Transition Protocols and Procedures
INTRODUCTION
The purpose of the Liverpool Transition Protocol and Procedures is to provide co-ordinated multi-agency support for young people who have a Statement of Special Educational Needs (SEN), a disability, and/or complex needs. It is the responsibility of all relevant agencies in Liverpool to work together to remove any barriers to make the transition from one service to another as smooth, seamless and person-centred as possible for every young person.

In order to achieve a smooth transition, all agencies need to ensure that they are planning with the young person and their parents and carers in preparation for these changes. This means that each involved agency must be clear about the project needs and wishes of the young person from the age of 13 years onwards, must contribute to the planning of transition and must ensure that they are working closely and sharing information with colleagues from other agencies.

The policy applies to young people who live in Liverpool, those who are looked after out of Liverpool and those who attend day and/or residential schools out of Liverpool. This policy is intended to support staff to ensure quality standards are met and a safe and transparent transition from children’s to adult’s services.

SCOPE
Who the protocols and procedures apply to:
They apply to all agencies and staff who work with young people (between the ages of 13 and 25) in a time of transition in Liverpool between Children’s and Adults’ social care services and education. It also applies to local council, health and other voluntary and statutory services in contact with children and young people.

NATIONAL CONTEXT
In recent years there has been a wide range of national legislation highlighting the principles that agencies should apply when working with young people in a time of transition. A large number of these agencies and principles have influenced the development of the Liverpool Transition protocols and procedures: (Appendix 1, page 17)

WHO ARE THE AGENCIES RESPONSIBLE
• Education.
• Social Care (Children’s and Adults’ Services).
• Health Care (Children’s and Adults’ Services)
• CAMHS (Children and adolescent mental health services)
• AMHS (Adult mental health services)
• Connexions.
• Housing
• Job Centre plus
• Leisure
• Transport
• Young Peoples Learning Agency (YPLA)
• Colleges
• Commissioned voluntary sector services

What we mean by ‘transition’:
There are many transitions in a young person’s life, but in this strategy we are referring to the move that young people who have a Statement of Special Educational Needs (SEN), a disability, and/or complex needs make between children’s and adult’s social care service provision and education.

Who we mean when we talk about ‘young people’:
Within the protocols and procedures we have used the term ‘young people’ to mean people between the ages of 13 and 25. As the strategy is about the transition between children’s and adults’ service provision, it is relevant to agencies working with all young people between the ages of 13 and 25 in a time of transition.

WHO IS ELIGIBLE FOR SUPPORT
Any young disabled person, parent and carer who has been identified as meeting the criteria for services and has been referred to the Transition Operational Managers Group prior to their 18th birthday.

The referral for the young person will be sent to the transition operational managers group on the young persons 16th birthday. This will give the transition social worker for adult services the opportunity to work in partnership with all concerned and the relevant allocated children’s social worker to ensure a seamless transition. It has been recognised that some young carers may fall outside this eligibility criteria and therefore a pathway has been developed between Barnardos young carers and Liverpool carers centre to ensure a smooth transition (appendix 2, page 17)

Children and young people who are eligible may:
• require support in adult life to achieve economic independence or to live independently
• require an adult health, including a mental health, service
• require an adult social care service
• be placed in out-of-borough schools or specialist colleges
• be educated at home
• be placed in a hospital school
• be placed in one of the Local Authorities maintained schools
• be placed in a school sixth form
• be placed in a special sixth form
• be placed in an independent school in the City
• be placed in an academy
• be placed in care or identified as care leavers
• be outside formal education

PERSON CENTRED TRANSITION
All agencies take responsibility to ensure Young people are central to aspects of transition planning, and involved at every stage.

Liverpool transition strategic management group are committed to ensuring that the transition planning process is person centred and takes into account all aspects of a young person’s life that includes education, social care needs, health needs, personal and social development, training, employment, housing, transport and leisure activities.

CHILDREN’S SOCIAL CARE SERVICES
All agencies involved with children and young people have a duty to ensure they are up to date with inter-related protocols and procedures.

We aim to provide high quality, effective services, working with schools and other children’s services to meet the needs of children in care or those getting support.

We also:
• Support families so that children get the best possible care.
• Take action to protect children - in agreement with parents and carers wherever possible.
• Support the work of the Liverpool Safeguarding Children Board.
• Recruit and support foster carers and adoptive parents.
• Commission services for children and families as well as providing them.
• Encourage young people to become involved in making decisions about our services via an active participation group.

