicated by changes in young person's health needs, including Parallel Planning for young people with unstable health needs o Information and signpost regarding health issues, acting as consultative role with other professionals o Participate in SAFA, MCA, DOLS and Mental Capacity Assessments as needed	**HEALTH**
	• Allocated worker from the Team will attend Leaver's Review. • Will continue to ensure particular focus/completion of relevant sections of the Learning for Living and Work Framework. • Update Universal Assessment where appropriate to produce an Indicative Budget. • Review/create the Care and Support Plan and amend where necessary working alongside Young Person, Parents/Carers, Youth Connexions, Schools and Colleges and Providers as appropriate. • Commission HCS services ensuring a smooth handover of support from Children's services to HCS. Particular care must be taken around the commissioning of any services to ensure the young person does not experience a break in support between financial transfers. For example Direct Payments, short breaks, residential.	**TRANSITION TEAM**
20-25 YEARS		
	• Allocated worker from the Team will ensure reviews take place involving all parties. • Update Universal Assessment where appropriate to produce a revised Indicative Budget/Care & Support plan working alongside Young Person, Parents/Carers, Youth Connexions, Schools and Colleges and Providers as appropriate. • Commission services.	**TRANSITION TEAM**

	• Early notification will be sent to relevant HCS team.	
	• Transfer Summary will be written ready to go with referral to appropriate HCS team • Referral will be made to relevant HCS Team in time for 25th birthday. • On ceasing of TT involvement allocated worker/Assistant Manager will create a task to business support team (Kevin McAuliffe and Neil Wiggins) to cease existing package of services and start new service in relevant HCS Team. This needs to be completed in a timely manner to ensure no gap in service provision for Young Person. • Where appropriate arrange handover meeting with relevant HCS Team. • Young Person, Parents and Carers informed. • Case transferred to HCS Team.	**TRANSITION TEAM**
	• Work as allocated worker for young people with complex / extra ordinary health needs. Assess their nursing needs, write care plans and risk assessments in conjunction with other professionals. Ensure care services communicate with each other and social care and arrange Core Team Meetings as necessary. • Carry out nursing tasks such as; medication monitoring, attending Psychiatry Clinics, behavioural monitoring, implementing social stories, health facilitation, health promotion and education, coordination of health input and liaison with GPs and other health professionals. • Participate in relevant assessments as needed. • My Purple Folder is in place and action plans have been completed to update. • Attend relevant meetings and/or ensure there is a health input in development of the Transition Plan. • Ensure that all planning and assessments have the Young Person at the centre and that there is evidence of their wishes and aspirations.	**TRANSITION TEAM NURSE/HEALTH CARE ASSISTANT**
	• PA will continue to offer information, advice and guidance to all young people in colleges, training or if NEET on request. • PA will attend college reviews to offer support if required. • PA will continue to track young people that are NEET until 25th birthday. • PA will liaise and refer onto other agencies if appropriate.	**YOUTH CONNEXIONS**
	SLD • Learning for Living and Work Framework reviewed as necessary for learners needing additional support. • Annual learner review including Young Person, Parents/Carers, Youth Connexions PA, LFLW Broker, Social Worker as appropriate • Appropriateness of current provision considered including opportunities to transfer to other courses progression to mainstream if appropriate. • Appropriate agencies informed of any major concerns and any services needed.	**COLLEGES**

	• Appropriateness of current provision considered including opportunities to transfer to other courses progression to mainstream if appropriate. • Exit strategy/ learning plans continue to be developed including progression to employment where appropriate.	
	• Will assess Young Persons nursing needs, write care plans and risk assessments in conjunction with other professionals. Ensure care services communicate with each other and social care and arrange Core Team Meetings as necessary. • Carry out nursing tasks such as; medication monitoring, attending Psychiatry Clinics, ABC/behavioural monitoring, implementing social stories, health facilitation, health promotion and education, coordination of health input and liaison with GPs and other health professionals. • Participate in CPA, SAFA, MCA, DOLS and MHA Assessments as needed. • Review Care Plans and Risk Assessments every 6 months within multi agency context. • Ensure that all planning and assessments have the Young Person at the centre and that there is evidence of their wishes and aspirations. • Where appropriate arrange handover meeting with relevant member of CLDT and CPA Meeting if needed. • Update EPR in Care Notes. • ACSIS case to be closed to Transition Team Nurse. • Contact GP by letter to inform of discharge from Transition Team and new team details.	**TRANSITION TEAM NURSE/ HEALTH CARE ASSISTANT**
	End of Course • Final Annual Learner review College to invite Youth Connexions PA, LFLW Broker, HCS Social Worker, Work Solutions as appropriate. • Appropriate agencies informed of any major concerns and any services needed in the future. • Exit strategy agreed and progression routes established. • Ensure appropriate transfer of information and equipment.	**COLLEGES**

ABBREVIATIONS:

- CS – Children's Services
- DCT - Disabled Children's Team
- TYS -Targeted Youth Services
- FAC's -Fair Access to Care
- HCS -Health & Community Services
- TC -Transition Coordinators
- TT -Transition Team
- LFLW – Learning for Living and Work
- CPA – Care Programme Approach
- SAFA – Safeguarding Adults from Abuse

- DOLS – Deprivation of Liberty
- MHA – Mental Health Act
- MCA – Mental Capacity Act