Transition Planning

Making Transitions Work

A Policy for Young People with Complex Needs or a Disability in Dumfries & Galloway
Making Transitions Work

Transition Planning
For Young People In Dumfries & Galloway
With Complex Needs Or A Disability

This policy has been developed with advice from young people, their parents and carers, representatives of voluntary/independent service providers and further education. This includes the following:

• Education and Community Services
• NHS Dumfries and Galloway
• Dumfries and Galloway College
• Careers Scotland

The policy has been developed in the spirit of the Children and Young People's Charter (2004) and of The Same as You? (2000).

This Children and Young People’s Charter was developed through talking to children and young people who have experienced the need to be protected and supported and outlines how they can expect to be treated in order to feel safe. Young people expect those working with them to:

• Get to know us
• Speak to us
• Listen to us
• Take us seriously
• Involve us
• Respect our privacy
• Help us to be safe
• Be responsible to us
• Think about our lives as a whole
• Think carefully about how you use information about us
• Put us in touch with the right people
• Use your power to help
• Make things happen when they should

The Same as You?, the Scottish Executive’s review of services for people with a learning disability, has seven principles. People with a learning disability should:

• be valued. They should be asked and encouraged to contribute to the community they live in. They should not be picked on or treated differently from others.
• be seen as individual people.
• be asked about the services they need and be involved in making choices about what they want.
• be helped and supported to do everything they are able to.
• be able to use the same local services as everyone else, wherever possible.
• should benefit from specialist social, health and educational services.
• have services which take account of their age, abilities and other needs.

The Education (Additional Support for Learning) (Scotland) Act 2004 states clearly that all transitions need to be improved for those pupils with additional needs, and the transition from school education to adulthood is invariably the most important of all the transitions.

Our proposals aim to encourage innovative, cross-sectoral working….and must also:

• improve the actual services users and carers receive through a holistic approach to planning which touches on every aspect of the young persons future life: living arrangements, personal and social life, well-being, education, leisure, training and work.
• ensure wasteful duplication and gaps in services are avoided by the clear delineation of responsibilities across all agencies
• ensure public funds are used more efficiently and effectively.

The Government has mandated that local authorities and health must remove barriers to joint working to allow more flexibility to enable:

• pooled or aligned budgets;
• all new services to be jointly commissioned;
• integrated provision.
Index

1.0 Purpose .................................................................................................................................... 5
2.0 Scope ........................................................................................................................................ 5
3.0 Legislation, Guidance and other Key References .................................................................. 5
4.0 Definitions ................................................................................................................................ 5
5.0 Values and Principles ................................................................................................................ 6
6.0 Planning for Transition ............................................................................................................. 7
7.0 Standards .................................................................................................................................. 9
8.0 Planning and Information Strategy ........................................................................................... 9
8.1 Information for service planning ................................................................................................. 9
8.2 Information about services ......................................................................................................... 10
9.0 Assessment and Care Planning ................................................................................................. 10
9.1 Assessment ................................................................................................................................. 10
9.2 Care planning ............................................................................................................................... 11
9.3 Financial support for care plans ................................................................................................ 11
9.4 Reviews ...................................................................................................................................... 11
9.5 Autonomy .................................................................................................................................. 12
9.6 Outwith authority placements ..................................................................................................... 12
9.7 Post-school provision ................................................................................................................ 12
10.0 Service Monitoring ................................................................................................................... 12

Appendices

A Protocols ....................................................................................................................................... 13
TAP1 Schools’ Transition Procedure ................................................................................................. 13
TAP2 Schools’ Transition Pathway .................................................................................................... 16
TAP3 Schools’ Transition Flowchart ................................................................................................. 17
TAP4 Transition Action Plan Template ............................................................................................. 19
TAP5 Checklist & Role for School Co-ordinator ............................................................................. 21
TAP6 Social Services’ Protocol- Assessment, referral and handover between services & interface with schools’ Transition Planning ................................................................................................. 22
TAP7 Social Services’ Pathway .......................................................................................................... 25
TAP8 Social Services’ Flowchart ....................................................................................................... 26
TAP9 Social Services’ Eligibility Criteria and Team Manager contact list .................................... 27
TAP10 Proforma letter to Parents ..................................................................................................... 29
TAP11 Proforma letter to Professionals ............................................................................................ 30
TAP12 Professional Report Template ............................................................................................... 31
TAP13 Pupil Profile document ........................................................................................................ 32
TAP14 Community Paediatrician Protocol ....................................................................................... 36
TAP15 Information Protocol ............................................................................................................ 36
TAP16 Consent to share Information form ........................................................................................ 38
TAP17 CAMHS Transition to Adult Mental Health Services protocol ............................................ 39
TAP18 CAMHS Integrated Care Pathway ........................................................................................ 40
B Legislation and Policy Framework ............................................................................................... 41
1. Purpose

1.1 To address the difficulties encountered by young people with complex needs or a disability which they face moving from adolescence to adulthood, and to ensure the smooth transfer of responsibility between relevant agencies. Although the Additional Support for Learning (Scotland) Act applies a 12 month transition period, prior to a child leaving school, it is of fundamental importance to this policy that planning is initiated in S3, or 14 years of age.

2. Scope

2.1 The policy relates to young people with complex needs or a disability aged 14 to 25 years.

2.2 The policy is endorsed by both children’s services and adult’s services teams and endorsed by Dumfries and Galloway Council, NHS Dumfries & Galloway, Careers Scotland and Dumfries and Galloway College. It will be put into practice through a series of agreed protocols and will be widely available to young people and to their parents or carers in a variety of formats.

2.3 These transition protocols form part of the appendices to this document (Appendix A)

3. Legislation & Policy Framework

The relevant legislation, policy guidance and other key references are attached in Appendix B.

4. Definitions

Within the Disability Discrimination Act 1995 a disabled person is defined as someone who has a physical or mental impairment which has an effect on his or her ability to carry out normal day-to-day activities. The effect must be:

- substantial
- long-term (that is, has lasted or is likely to last for at least a year of for the rest of the life of the person affected), and
- adverse

Learning Disability

“The Same As You?” gives the following definition:

A learning disability is a significant, lifelong condition which has three facets:

- reduced ability to understand new or complex information or to learn new skills;
- reduced ability to cope independently;
- a condition which started before adulthood (before the age of 18) with a lasting effect on the individual’s development.