ADULT SOCIAL CARE SERVICES
Whilst the emphasis of support for children and young people under 18 years with complex needs is to provide services that will directly ensure their safe care and development, in services for vulnerable adults the emphasis has shifted towards self directed support to enable independent living within the community. Assistance will then be provided to enhance access to positive lifestyles in accordance with the young adult’s own aspirations, as set out in the Department Of Health publications ‘Valuing People’, ‘Valuing People Now’, ‘Our Health, Our Care, Our Say’ and ‘Putting People First’. Lead professionals will be identified from each appropriate service at (or before) the young person’s 18th birthday. This support could be from Connexions, Job Centre Plus, a school offering post-18 education, Liverpool Community College and voluntary organisations in the area. In all cases the lead professionals involved will explain the implications of this at the earliest possible stage so that young people, their family and carers are aware of the different types of resources and support they will be able to access and arrange post-18. To access specific support from Adult Social Care & Health eligibility will be assessed using the FACS (2010) criteria. Eligibility will be determined by the age of 18 at the latest.

DISABLED CARE LEAVERS
The Children (Leaving Care) Act 2000 is intended to improve and lengthen the transition process for all looked after young people, and to also help meet the transitional needs of young disabled people who are looked after.

The transition planning process must take account of the developmental process that is
occurring for all disabled young people as they move towards adulthood. This process must place the young person at the centre in order to ensure that any plans made genuinely reflect the individuals’ wishes. It is vital to provide the young people and their parents and carers with good information throughout, both about the stages in the process and the range of options for the future.

For young care leavers who have a disability and whose needs have been considered, a Transition Plan will already have been developed and monitored at the young person’s annual school review. As a planning process, transition is complex and may involve a range of different service providers. However for disabled young people who are also looked after by the Local Authority the Transition Plan as completed for all disabled young people may not address all the relevant areas of concern. Where a young person is looked after their accommodation and post 16 support needs will be different and plans to assess and meet them must be made in a separate Pathway Plan, which will be developed from the first review after the young person reaches the age of 15 ½ years old. This pathway plan will be completed by their allocated social worker and must be completed by three months after the young person’s 16th birthday. In the case of a child with disabilities who has been looked after and qualifies for after care, it is the Pathway Plan that is the statutory plan which meets the requirements under the Children Leaving Care Act 2000 and it is this plan that is dominant. The transition plan may compliment the Pathway Plan but may not be substituted for a pathway plan.

TRANSITION STRATEGIC MANAGEMENT GROUP
This group takes strategic ownership for maintaining and raising quality standards across all agencies providing Transition support to young disabled people, their carers and families.

Key Purpose
- To ensure the commissioning and planning of the Liverpool Inter Agency Transition Strategy through effective planning encompassing all the major service agencies for children, young people and adults.
- To improve the transition experience of disabled children and young people.
- To ensure effective and transparent delivery to support joined up strategies.

Objectives
- To produce seamless transfer of social care, health and wellbeing for disabled children and young people to adulthood.
- To act as strategic scrutiny and champion for transition.
- To be a conduit for service users to ensure transition strategy development includes young people and young adult’s voice.
- Be responsible for the development of specific Transition Strategies to ensure seamless delivery of services and promote a Think Family approach.
- Ensure the views of young people, parents/carers influence the design, delivery and evaluation of services.
- Provide a strategic overview of the work of other groups which address transition issues.

Membership
- Schools
- LCC – Children, Family and Adult Services
- Clinical Commissioning Group
- Housing
- Transport
- Young People and Parents
- Health Providers – Alder Hey, NHS Merseyside, Adult Acute Health Care Trusts
- Public Health
- Connexions
- Making It Happen Groups (MIH) – Adults
- CAMHS

PARTICIPATION OF DISABLED CHILDREN AND YOUNG PEOPLE
- MIH Groups in Adult Services
- Schools Parliament
- Parent Partnership
- People First
- Parent Matters Network
- Camhs VIP group
- Barnardos Action with young carers

REPORTING TO THE CHILDREN’S TRUST AND THE LIVERPOOL HEALTH AND WELL BEING PARTNERSHIP BOARD – ADULTS & FAMILIES
Governance – Board will ensure delivery of strategic arrangements are commensurate with City wide arrangements with Local Area Arrangements, Children & Young People’s Plan and Operational Plan for PCT

FREQUENCY OF MEETINGS
The group meet quarterly
Co-Chairs
- Director of Integrated Adult Health & Social Care
- And Assistant Director Children and Families Social Care

TRANSITION OPERATIONAL MANAGEMENT GROUP
This group is responsible for identifying and monitoring children and young people who will require continuing services prior to reaching adulthood and identifying the appropriate lead professionals to work closely with the young person and liaise with each other so as to ensure a smooth transition. This group will identify and monitor children and young people who will require continuing services when they enter adulthood. The group meets every eight weeks. A list of all children aged 13 years or more who are subject to a statement of special educational needs and who are approaching their year 9 review is provided for the group by the SEN section.

This group is responsible for ensuring that the needs of a young person are identified prior to a young person reaching adulthood and identifying the appropriate lead professionals to work closely with the young person and liaise with each other so as to ensure a smooth transition.

Key Purpose of the Group
- To provide a regular opportunity for operational managers across all disability services within Liverpool City Council, Liverpool PCT children and adult services, Liverpool Community Health, voluntary sector managers, Alder Hey Community services, Mersey Care, 16-19 team, Education (schools and support services within SEN section) and Connexions to exchange and share ideas on best practice and continuous improvement of services within their management scope.
- To support the development of an integrated transition hub for services including setting in place a joint performance management system to review quality of transition plans and impact on outcomes for young people.
- To agree service development and integrated working opportunities across organisations and teams and raise areas of organisational concern which are causing barriers to improvements in the transition experience for young people.
- To lead on innovative thinking and planning of services for young people with a disability through transition.

FOSTER PLACEMENTS
No young person should be placed with a foster carer without due consideration and responsibility for what happens when the child becomes an adult. From 2012 all Liverpool foster placements including out of city Foster placements will detail transition arrangements including roles and responsibilities, legal obligations and good practice guidance.

MANAGEMENT FRAMEWORK and SYSTEMS
This section details Liverpool’s current strategic and operational management framework, and the systems in place to control and monitor performance.
Remit and Responsibilities

To provide a focal point for discussing priorities and communicating developments for young people with disabilities in transition.

To ensure that young people with disabilities become known to adult services in sufficient time for their needs to be assessed and their entitlement to appropriate services established.

To share relevant information between child and adult teams so that timely and appropriate allocation of caseworkers can take place.

To encourage positive planning for each young person in transition that is person centered and reflects what is important to that person and to those who know them best.

To ensure that a clear plan for each young person’s future, including the support they will require from services, is in place before they reach school leaving age.

The plan should have clear outcomes and should specify who will be responsible for delivering them.

(Appendix 4 & 5, page 18)

To track and monitor progress at regular intervals throughout the year.

To promote joint working between agencies and between child and adult practitioners, together with a realistic appreciation of each others priorities and constraints.

To develop agreements and protocols between teams as to how the Transition process will be managed, with clarity about roles and responsibilities.

To review and evaluate the effectiveness of these protocols.

To identify actual or potential gaps in provision and priorities for commissioning services.

To receive reports from the Transition Social Worker about their work and any relevant issues raised.

It will not be the task of this Group to discuss individual cases in detail nor to share confidential information about young people and their families, except between those professionals who need to know. However, there may be occasions when the Group is invited to problem solve issues or situations that arise for individuals within the Transition process.

Accountability

The Group will report to the Transition Strategic Management Group.

The minutes of the meeting will be provided to the members of the group for wider distribution to their respective organisations.

Membership/Attendance

The Group will consist of representatives from:
• The Disabled Children’s Team
• Children’s Community matrons
• Children’s community nursing team
• The Alder Hey Learning Disability Team
• The Learning Care Team
• Prescott Drive
• All CAMHS services operating across the City
• The Adult Learning Disabilities Social Work Teams
• The Adult Physical Disabilities and Sensory Impairments Social Work Team
• Statutory Mental Health Adult Social Work Teams
• The Learning Disabilities Directorate in Merseycare NHS Trust
• The Children’s and Adults Commissioning Teams in Liverpool
• The Children’s and Adults Commissioning Team in the Local Authority
• Greater Merseyside Connexions Service
• Employment services
• The16-19 Team
• Further Education Colleges
• Voluntary sector
• Special Schools Head Teachers and mainstream secondary school inclusion leads
• Inclusion Development Officers

STAY IN LIVERPOOL MANAGEMENT GROUP

Key Purpose of the Group

To enable all disabled young people living in Liverpool to stay in the City after leaving school.

To ensure high quality options for further education, training, health, employment, leisure, transport, housing and financial benefits which will enable real and full participation for disabled school-leavers.

Remit and Responsibilities

To identify the post-school needs of all disabled young people in Liverpool

To develop systematic, integrated, person-centred planning arrangements around post-16 options for disabled young people in Liverpool

To promote effective multi agency integrated support arrangements in order to effect seamless transfer and engagement for disabled young people in Liverpool

To secure the real and meaningful participation for disabled young people in Liverpool in their chosen post-16 routes

Connexions Identify young disabled people who may be considering residential College provision or who may be at risk of not entering further education, training, paid employment or other meaningful activity

Work in partnership with the LCC post 16 team to provide appropriate information about the young person’s education, health and social care needs.

Work to a timeframe that provides timely information and supports the LCC post 16 team to make decision making and commissioning process.

Provide person centred planning and health action plans for every Young Disabled Person identified.

Identify housing, further education, training, employment, transport, leisure and benefit needs.

Work with Young disabled people, parents and carers to look at choices and options.

Through the Greater Merseyside Connexions and LCC post 16-19 team work with providers to ensure provision is available within Liverpool.