This includes people with autistic spectrum disorders and Asperger’s Syndrome

Physical Disability

The Disability Discrimination Act 1995 defines someone as having a disability when they have a condition which has an impact on their day to day life. This, for example, means people who have cancer, multiple sclerosis, a hearing impairment or a sight impairment; or perhaps a mobility difficulty. The physical impairment will have a substantial and long term adverse effect on the ability of the young person to carry out normal activities.
Mental Health Problems

The Mental Health (Care & Treatment) (Scotland) Act 2003 provides a range of new rights and protections for all individuals with a mental disorder. This term covers a range of mental health problems, including mental illness, learning disability, and personality disorders. It also includes a range of syndromes which have an impact on day to day life or on a young person’s resilience to future mental distress. It could also include co-existing problems such as substance misuse.

5. Values And Principles

5.1 The Children (Scotland) Act 1995 makes it plain that children with complex needs or a disability are children first and, as such, are entitled to the same services as other children. They are defined as children “in need”, and entitled to an assessment of their need. Services should be designed to enable such children to maximise their independence.

5.2 It is important that the adult status of people with complex needs or a disability, is recognised and reinforced. We believe that each person is an individual and that society should respect that individual and their fundamental rights. These rights include the following:

CHOICE: the opportunity to select independently from a range of options

RIGHTS: the maintenance of all entitlements associated with citizenship

FULFILMENT: the realization of personal aspirations and abilities in all aspects of daily life

INDEPENDENCE: opportunities to think and act without reference to another person including a willingness to incur a degree of calculated risk

PRIVACY: the right to be alone or undisturbed and free from intrusion in relation to individuals and their affairs

DIGNITY: a recognition of the intrinsic value of people regardless of circumstances by respecting their uniqueness and their personal needs

Young people, including those with complex or profound needs, are entitled to support in order to exercise these rights.

5.3 It is important that families have the right to lead ordinary lives. The process of transition should not impact on family life to the extent that parents automatically become “carers”. Families should be able to make decisions within the boundaries of ordinary living, and that should include the decision to take up or continue to work. This may constitute a major cultural change.

Dumfries and Galloway is committed to enabling families to maintain these rights.
6 Planning for Transition

6.1 The transition from adolescence to adulthood happens at different ages for all young people, including those with complex needs or disabilities. Each young person will encounter different problems and opportunities during this period in their life. It is important that appropriate information on available services is accessible to young people and to their carers, and that they are able to access and use support systems which meet their needs, during the key points of transition. These include:

- leaving school, entering work, on going education and the full range of leisure and sport activities;
- leaving one’s family and setting up a home;
- becoming involved in adult personal relationships;
- becoming an independent adult.

In addition there are a number of age related transitions that occur during the late teenage years. These transitions are all inter-connected; a good transition to adulthood depends upon a holistic approach to supporting a young person with the changes that are occurring in their life. Transition planning should be person-centred.

6.2 Developmental objectives during transition

There are certain objectives for all young people of this age in moving through to adulthood. These include:

- the development of a sense of identity, personal autonomy and self-advocacy.
- transition from school to further/higher education, work experience, and/or employment, and meaningful activity (including training, voluntary work, leisure opportunities and life-long learning).

- the development and the skills that are needed for independence.
- the identification and negotiation of appropriate accommodation (with the necessary supports in place).
- opportunities to participate socially and economically
- the development of a sexual identity and the formation of adult sexual relationships.
- a shift in the parent/child relationship through developing maturity, and leaving home where appropriate.
- the development of new relationships outside home and school.

6.3 Process

Transitional arrangements for individual young people with complex needs or disabilities will be planned jointly by:

- NHS Dumfries & Galloway
- Education, Social Work and Community Services
- Careers Scotland
- Dumfries and Galloway College, other Further or Higher Education centres
- other relevant voluntary and independent agencies,

in partnership with the young person, their parents and their carers.

Where consideration has to be given to placing a young person in a specialist post-school educational establishment outwith Dumfries & Galloway, this will be done in line with the policy currently being developed for agreement by the Education, Social Work and Community Services Committee.

Young people, their parents or carers should be encouraged to consider support from independent advocacy services.
The focus should be on the positive aspects of the young person’s life, their aspirations and how these can be realised in as inclusive a way as possible.

6.4 Care and support will be based on a person-centred assessment of need which takes account of the aspirations of the young person and is agreed by all parties.

6.5 Young people will be involved in their Transitional planning from the age of 14 years. It is good practice to begin to involve all children in decisions about their lives as soon as possible. In some cases, a young person’s needs may not become apparent until later in adolescence in which case the appropriate planning should begin at the earliest opportunity. Examples of this might include the onset of severe and enduring mental illness or some physically disabling conditions. Education, Social Work and Community Services must formally notify relevant agencies about young persons who are undergoing a transition. They have a duty to identify who will be involved in supporting the young person in realizing their ambitions in the future.

6.6 Information will be shared jointly with relevant agencies, with the informed consent of the young person and, where appropriate, their parents and/or carers.

6.7 Young people will be supported to make informed choices.

6.8 Young people will be encouraged and supported to access mainstream services wherever possible and appropriate.

6.9 Young people will be supported in their community as far as possible and consistent with their wishes and needs.

6.10 A nominated lead agency must be agreed by all relevant parties and specified in each individual case at the S3 review, to ensure that the necessary collaboration of care and support planning takes place across all relevant agencies. The lead agency will co-ordinate the process for that individual: funding streams and budgets remain with relevant agencies or services who also remain responsible for carrying out their part of the transition process effectively, in partnership and in accordance with this strategy and the agreed protocols.

6.11 Joint agreements on future planning will be reached on:

- the assessment, planning and review process
- the nominated key worker
- funding arrangements
- time scales and action planning

It is our expectation that this will be taken forward through a joint assessment process - single shared assessment in adults services, and integrated assessments in Children’s services.
7. **Standards**

For professionals working with young people and their families through the transitional stage of the young person’s life, effective joint working is vital. Joint working principles and arrangements for Dumfries and Galloway Council and NHS Dumfries and Galloway are set out within the Extended Local Partnership Agreement and the Integrated Children’s Services Plan.