Explore options to develop provision where it does not exist

Improve accessible provision which is not currently accessible

Provide a leaving school action plan to identify education, training, employment, health, housing, leisure, transport and financial benefits plan

Where there are gaps in provision or accessibility include these into Liverpool’s statement of priorities, which is used to inform the Post 16 commissioning statement.

This Group will report to:

Director and Assistant director of children and adult services.

Membership / Attendance:

Local Authority representative 16-19 group

Frequency of meetings:

The Group will meet every month from September to July with focused actions being taken forward between meetings.

MANAGERIAL RESPONSIBILITY FOR TRANSITION SOCIAL WORK PRACTICE

The Team Manager is responsible for the management of transition social work.

The performance, quality and workflow of the transition social work service will be monitored by team managers and service managers across all disciplines of children and adult social work.

TRANSITION SOCIAL WORKER

Key Purpose

The Transition social worker provides professional social work support for young people with disabilities and their carers and families.

This is a key role to ensure effective partnership working across, schools, connexions and health and social services.

The social worker will identify individual needs through assessment and care planning. To work in partnership with the young person to plan and design individual care plans to meet those needs. To ensure outcomes and the delivery of services are met as identified in care plans.

To ensure that regular monitoring and reviews take place during the young persons individual transition pathway.

Transition Social Worker role with young people age 17-19 (year 12-13) Looked After Children (LAC)

• The Looked After Care Team provide the multi agency transition plan (Appendix 5) to the Transition social worker and Children’s services retain case and funding responsibility.

• Transition social worker to work in partnership with the Looked After Care social worker to co-ordinate future planning and share information with the relevant Adult team.
• Transition social worker to inform relevant Adult team and liaise regarding possible future plans.

Young people (aged 17) known to the Disabled Children’s Team.
• The Disabled Children’s Team provide the multi agency transition plan (appendix 5) to the Transition social worker and Children’s services retain case and funding responsibilities.
• The Transition social worker works jointly with social worker from children’s services.
• Transition social worker begins exploration of adult services/community resources with the young person and their family in preparation for leaving school.
• Transition social worker completes:
  - Community Care Assessment and Care Plan at least 3 months prior to the young person’s 18th birthday.
  - Resource Allocation System (RAS) for Care Package to be funded by Adult Social Services and to be in place for the young person’s 18th birthday.
  - Transition social worker:
    - Reviews new care package 3 months following the person’s 18th birthday.
    - Begins transfer of case responsibility with adult social worker 3 months prior to 19th birthday and handover to adult social work team.

Obtain annual review dates and attend review meetings from 17th birthday.
• Provide further information about transition arrangements and information about adult provision and services.
• Act in a co-ordinating role where clarity around adult provision is needed.
• Input onto Transition Information Database.
• Up dates the multi agency transition plan to identify actions.

If parent/carers not able to attend – Home visit arranged with Connexions Personal Advisor.
• Provide further information about transition arrangements and information about adult provision and services.
• Act in a co-ordinating role where clarity around adult provision is needed.
• Update Transition Information Database.
• Up dates the multi agency transition plan to identify actions.
• Provide information about “Have your say” and the compliments and complaints procedure.

Transition Social Worker role with young people age 17-19 (years 13 and 14) Not Known to the Disabled Children’s Team.
• Identify cohort of young disabled people not known to the Disabled Children’s Team.
• Referrals from school and Connexions

Obtain annual review dates and attend review meetings
• Compile multi agency transition plan to identify actions.
• Update Transition Information Database.

If parent/carers not able to attend – Home visit arranged with Connexions Personal Advisor.
• Provide further information about transition arrangements and information about adult provision and services.
• Act in a co-ordinating role where clarity around adult provision is needed.
• Update Transition Information Database.
• Compile multi agency transition plan to identify actions.
• Provide information about “Have your say” and the compliments and complaints procedure.

YEAR PLANNER ROLES AND RESPONSIBILITIES
- LOCAL AUTHORITY
- SCHOOLS AND ACADAMIES
- SOCIAL SERVICES
- CONNEXIONS

Year 9
• Relevant attendance at annual review/ person centred review.
• Social worker supports the development and implementation of the Transition Plan/PCP
• Disabled Childrens Service Manager receives Transition Plan from school.
• Appropriate provision/services identified and funding agreed in line with Transition plan action point.
• Participate in Team Around the Child.

Year 10
• Relevant attendance at annual review/ person centred review.
• Feedback on progress against actions in Transition Plan/PCP
• Disabled Service Manager receives updated Transition Plan from school.
• Appropriate provision/services identified and funding agreed in line with Transition plan action point.
• Participate in Team Around the Child.

Year 11
• Relevant attendance at annual review/ person centred review.
• Post 16 educational provision identified
• Feedback on progress against actions in Transition Plan/PCP
• Service Manager receives updated Transition Plan from school.
• Appropriate provision/services identified and funding agreed in line with Transition plan action point.
• Participate in Team Around the Child.