Following from these principles and as a result of this policy:

7.1 Young people, their parents and carers will be fully informed about and involved in their assessments and future life plans, the services which will be provided, and the monitoring of needs and services.

7.2 All services will respect the racial, cultural, religious heritages, sexual orientation and gender of young people with complex needs or a disability. Young people and carers will be treated fairly and with respect for their particular life styles. Services will promote the development of the young person’s autonomy.

7.3 All transition planning will be undertaken in consultation with the young person, their parents or carers, and with relevant agencies, and will be provided in a co-ordinated and consistent manner.

7.4 Services for young people with complex needs or a disability will be of the highest quality: consistent, accessible, and provided in accordance with Care Commission standards where appropriate.

7.5 As part of its statutory responsibilities, Dumfries and Galloway Council, in partnership with NHS Dumfries & Galloway, will regularly monitor and review:

- individual care plans and support;
- opportunities for young people with complex needs or a disability;
- consultation processes (including with the young person, their parents or carers);
- information available for young people with complex needs or a disability, their parents and carers.

8. **Planning And Information**

8.1 **Information for Service Planning**

Education, Social Work and Community Services, along with NHS Dumfries & Galloway, will work jointly to compile information on the needs of young people with complex needs or a disability from the age of 14 (S3). Where unmet needs for individuals are identified, these should be noted by the chairperson and forwarded to strategic planners in Children’s and Adult’s services to aid future service development.

The voluntary sector, user and carer groups will be involved in informing views in relation to service planning and development at various levels:

- direct involvement in own individual care planning;
- specific projects or pieces of work e.g. questionnaires, focus groups, workshops, etc.;
- participation in strategic planning groups.
8.2 Information about Services

It is essential that the younger person, their parents or carers can access information about services that would be appropriate for them at this stage in their lives. The Children’s (Scotland) Act, and the Health and Community Care Act, require the production of information targeted at families who will benefit from these services.

There will be a range of information provided for young people and their families about transition planning services that may be available. This will include a jointly produced “school leavers” information pack.

Information will be produced in a variety of accessible formats. Staff in all agencies will be informed about the full range of services and benefits available. Training programmes will be in place to ensure that staff and parents, whether located in adult or children’s services, are aware of the full range of needs, services and entitlements of this age group.

Information should include mainstream provision, and mainstream services (including leisure services and transport) should be encouraged and supported to make access to their services easy and welcoming, in line with the Disability Discrimination Act (1995) and upcoming legislation.

Information and publicity will be shared between all relevant agencies.

9 Assessment And Care Planning

9.1 Assessment

A transition plan, based on the single shared/integrated assessment format will be developed and reviewed on a yearly basis.

Where the views of the young person and their parents or carers conflict, the rights of the young person to develop skills and to gain new experiences, with due regard to minimizing and managing risks, will be the first consideration.

Features of good assessment and care planning include the following:

- work is undertaken in partnership with the young person and their parents or carers
- use is made of existing assessments wherever possible
- agreement is obtained before new assessments are conducted
- services from different agencies are planned and reviewed together as a single process to avoid duplication wherever possible
- account should be taken, without discrimination, of a young person’s disability, gender, religious persuasion, racial origin, cultural and linguistic background

The assessment process will address all the dreams and aspirations of the young person. It will give particular emphasis to the strengths and potential of that young person and the barriers they may encounter when striving to achieve the normal objectives of moving into adulthood, such as employment, independence, new relationships and accommodation.

The special needs of young people with complex needs or disabilities, in areas such as personal assistance, equipment and adaptations, mobility and communication equipment, will be addressed in an age appropriate way, to reflect the transition from adolescence to adult maturity.

As with all young people, any assessment will address issues of risk, vulnerability, maturity, continuity and, in planning services, the ability of a particular service to meet those needs in a locality that is acceptable to the young person and his or her family.
9.2 Care Planning

The planning process will involve the young person, parents and carers and key individuals.

Co-ordinated planning between NHS Dumfries & Galloway, Education and Community Services, Careers Scotland and the Further Education Funding Council for Scotland, is essential to manage boundaries and funding and to ensure appropriate support services are provided.

When care planning identifies the future needs of young persons to be met via Careers, Employment Services and Housing providers, direct consultation with them will take place. As such, relevant providers of services could become an integral part of the care planning process. This will be important to reach agreement on the equipment, adaptations and support that may be necessary to enable a young person to live independently.

9.3 Financial support for care plans.

A young person’s needs will be assessed in accordance with eligibility criteria adopted by Children’s and Adult’s Services, and will be made available to young persons and their parents or carers.

Agreement on funding of care packages must be made with relevant budget holders. Unmet needs should be measured and evidenced and presented to both commissioners and funders to enable the appropriate development of future services.

The overall aim is to secure a seamless transition of funding arrangements from Children’s to Adults’ Services. It may be appropriate for a young person to receive Direct payments to purchase services for themselves.

9.4 Reviews

All transition plans for young people will be subject to reviews held at appropriate times with all relevant people present. Young people, their parents and carers will be supported to actively participate in the review.

Where young people with complex needs or a disability are looked after, reviews will be held on a six-monthly basis and linked with other reviews to minimize the impact of possible duplication on young people, their parents and carers.

All relevant agencies have a shared responsibility to participate in the review process to ensure that young people and their parents are not left unsupported and without clear goals. This should make the need for crisis intervention minimal. The outcome of the review will be that a clear plan will be drawn up early identifying the roles, responsibilities and timescales for achieving tasks identified.

Adult Services will be notified in advance by Children’s Services (via schools) of a young person’s review from S3 (age 14). They will also subsequently be informed in writing of the outcome of such a review. Children’s and Adult’s Services will ensure that they work co-operatively to enable a smooth transition from childhood to adulthood.
9.5 Autonomy

Young people will be encouraged to be fully involved in their care planning and service provision. Their aspirations will be of central importance to the process and their views will be treated with respect and dignity. Creative ways of establishing the views of young people with severe and complex communication problems will be considered. Wherever possible, the assessment process should facilitate the young person’s personal autonomy. Advocacy and interpreting schemes will be made available as appropriate for the young person.

Information on the full range of services and benefits at transition will be made available in a range of formats understandable to the young person concerned.

In response to current disability legislation the Council and NHS Dumfries and Galloway will

- not treat young people with a disability less favourably for a reason related to their disability
- make reasonable adjustments to avoid putting young people with disabilities at substantial disadvantage.

This will include steps to ensure that issues of accessibility to buildings and services are systematically planned for and addressed.

9.6 Outwith authority placements

Some children and young people with profound or multiple disabilities spend a lot of time away from their families and local communities in residential care or schools in out of authority placements. Although, of itself, the placement may meet the young person’s highly specialist needs, the disadvantage of living away from their families and local networks mean that such young people may grow up lacking a sense of belonging, and the local community no longer feels a sense of responsibility for them.

Therefore, where any placement for a child is being considered, the issue of their return into the community will be an active consideration at each review.

The suitability of the placement for the child/young person, their wishes and feelings and those of their parents and carers will be key factors in any such placement, while at the same time local agencies will actively seek to provide appropriate services locally.

9.7 Life After School

In line with the values and principles stated in section 5, young people will be encouraged and enabled to pursue a range of further opportunities. This will include further education and employment within their local area.

The Council also has a commitment to promote access to community learning, sport and leisure activities for all its citizens, including young people with disabilities, as well as a legal duty to make these sorts of activities barrier free.

10 Service Monitoring

Performance measures will be agreed and established to review the implementation of this strategy and the outcomes of transition planning in practice.

Services will consult with young people, their parents or carers to obtain their views on the services.

All feedback, including complaints, will be monitored to help improve services and to inform future service development.
Appendix A – Protocols

The following pages contain protocols which have been developed in consultation with relevant staff groups across Dumfries & Galloway and which describe working arrangements and procedures to ensure Transition Planning is person-centred and thorough.

TAP1

EDUCATION

TRANSITION ACTION PLANNING PROTOCOL

Preamble

The Additional Support for Learning (Scotland) Act 2004 (ASL) has replaced the Future Needs system for planning post-school life. This legislation seeks to offer a more co-ordinated, person-centred approach to transition planning which requires meaningful input from all professionals involved with a Young Person (YP).

Ground Rules and Underlying Principles applying

1. Everything done to empower young people and their families
2. Emphasise flexibility and keep person-centred planning at heart of all planning
3. Focussing first on needs of the individual, not the availability of services
4. Re-emphasise this process is about planning together
5. Identification of what information on options and what key reports are required and assembling these
6. More emphasis on meaningful Action Plans with the minuted discussions, with clearly noted responsible persons
7. Checks built in to ensure progress and communication with YP/Families
8. Clarity on identification of Lead Person for Young Person and their role in co-ordination of planning process
9. Schools and all other parties involved should be able to expect a two-way flow of relevant information

Who Transition Planning is necessary for

Transition Planning must be provided for Pupils who have Co-ordinated Support Plans (or until 2007, existing Records of Needs under the old system) and should be considered on an individual needs basis where there are additional support needs for:

- Pupils who have otherwise required significant levels of support because of learning difficulties, or because of emotional, behavioural, social or home difficulties, or enduring medical needs, or
- Pupils who have disengaged from the secondary curriculum
- Pupils for whom English is a second language (NB many pupils in these last 3 categories might have an Individualised Educational Programme (IEP))
Protocol

1. An initial Transition Planning meeting should ideally be held in S3 (or by age 15). In advance of this, the Pupil Support Co-ordinator should issue a Transition information pack and have an informal preparatory discussion (in person or by phone as appropriate) with YP/family on:

- the purpose of the Transition planning meeting
- who the YP/family would like to have present at planning meeting (offer help with recommendations*)
- what information is needed and from whom
- whether the YP and their family understand the options they might explore for post-school life
- a list of questions/issues that they might usefully raise at the meeting (included in pack); (NB ensure YP’s views are elicited and noted in advance of meeting)
- check if social services are already involved with YP and should they be asked to assess support needs for the future; is need for new referral indicated?
- considering who would be most appropriate Key Worker
- seeking signed informed consent to ask for information from relevant other professionals and to share it appropriately with other professionals involved
- the existence of peer support groups such as PIN and PLUS, and independent advocacy providers, should help/support be needed to raise issues at any time

2. Plan multi-agency meetings well in advance (at least 10 weeks in advance of date)

- coincide meeting with any other multi-agency meeting for this YP whenever possible (e.g. Looked after reviews)
- consider where parents would prefer to meet (in school, office, elsewhere?)
- invite all relevant personnel as agreed above
- seek reports from all relevant teaching and school support staff from which to compile an integrated school report to be issued ahead of meeting, to give parents time to digest content
- advise other invitees to submit reports or information relevant to preparing for post-school for distribution in advance of meeting
- advise any other parties, from whom a report alone is required
- circulate information, confirming purpose of meeting and enclose copies of reports (at least 2 weeks before)

3. Hold Meeting (chaired by PT Pupil Support or Senior Management Team):

- stress the need for person-centred approach throughout meeting
- stress the planning element to ensure remaining time at school is targeted at YP’s needs and interests
- identify if all required information is to hand/ what might still be required
- consider most appropriate transition planning strategies for YP such as input of additional guidance support to explore options, extended meetings with careers officer, work experience, visits and tasters with necessary supports
- define and list action points
- identify responsible person(s) for each action point
- reiterate name of the co-ordinator for young person and contact details
- re-verify with YP and parents, that they give their consent to sharing action plan/other information

4. Generate an action minute of the discussions with clear Transition Action Plan detailing future actions/responsible persons. Circulate this to all attending and those who sent apologies and also to Additional Support for Learning Manager.