Year 12-13
• Information passed at set meetings to identify resources for input or services.
• Allocation of Transition Social Worker on 17th Birthday.
• Adult Services attend final Annual Reviews before transfer for those with complex needs.
• Community Care Assessment before 18th Birthday.
• Post 19 education provision identified
• Care plan completed as required.
• CCA will indicate appropriate adult

Ages 16-18
in College/Work based learning or not in Employment Education or Training. (not in school)
• Referrals to adult services at age 17.
• Community Care assessment undertaken.
• Allocation of Transition Social Worker on 17th Birthday.
• Care Plan completed as required.
• Referral to connexions/Post 16 provider
**TRANSITION INFORMATION MANAGEMENT**

Data for disabled children and young people are stored in the council’s Management Information System (Capita One) which is used for day to day administration and management, and monitoring performance data. Activity and personal data for Adult Social care clients is currently stored in the SUIIS electronic care management system although the service is currently in the process of procuring a replacement system. At present children have a unique pupil ID to identify them within Capita One, and for the adults all clients have a unique SUIIS ID, although this will be the clients NHS number in the new system. Both data sets are used in accordance with Data Protection and Caldicott guidance and are used to ensure current services are working effectively and to inform future service planning.

In accordance with this guidance there are currently issues regarding the sharing of identifiable client data between children’s and adult services. In order to address the need of the transitions service, it has been specified in the Statement of Requirements that the new adult’s electronic care management system contain a field for populating with the unique ID from the Capita One system.

The proposal is that all transitional 16/17 year olds will be recorded on the new system by the transitional social worker, although access to this information will be restricted to the privileges of the transitional social worker allocated and their manager only. Should the client require and be eligible for adult social care services once they had turned 18, appropriate information would be then be available to the allocated social worker within the appropriate adults team. Information management and technology systems operate to support education, health and social care across children’s and adult services.

**FINANCIAL TRANSITION PROCEDURES**

To ensure a safe transition of financial management across Children and Adult services a common set of principles and procedures have been developed.

**Commissioning across Children’s and Adult services is based on:**

- a comprehensive mapping of existing services
- a vision of how local needs may be better met
- a strategic framework for procuring all services within politically determined guidelines
- a bringing together of all relevant data on finance, activity and outcomes
- an ongoing dialogue with service users and carers and service providers in all sectors
- effective systems for implementing service changes, whether of in-house or of independent sector services
- an evidence-based approach which continuously evaluates services with a view to achieving measurably better outcomes for service users and their carers
- an improving alignment with the way that other health and social care services are commissioned

(Based on making ends meet 1) [http://www.audit-commission.gov.uk/pressoffice/pressreleases/Pages/makingendsmeetwebtoolre-launched.aspx](http://www.audit-commission.gov.uk/pressoffice/pressreleases/Pages/makingendsmeetwebtoolre-launched.aspx)

**FINANCIAL TRACKING SYSTEMS**

The transition tracking system will monitor high cost packages of care. No financial commitment from Children’s social care to support packages of care extending beyond a young persons 18th birthday will be made without explicit written agreement by adult services, based on needs assessment. All young people and their parents and carers will have clear written information about the agreed plans for support post 18th birthday. This will ensure commissioners of both Children and Adult services adhere to the principles of prudent financial management. It will reduce and eradicate financial risk and identify local commissioning priorities.

The data analysis team will report to and meet with the Transition operational managers group to report on high cost packages of care. Tracking high cost packages of care will ensure:

- Regular reviews take place
- Outcomes are reported and evaluated
- Commissioners better informed
- Reduced financial risk
- Young person and parent and carer better supported

**PROCEDURES**

- Young person and parent and carer better supported
OVERVIEW OF THE PROCESS / POLICY AND PRINCIPLES

All agencies responsible for young disabled people, parents and carers and responsible within these transition protocols and procedures will:

- Report to; and attend the Transition Operational Managers Group (TOM) and provide clear and timely information about transition including options for the future. This group has been established to support and monitor the transition journey that young people, their parents and carers go on.
- All individuals coming through transition will be discussed from the age of 17 at the transition operational managers group. This group is attended by senior managers and representatives from the Children Looked After Team (CLAT), Leaving Care team (LCT), Disabled Children’s Team (DCT), Adult services (Adult physical disabilities and sensory services, Mental Health Services, People with Learning Disabilities service(PLD)), CAMHS, Health, Connexions and education, Young Peoples Learning Agency
- The transition operational managers group will identify if the young person is likely to need Adult Services and if so pass referral details to the transition social worker.
- A Fair Access to Care Services (FACS 2010) assessment will be completed by the transition social worker to establish their likely eligibility. Where the young person has a range of disabilities or is looked after this may be a joint assessment. The involvement of an Adult Service for the assessment does not infer that they are responsible in any way for this young person.
- If the young person is not eligible for Adults’ Services they will be referred on by Education and Children’s Services to Connexions and any other relevant organisations. This young person will be closed to Adults Services unless their circumstances change entitling them to a new assessment.
- Special Education Need (SEN) department notify Liverpool City Council education department of young people with statements in year 8 (age 13) and above. This process will continue year on year until the young person with a statement of educational need leaves school.
- Parents and carers notified to detail transition planning process, key stages, rights and responsibilities.
- Year 12 (age 17) If young person is eligible for a service at their 17th birthday they must be referred to the Transition operational managers group for allocation to the transition social worker.
- Young person’s details put onto the transition data base for tracking and monitoring.
- Young person is referred to the transition social worker for information, advice and assessment.
- Multi agency assessment takes place and eligibility for services discussed and reported to funding panel within health and social care.
- Multi agency transition plan and care plan completed with clear information detailing actions, roles and responsibilities.
- At age 18 the young person transfers to the appropriate social services adult disability team, including pre-agreed budget responsibilities.
- Transition social worker reviews care plan and details future social work roles and responsibility. Following review transition social worker will transfer case to allocated social worker or places the case details onto review and monitoring system.
- Any new or changed needs after this period can be reported to Liverpool Careline for re-assessment.

MULTI AGENCY TRANSITION PLAN

A Multi Agency Transition Plan has been put in operation to ensure:

- Good practice transition arrangements across all agencies
- Information is consistent, timely and well co-ordinated
- The young person, family and carer know what is happening
- Improved Quality standards
- Mental Capacity Act (Appendix 3, page 18)

Transition Multi Agency Action Plan Guidance Notes (Appendix 4, page 18)
- Transition Multi Agency Action Plan (Appendix 5, page 42)

EVALUATION, MONITORING AND REVIEW

Agencies should ensure that they have robust and continuous evaluation processes in place so they can effectively monitor and review the young persons individual transition pathway arrangements.

Agencies should make sure that they make contact with every young person preferably 3 months after they have formally left their service as part of the monitoring process.

Young people should be at the core of the monitoring and reviewing processes to make sure that their individual needs are being met in the best ways possible. They should help to define what constitutes a positive outcome for them. These outcomes should then be used within the monitoring process.

Agencies should ensure that the feedback and any recommendations are addressed. These views of young people should be captured at every stage of the transition process so that the suggestions of those aged 13 through to 25 influence the development and improvement of services.

The Policy team will be responsible for any necessary amendments/revisions to the policy and disseminated to named managers.

DISAGREEMENTS

This section clarifies how disagreements between agencies regarding multi-agency responsibility should be resolved.

If a disagreement occurs in relation to a specific case between partner agencies it should be referred to the Team Manager.

The relevant Team Manager should then liaise with the relevant Service Manager in order to attempt to resolve the situation.

If this does not successfully identify a resolution then the Team Manager/ Service Manager should take responsibility for referring the matter to the Transition Operational Management Group who will review the matter and attempt to find a satisfactory solution acceptable to all agencies involved.

Agencies involved should ensure that services to the young person/parent/carer, are not disrupted or delayed whilst a resolution is found.

In cases where young people or their parents or carers are dissatisfied with any element of their care they can first speak to the staff involved and share their concerns or if they are not happy to do this they can follow the individual agency’s complaints procedure.
APPENDIX 1

NATIONAL CONTEXT

- Children Act 1989/2004
- Community Care (Direct Payments) Act 1996
- Disability Discrimination Act 1995/2005
- The Learning and Skills Act 2000
- Children (Leaving Care) Act 2000
- Health and Social Care Act 2001
- Special Educational Needs and Disability Act 2001
- Valuing People, March 2001, and Valuing People Now, April 2009
- National Service Framework for Children, Young People and Maternity Services 2004
- Equality Act 2010
- Care Matters: Time for Change, 2004
- Department of Health (2006). Transition: getting it right for young people. Improving the transition of young people with long term conditions from children’s to adult health services.
- The Mental Health Act, 2007
- Care Matters: Time for Change, 2007
- Equalities Act 2010
- National Frameworks for Continuing Care (Adults and Children)
- National Carers Strategy (2008) – Carers at the heart of 21st Century
- Working together to support young carers – A model of memorandum of understanding between statutory Directors for Children’s Services and Adult social Services (ADASS/ADCS 2009)
- Think Child, Think Parent, Think Family: a guide to parental mental health and child welfare (SCIE 2009)
- Special Educational Needs Code of practice (DfES/S81/2001 November 2001)

APPENDIX 2

YOUNG ADULT CARERS

Transition Pathway between Barnardo’s Action With Young Carers and Liverpool carers centre

- Discussions with the Young Carer about their transition to adult services will start when they are 17 (or earlier if appropriate) with their AWYC Project Worker.
- A transfer referral form will be completed and sent to Local Solutions along with a completed Liverpool Carers Self Assessment Form.
- If appropriate, a request will be made through Careline for a Carers Assessment (if the Young Adult Carer is providing ‘substantial care on a regular basis’)
- The Young Adult Carer will be given a Liverpool Carer’s Information Pack and a copy of the I Care leaflet (depending on where they live)
- Prior to their 18th birthday, a meeting will be arranged with the Young Adult Carer, their project worker from Barnardo’s Action With Young Carer and the appropriate worker from Liverpool Carers Centre. A plan of support will be drawn up.
- A visit to the Carers Centre will be arranged
- The AWYC project worker will remain in contact with the Young Adult Carer and Local Solutions worker for up to 3 months after their 18th birthday.