5. Co-ordinator should ensure arrangements for college taster sessions, visits to any day services or other establishments, or work placements are actioned

6. Co-ordinator should re-visit action plan every 3 months to check progress, pursuing any outstanding matters

7. Annual review meetings should be held, with attendees, content and means of updating plans discussed in advance with parents and young people as above

8. Action Plans should be redefined, updated and shared appropriately as above

9. No less than 6 months before the YP is due to leave school, an information profile on the YP which identifies any pertinent risk assessments, behaviour strategies, any existing personal life plan, targets, support needs, and teaching strategies should be developed and consent obtained/agreement reached on sharing this with adult agencies, college, workplace etc as deemed appropriate

10. Good Practice would recommend that the Co-ordinator has a final discussion with YP/family on how well they felt supported throughout the planning process, noting any learning points from this discussion

The key Learning Support teacher and the Head Teacher or nominated deputy would usually attend planning meetings, the latter to chair and facilitate. Depending on individual circumstances, other individuals would normally be invited from the following list which need not be seen as exclusive or indeed compulsory:

- Community Paediatrician (school doctor)
- Educational Psychologist
- Careers Adviser
- Social Work representative if already involved
- Representative(s) from Colleges/universities as appropriate
- Any health professional involved

- Any support workers involved from e.g. Crannog, YPSS,
- Any voluntary agency involved e.g. Quarriers
- Hope Services or other supported employment representative
- Adult Day Services representative
- A befriender or someone from PIN, PLUS, or other advocacy organisation
- Any other key worker not otherwise involved with the above

NB Review of protocol

This Protocol should be checked and reviewed by May 2008.
School Pathway for Pupils in Transition from School setting to Adult setting

At S3 (to be concluded a minimum of 12 months before school leaving date)

1. Issue Transition information pack to YP/family

2. 10 weeks before Transition meeting, school discusses with YP/family information needed, invitees and list of questions. Seeks informed consent to obtain and share information

3. Meeting date set and school sends invitations out to all parties, seeking written reports from professionals by 2 weeks before meeting

4. When reports are to hand (at least 2 weeks before meeting), schools copy to all invitees

5. Person-centred meeting held to generate transition action plan for YP noting clear actions and key people

6. Annual Review meeting date provisionally booked and 3 month revision check of action points carried out with YP and family

7. Annual reviews held with Transition Plan updated as necessary and appropriate visits organised etc

8. Tasters and visits organised as appropriate

9. Co-ordinator copies action plan to all parties and ASLM. Also discusses with YP and family to ensure comprehension

10. Is Social Work input appropriate?

   a. YES
      - If Social Work Team already involved, school contacts relevant worker direct

   b. NO, proceed without SW (but if appropriate, highlight info pack/voluntary sector)

11. Where new referral to social work is felt to be needed, school sends to relevant Local Area Team. Social Work will make decision on referral within 1 week. If Social Worker allocated, school notified of name to contact direct; if declined as not meeting eligibility criteria, school and family advised accordingly

12. Passport of information (pupil profile) prepared as appropriate for transfer to post-school settings at least 6 months pre school-leaving

13. YP/family have final discussion with Co-ordinator to ensure happy with all arrangements
Transition Planning Protocol - Schools Flowchart

Transition Planning Meetings planned for pupils at least 12 months before age 16

School Co-ordinator to issue Tr info pack to YP/Parent and discuss:
- purpose of Transition Planning Meeting
- any targets and Personal Life Plan available (strengths, wishes, abilities)
- who to involve in Tr Planning Meeting to discuss future needs*
  - list of questions/possible issues to address
- possible options, information needs, work placements to consider
- if Social Worker is/should be involved to access future services
- seeking informed consent on obtaining reports/sharing information

Organise multi-agency Tr Planning Meeting
- invite relevant class teachers and support staff to contribute to comprehensive school report
  (for distribution to all parties at least 2 weeks pre-meeting)
- if appropriate, seek social services input (report and attendance)
  - range of other professionals invited as per YP/Parent list*
  (seek written reports from relevant professionals for copying 2 weeks pre-meeting)

Hold Transition Planning Meeting
Agree actions, tasters, educational needs, support needs and who is lead worker

Complete Transitional Action Plan and circulate
(with who responsible for what actions and when)

Arrange for College Tasters, work placements, Day Services visits as appropriate

Maintain check on agreed actions (re-visit termly with YP/Parent)

Conduct annual review(s) up to school leaving date
Prepare and pass information summary to next setting no later than 6 months before school leaving date
* (relevant parties likely to include some or all of the following:)

- Young Person and Family (PLP or own “thoughts plan”?)
- Community Paediatrician
- Educational Psychologist
- Careers Scotland
- Social Work Dept if already involved
- College Representative
- Any health professionals involved
- Any support workers involved from e.g. Crannog, YPSS,
- Any voluntary agency involved e.g. Quarriers,
- Hope Services representative if applicable
- Key learning support teacher
  (Head teacher or deputy may also be involved)
## TRANSITION ACTION PLAN

<table>
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<tr>
<th>School</th>
<th>Class:</th>
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<tr>
<td>Pupil’s Name</td>
<td>Key Co-ordinator</td>
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<td>DoB</td>
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<tr>
<td>Support Teacher(s)</td>
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### Date of Transition Meeting

| Chaired by | |
|------------||

### Other Personnel/Agencies Involved:

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<thead>
<tr>
<th>Names</th>
<th>Agency</th>
<th>Report (Y/N)</th>
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### Apologies from:

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### Pupil’s stated views, needs, ideas for future

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### Careers Ideas/ Post-school plans

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### Educational Objectives for the next year (e.g. ASDAN, life skills courses etc)

1. 
2. 
3. 
4. 
5. 
6. 
7. 
8. 
### Additional points to take account of from other agency reports

### Additional views/concerns of parents/carers

### Action Points (for named Agencies)

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<thead>
<tr>
<th>Action</th>
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<th>Proposed school leaving date:</th>
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<tr>
<td>Transition Planning Review meeting to be held</td>
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<tr>
<td>Signature of PT Pupil Support</td>
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<td>Signature of Pupil</td>
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**Copies to Pupil /Parent /PT Pupil Support /SMT /Key Worker /ASL Manager (tick)**

**Other Agencies (list):**

| School Co-ordinator | Contact No |
Role of School Co-ordinator

(may be PT Pupil Support or nominated Teacher, Pupil Support)

- would be both proactive (organising and seeking out information) and reactive in responding to requests for information and updating action plan appropriately
- this is an important key person who will co-ordinate all other parties’ input to help the YP/family to plan a seamfree transition
- ensures checklist is addressed and action plan is revisited to ensure progress
- mainstay of communication between school, family and other professionals

Has specific responsibility for overseeing:

- Arrangements for meetings, venue, agenda, sending invitations, gathering reports
- Organisation of minutes (if used) and action plan and their distribution
- Co-ordination of tasters and visits
- Transfer of pupil profile to relevant post-school setting and
- Being the point of contact for all communications regarding the pupil’s preparation for transition

Checklist for Co-ordinators

1. Have you explained the purpose of the Transition Action Planning (TAP) meetings to the YP/Parents and have you helped the parents to form an idea of questions and issues they might want to have discussed at the meeting?