YOUNG ADULT CARERS

It is expected that the young carer will have had a young carer assessment, CAF or specialist service assessment in place. The transition social worker for adult services should work with (at least) the young carer, parent or guardian, specialist young carers service (were applicable) adult carers service and parents social worker to undertake a carers self directed assessment and develop a carers support plan to ensure all of their needs are identified and outcomes can be met.

All professionals working with young carers should be mindful of. The 2001 census which identified that there are 230,000 young adult carers, defined as young adults aged 18-24 who provide unpaid family care. In addition, there are 61,000 16 and 17 year olds who are on the cusp of moving from being ‘young carers’ to ‘young adult carers’.

The move into adulthood for young carers is very likely to be hampered by lack of qualifications, limited social skills and continuing caring responsibilities, making entry into the labour market difficult.

Indeed, this is supported by research in this area by Chris Dearden & Saul Becker, looking at the affects of caring during childhood as young people move into adulthood: A transition pathway has been developed specifically for young people.

APPENDIX 3

MENTAL CAPACITY ACT

The impact of the mental capacity act on young people in Transition to adulthood

The Mental Capacity Act 2005 (MCA) marked a major and welcome step forward in disabled people’s rights. For the first time in UK history we have a legal framework through which to formally recognise and protect the fundamental rights of people who lack mental capacity to make their own decisions. It should be recognised how the MCA can impact on young adults with limited mental capacity, the following should be considered;

Parents and family carers whose views were seen to take priority over those of the young disabled person.
Local authority funders concern over cost considerations overruled the need to offer choices (combined with local authorities’ perceived need to take parental views into account).
Policy and practice issues such as the values of individual managers and the complexities of managing different legislation, together with the wider regulatory framework such as care standard inspections, risk assessments and duty of care.
Medical professionals who had not received training about the MCA or chose to ignore it because of ethical medical decisions. In each service doctors’ instructions were considered unchallengeable and therefore staff followed them.
All professionals working with young disabled people should be appropriately trained in respect of the Mental Capacity Act and up to date with current guidance and procedures.

Further information, guidance and support can be found on Liverpool City Council Intranet web site.

APPENDIX 4

MULTI AGENCY TRANSITION PLAN and GUIDANCE INFORMATION

Multi agency transition plan guidance notes
Purpose:
This multi agency transition plan is to ensure:
- Good practice transition arrangements across all agencies
- Information is consistent, timely and well co-ordinated
- The young person, family and carer know what is happening
- Improved Quality standards

This multi agency transition plan is Not:
- An assessment document
- A Care plan
- A statement of aspirations wishes
- A contract

SECTION 1

NAME/CONTACTS
Key information to give the reader basic details. More detailed information will be obtained from CAF, and other assessment documentation.

SECTION 2

EQUALITY AND COMMUNICATION
Key personal information.

SECTION 3

ACCOMMODATION TRANSITION INFORMATION
Information is needed about past accommodation arrangements and significant involvement. This will help advise how the young person came to the present accommodation.

Detail significant information and include any LAC, Foster care arrangements. Team responsible and review information.
SECTION 4
CONNEXIONS TRANSITION INFORMATION
Detail information relating to connexions and any planned reviews including dates.

SECTION 5
HOSPITAL TRANSITION INFORMATION
If the young person is known to Alder Hey or any other children’s hospital it should be recorded here the date of transfer to adult acute hospital. Detail any action that may be required and record any significant contacts.

SECTION 6
HEALTH ACTION PLANS/ ANNUAL HEALTH CHECKS/HEALTH PASSPORTS
All information should be recorded and detailed in the Transition action plan.

SECTION 7
FORM COMPLETED BY?
Consent information

SECTION 8
TRANSITION ACTION PLAN
This section must summarise each transition action plan. It needs to include: 8.1: What decisions have already been made (This must be evidenced and based on fact)
8.2: What is pending decisions (This must clearly state responsibilities and review dates)
Person Centred Planning.
Has a person centred plan been completed?
Any significant actions from this?

ACCOMMODATION
Past accommodation information if this is important to understand present situation For example young person lived at home until move to foster care etc.
Where does the person live?
What are the present contractual, financial agreements and any end dates for contracts.
What needs to happen?
Any decisions made (Evidence and ownership)
Any pending decisions?
Review dates.

EDUCATION
This should detail review dates and summary of any agreed action. It must detail the date of leaving school.
Any agreed or pending decisions?

CONNEXIONS
This should detail the contact details of the named connexions PA. Detail a summary of connexions action. Is the person entitled to a 139a assessment?
Is Young Person Learning Agency (YPLA) currently involved?
Any agreed decisions (whom and when?)
Any pending decisions?

HEALTH CARE
Detail any transition arrangements from children’s hospital to adult health care.
Information would include date of care transfer.
Health care arrangements including health passports, health action plans.
If young person is attending Alder Hey what actions are taking place to ensure G.P is fully involved and Adult Acute Health have appropriate information of individual need.
This area will be crucial to any effective health transition including CAMHS TO AMHS transition.
Detail any decision made between CAMHS and AMHS.
Detail any pending decisions made between CAMHS and AMHS.
Detail any Social Work involvement / Team and Team Manager

SOCIAL CARE
Detail Children Social Work involvement/ Team and Team Manager.
Aids and Adaptations.
Detail any aids and adaptations.
Detail any health and safety requirements.
For example equipment needs to be checked annually.
Detail any financial cost implication. For example is any equipment on loan and or paid for by children's services?

CARERS
Has a carer’s assessment been done?
Detail Short Break / Respite information.

BENEFITS
Detail any sign posting /age appropriate financial benefits required.

APPENDIX 5

MULTI AGENCY TRANSITION PLAN

<table>
<thead>
<tr>
<th>Title</th>
<th>Forenames:</th>
<th>Family Name:</th>
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<tr>
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<table>
<thead>
<tr>
<th>Preferred Name:</th>
<th>D O B:</th>
<th>Age:</th>
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<table>
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<tr>
<th>Current Location:</th>
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<table>
<thead>
<tr>
<th>Tel No(s):</th>
<th>Mobile:</th>
<th>Minicom No:</th>
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<table>
<thead>
<tr>
<th>Email address:</th>
<th></th>
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<table>
<thead>
<tr>
<th>Present Address (If different from above):</th>
<th>Person Centred plan completed</th>
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<tbody>
<tr>
<td></td>
<td>Yes: No:</td>
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<table>
<thead>
<tr>
<th>G.P</th>
<th>Key Worker:</th>
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<table>
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<tr>
<th>Connexions Advisor:</th>
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<tr>
<th>Lead Teacher</th>
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<th>Social Worker / Team Manager/Team responsible</th>
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2. Equality and Communication

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<th>Ethnicity:</th>
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<table>
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<th>Nationality:</th>
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<table>
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<tr>
<th>First Language:</th>
<th>British Sign Language:</th>
<th>Interpreter needed?</th>
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<tr>
<th>Religious/Spirituality /beliefs described as:</th>
<th>Not disclosed:</th>
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<table>
<thead>
<tr>
<th>Summary of Communication Needs:</th>
<th></th>
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| Summary of Advocacy Needs: | |
3. ACCOMMODATION TRANSITION INFORMATION
This must also include Looked After Care and Foster Care arrangements.

Past:

Present:

4. CONNEXIONS TRANSITION INFORMATION

5. HOSPITAL TRANSITION INFORMATION

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Date of Transfer</th>
<th>Action</th>
<th>Key Contact</th>
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<tbody>
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6. MENTAL CAPACITY / HEALTH ACTION PLANS / ANNUAL HEALTH CHECKS

- Is a Mental Capacity assessment required (Detail in Action Plan)
- Health Action Plan completed in the past 12 months (Date)
- Does the person need a Health Action Plan
- Has the Health Action Plan been reviewed (Date)
- Has an Annual Health Check taken place by the General Practitioner (GP) (Date)
- If not a referral to the General Practitioner must be made. (Detail in Action Plan)
- Does the person have a Health Passport
- Does the person need a Health Passport (Detail in Action Plan)

7. WHO HAS PROVIDED THIS INFORMATION, IF NOT THE PERSON?

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to person:</th>
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Has consent been given for this information to be recorded? Yes ☐ No ☐
### 8. TRANSITION ACTION PLAN:

(Healthcare/Connexions/Social Care/Mental Capacity/Self-Directed Support/Person Centred Planning/Carers/Benefits Advice)

| Action plans must name person responsible for each action, record significant dates and why? |
| And include date of review. Social worker to provide history and care plan to support this Transition Plan. |

### 9. CONTACT DETAILS OF PERSON COMPLETING THIS FORM

<table>
<thead>
<tr>
<th>Name and Agency</th>
<th>Tel No:</th>
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<tbody>
<tr>
<td>Email address:</td>
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</tr>
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Version 1, July 2012, Author: A Durkin.