2. Separately, will a member of support staff elicit the needs, hopes and views of the YP and will you ensure that these can be contributed as a starting point to the TAP meeting? (“Good Questions” sheet included in information pack may be useful prompt with recorded answers available in appropriate format – list, map or tape?)

3. Have you had a preliminary discussion on what options might be explored, and who the YP and parents think should be involved in the TAP meeting?

4. Do any differences in views between YP and parents need to be considered?

5. Has a Personal Life Plan already been prepared for the YP? Is one needed?

6. Have you issued a YP/Parent Transition Information pack?

7. Have you sought the YPs and Parents’ consent to seek and share information from other professionals?

8. Are you clear about your role as Co-ordinator, how you will check progress and address the action plan which is formed?

9. Have clear lines of communication been described to all others feeding in to the action plan?

10. Are there outstanding issues to pursue to ensure a good transition for the YP?

11. Have you diaried a check discussion with parents for 3 months after TAP meeting and a date for the annual review meeting? Is the school leaving date known?

12. When appropriate and agreed by YP/family, is a pupil profile document being collated for transfer to the post-school setting no later than 6 months pre-transfer? (Would a communication passport be beneficial for the young person, and if this has not yet been developed, should advice from SALT be sought?)

13. Has someone been identified to take over as key person for the YP? Are their contact details readily to hand? What actions will make this a seamfree handover?
Social Services – transition Protocol

Referral, Assessment and Handover relating to Young People with Additional Support Needs

Interface with Schools Transition Planning and between Young People’s and Adult Teams on Transition

1. Underlying Principles
   a) Remembering children with support needs are children first
   b) The process should empower young people and their families with emphasis on person-centred planning
   c) Emphasise flexibility in considering individual’s needs
   d) The process is based on assessing the needs of the individual, not the availability of services
   e) Identification of what information on options is required
   f) Involvement and commitment to joint working in appropriate multi-agency settings with timeous inputs and outcomes
   g) Emphasis on meaningful Action Plans with clearly noted responsible persons and timescales
   h) Open communication with young people/families and follow up as appropriate
   i) Appropriate information-sharing based on informed consent
   j) Aim for seamless transitions to adulthood with service allocation based on the assessment of need and optimum use of available resources

2. Social Work essential involvement in Education Transition Planning
   • The Additional Support for Learning (Scotland) Act 2004 (ASL) has replaced the Future Needs system for planning for post-school life. This legislation seeks to offer a more co-ordinated, person-centred approach which requires meaningful input from all professionals involved with the young person (YP) who has additional support needs.
   • Schools will lead in co-ordinating action plans based on personal life plans and social services will assess, identify and organise any necessary future supports for young people with additional support needs who meet their eligibility criteria
   • To enable greater understanding of supports available, schools should be given a summary of children’s social work teams’ contact details and responsibilities,
   • Clear communication of detail and timing of input is of paramount importance to inform the YP’s Action Plan; any outstanding action points will have a nominated key person responsible for actioning and feeding back to school Transition Co-ordinator
   • The following working protocol is advised:
      a) School to begin Transition Planning at S3 or age 15 (at least 12 months before school leaving age)
      b) Head of Pupil Support to establish with family whether appropriate to involve any social worker already involved or if a new referral should be made to social services; thereafter confirming the date of the transition meeting to social worker and if a report is needed and by when
      c) Children’s Social Worker will, if involved, endeavour to attend S3 planning meeting and any subsequent review meetings, involving Adult Services Worker once allocated; any unavoidable inability to attend should be notified and implications discussed with School Co-ordinator
d) Before meeting, assessment should at least be started for YP, if future support needs are likely to require adult services; This is an ideal opportunity to help the YP (and family) identify and discuss any issues pre-planning meeting

e) A report summarising assessed need and proposed options should be sent to the school which will then copy it to YP/family with school report

f) Meeting will generate an action plan. After meeting, any outstanding action points will be addressed by nominated persons and information fed to YP/family as well as the School Co-ordinator

g) If YP is not already known to any Social Work Children’s Team, but a new referral appears to be necessary to assess eligibility for future supports, permission from parent/carer will normally be sought and the necessary action taken to make referral to the local Social Work Team Manager. (NB If a new referral is aged 16 or over, this should normally go direct to the manager of the appropriate adult team to assess against the adult services eligibility criteria as to whether the YP is eligible for support)

3. “Looked after” Young People

• Young people with no disability or only mild or moderate disability but who are deemed to be “looked after” under the Children Act 1995, because of emotional, social, behavioural or other family reasons, will be supported by the relevant long-term Child Care Team until their 18th birthday.

• On leaving care, these young people will be offered support and guidance by the Through Care team, who can extend provision of such support until age 21 if necessary. Some, however, might meet eligibility criteria for adult services and their support could come from an adult team worker.

• If a young person who is “looked after” also has severe learning disability, physical disability or serious chronic illness they will usually have assessment, care management and social work support from the Children’s Disability Team. For some clients however, the long term team retains responsibility

• Those with a disability which would meet eligibility and priority criteria for accessing adult services would remain the responsibility of the relevant child care team until assessment of needs has been concluded and individual Team Managers have arranged a suitable handover point – around their 18th birthday or when they leave school, whichever comes first, but emphasising flexibility and mutually suitable timing. For handover arrangements see below.

4. Assessments/ Referrals

• Between age 14½ -16½, (or 12 –18 months before school leaving age is reached) CDT will use appropriate SSA documentation (Learning Disability or Physical Disability) to complete assessment as basis of referral on to adult teams

• New referrals of young people aged 16 and above should normally go direct to Adult Services for assessment using the Eligibility Framework. However if problems relate to potential short-term issues which would sit more comfortably with Childcare Teams, then referrals should revert to the appropriate Team Manager for their consideration.

• Assessment information should:
  • minimise duplication
  • be a fluid document easy to update and amend
  • be understandable to any authorised reader
  • provide enough information for decision on eligibility for services to be made
  • Team managers should acknowledge receipt of referrals by return, and consider and decide on referrals in line with allocation procedures
• Advice on allocation of worker (or rejection of referral) should be returned to referring Social Work Team manager or other referrer with anticipated time of uptake of case (or reason given for rejection)
• Team manager should advise the YP and family of decision and timescale
• Two Workers should commence working together with YP/family in preparation for handover, using the assessment paperwork as basis

5. Handover

Arrangements should ensure:
• thorough and gradual preparation of the young person/family
• ideally “two hands on the baton” approach for whatever time is necessary (not less than a 6 month period), in most cases, not extending beyond 18th birthday or school leaving date whichever is latest; flexibility should however allow consideration of individual need and exceptions to guidelines if this is mutually agreed to be desirable or necessary
• clear definition of roles and responsibilities during each stage –with appropriate and effective use of resources and no duplication
• that, to ensure smooth transition, where children’s services must end at age 18, support needs are fully assessed and appropriate arrangements made for any adult services which are required, including support services accessed from voluntary and independent agencies
• communication throughout with YP and parent/carer
• involvement of a social worker (could ideally be both) in school Transition planning meetings; it is essential that the adult worker attends final review meeting held at school to update action plan with information about future supports
• clarity on contact points and exact time of handover

6. Information-sharing and Record-keeping

• Information within the compiled SSA documentation should be checked by and made available to YP and family if desired
• SSA paperwork to be used as basis of referral and subsequently checked and developed by Adult Team worker
• Case records should be transferred when case is fully transferred from Children’s Team to appropriate Adult service

7. Review of protocol

This Protocol should be checked and reviewed by May 2008.
Social Services Flowchart – Transition Planning

School/family discuss if Social Services are already involved or is new referral appropriate

School makes contact with relevant existing Young People’s Social Worker or makes new referral if thought to be necessary (noting that any new referrals over age 16 to go to appropriate Adult Services)

Assessment started by SW using SSA paperwork if future need of adult services indicated

Summary Report - Available 2 weeks before School Transition Meeting

Appropriate SW attends Transition Meeting

School co-ordinator compiles and circulates action plan with actions, who and when

Where appropriate, referral made to relevant Adult Team by 1 year pre school leaving (or if leaving care, referral to Through Care Team by age 15)

Allocation of Adult Team worker notified to Children’s Team Manager no later than 6 months pre school leaving age (or Through Care Team worker, 3 months pre care leaving age)

Agreement made on appropriate joint working, date of handover and transfer of client caseload/records

New team worker makes joint visit with Children’s SW and both diary review meeting date(s)

New worker assesses necessary supports / researches options with family, using SSA

Visits, trials and tasters arranged by Co-ordinator/appropriate Worker as planned

Attendance by social services team worker at annual Transition Review meetings (Adult or Through Care team worker to attend at least final review)

School Co-ordinator keeps YP and his/her family appraised of progress and liaises with key professionals

Transition Planning - working together to identify actions that need to be taken and the supports needed to help a young person make a successful transition
**Making Transitions Work**

**Children and Families Social Work Eligibility Criteria**

Children and Families Social Work is not a universal service but a limited resource that is targeted at children and families where there is the greatest need to intervene. This intervention may for example be in the form of Child Protection or through accommodating children away from home, it may also include children with severe disabilities. Intervention may also be at an early stage in order to prevent crisis or emergency intervention at a later date.

Each Children and Families Social Work Team manager will decide, with their manager and/or their staff on the prioritisation of their work. If there are concerns about lack of intervention or the level of intervention provided, discussion should take place with the appropriate social work team.

For ease of reference a list of Social Services Team Managers’ contact details is attached. Referrers and families should also note the attached criteria which Social Service staff work to when allocating services. While new referrals should normally be addressed to the relevant children’s assessment team manager, new referrals of young people who are 16 years and over should be sent to the appropriate adult services Team Manager.

**List of Child Care Team Managers**

**Assessment and Referral Teams**

*East (Nithsdale, Upper Nithsdale, Annandale and Eskdale)*
- Graham Abrines, 5 Gordon Street, Dumfries – 01387 260847

*West (Stewartry, Newton Stewart and Wigtownshire)*
- Alasdair McGougan, Longacres Road, Kirkcudbright – 01557 339260

**Long Term Teams**

*East of Region*
- Beth Mitchell, 5 Gordon Street, Dumfries – 01387 260846

*Specialist Regional Teams*
- Rita Corbett, Children’s Disability Team, Nithbank, Dumfries – 01387 244690
- Jackie Dean, Fostering & Adoption, 27 Moffat Road, Dumfries – 01387 260681
- Tina Holliday, Leaving Care, Ladyacre, Craigs Road, Dumfries – 01387 268527
- Brian McClafferty, Youth Justice, Ladyacre, Craigs Road, Dumfries – 01387 268527
- Annie McMahon, Integrated Substance Abuse, Carmont House, The Crichton, Dumfries – 01387 245162
- Paul Sinclair, Young People’s Residential Services, Longacres Road, Kirkcudbright – 01557 339260
- Sarah McGarva, Planning & Assessment, Penninghame Centre, Auchendoon Road, Newton Stewart – 01671 403164
- Maggie Hutchings, Sensory Support Service, 24 Catherine St, Dumfries – 01387 253927

**Adult Services**
- Colin Lewis, Community Learning Disability Service (West), Garden Hill Primary Care Centre, Garden Hill, Castle Douglas – 01556 505777
- Stephen Hodgson, Community Learning Disability Service (East), Laurel Bank, Nithbank, Dumfries – 01387 244540
- Trevor Muir, Physical Disability Service, 1 Cresswell Gardens, Dumfries – 01387 268893
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<tr>
<td>HIGH</td>
<td>Parenting skills – need to be protected from risk of harm to self or prevent harm to others</td>
<td>Mental Health and other health needs parent/child</td>
<td>Family conflict</td>
<td>Young Offender</td>
<td>Substance Misuse</td>
<td>Social Isolation</td>
<td>Economic and Financial Difficulties</td>
<td>Housing Needs</td>
<td>Education Needs</td>
<td>Family needs - Loss or Trauma</td>
<td>Preschool needs - Developmental Disabilities</td>
<td>Physical disability</td>
<td>Emotional and Behavioural Difficulties</td>
<td>Parental Bereavement</td>
<td>Parental self-harm</td>
<td>Parental/Child relationship</td>
<td>Parental mental health needs</td>
<td>Parental physical health needs</td>
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<td>MEDIUM</td>
<td>Parenting skills – need to be supported to develop</td>
<td>Mental Health and other health needs parent/child</td>
<td>Family conflict</td>
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<td>Social Isolation</td>
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<td>Young Offender</td>
<td>Substance Misuse</td>
<td>Social Isolation</td>
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<td>Parental self-harm</td>
<td>Parental/Child relationship</td>
<td>Parental mental health needs</td>
<td>Parental physical health needs</td>
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Dear Transition Action Planning - <Name of Pupil>

At this time, it is usual to hold a meeting to discuss all the factors involved with planning for <Pupil’s> final years at school and move on to post-school life (this is called Transition). Although this could be 1, 2 or more years away, it is good to start thinking of the issues which need to be explored and ways to make the transition an easy one. An action plan will be drawn up so that the final years at school can be tailored to meet <Pupil’s> needs and arrangements made for visits and tasters to check out possible post-school settings.

The meeting will take place at <place>, on <date> at <time>. I hope that you and <pupil> can attend and that the relevant professionals from other services who provide supports for <pupil> will also be present. They will be asked to prepare a summary report of their views on supports needed, which will be copied to you before the meeting to help in the discussions. This might also mean that the school doctor or other healthcare therapist will contact you about conducting a medical examination.

Unless you tell me otherwise by <date>, I will assume you agree with my calling for reports and inviting the relevant parties to share in discussing these. I also enclose an information sheet which explains the need to share information and seeks your and/or your child’s written consent for this.

For young people who will require supports organised by adult services after leaving school, social services would normally be involved. If you do not already have a social worker, a new referral may need to be made to seek a needs assessment. We would discuss this requirement with you separately.

I <attach/have already provided> a folder of information which I hope you find useful. This explains the roles of some people who might help with planning transitions and gives information on some support services. It also contains phone numbers which might be helpful now or in the future and a list of questions, issues and possible areas to explore at the meeting. Before the meeting you might find it helpful to jot down any questions, concerns or points you wish to make yourself. <Pupil’s> support for learning teacher will help <him/her> to ensure <his/her> views are expressed at the meeting.

I look forward to meeting you on <date>. If you want to bring along a friend or other supporter to the meeting please let me know. Also, if you want to discuss any matter relating to transition, please don’t hesitate to get in touch on <telephone number>.

Yours sincerely

School Co-ordinator
TAP11

Pro Forma Letter for seeking professional reports/input

Dear Colleague

Transition Action Planning Meeting – *NAME OF PUPIL*

A multi-agency meeting is required to discuss the needs of ******** and to develop an appropriate action plan for the remaining years at school to prepare for his/her Transition to post-school life. This meeting has been arranged to take place at <venue> on <date> at <time>.

Your input via a summary report (template attached) <and hopefully your presence at the meeting> will enable appropriate consideration of any factors or other provisions which will help *Name* to make a seamless transition.

The school undertakes to pass copies of all reports to the young pupil and parents at least 2 weeks before the meeting, so I would appreciate having your report by <date>.

I look forward to <hearing from you>or<seeing you at the meeting unless I hear otherwise>. Many thanks for your assistance.

Yours sincerely

School Co-ordinator
### SERVICE REPORT

**Transition Action Planning Meeting**

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<td>DoB</td>
<td>GP</td>
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<td>Name of parent/guardian</td>
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#### SERVICE INVOLVED

1. **Background to Service involvement:**

2. **Special factors to be taken account of in current education setting:**

3. **Special health/social needs to be considered for the future:**

4. **Any mobility/personal supports likely to be needed:**

5. **Any comments on options for young person’s post-school setting:**

6. **Any other pertinent comments:**

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<th>Service</th>
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Confirming attendance at Transition Planning meeting: Yes /No (please circle)

The information contained in this form to be shared only with young person, parents/guardians and relevant professionals involved with the young person
**TRANSITION PLANNING - Pupil Profile Document**

This document is intended to provide a focus for young people, parents and school staff to prepare for transition from school post 16.

As such, it is a working document to be completed jointly over a period of weeks, (even months) prior to the young person’s final Transition Planning meeting.

Schools will know the most appropriate person or persons to lead the pupil through the document. It is envisaged that it will be a very useful resource for many pupils attending Learning Centres who require Transition Planning. It could quite easily form part of their Life Skills curriculum one period a week with the added bonus that it could also cover some core skills.

It is hoped that the profile would be passed (with the young person’s / family’s agreement) to any appropriate post-school setting(s) where sharing information would ensure smooth transitions and continuity of approaches.

### PUPIL PROFILE

#### Transfer of Information to Post-school Setting

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<th>Final review date</th>
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### Communications

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<th>Is English the first language?</th>
<th>Yes</th>
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<th>Are any communication aids/supports used?</th>
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<th>Does pupil have difficulty with understanding, expressing him/herself, or processing verbal language?</th>
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<td>What communication strategies work well?</td>
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<td>Any handouts/other supports needed to organise work or equipment?</td>
</tr>
<tr>
<td>Does pupil have a communication passport?</td>
</tr>
<tr>
<td>Is copy attached?</td>
</tr>
</tbody>
</table>

**Pupil’s abilities and additional support needed**

- What are pupil’s interests and strengths?
- Ability to read printed material?
- How does pupil indicate when they don’t understand or need help?
- Pupil’s written work (eg unaided writing)
- Pupil’s numeracy (eg social maths)
- How is pupil’s concentration and memory:
- Pupil’s use of IT/audio-visual aids?
- How does pupil cope speaking in groups/face-to-face?
- Any adaptations/special arrangements needed for exams or assessments?
- How pupil copes with breaks /unstructured times?

**Teaching strategies**

- What teaching supports have been used?
- Teaching strategies found useful
- Any amendments/adaptations made to curriculum or course work
### Personal & Social Skills

<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the pupil have a good level of self-confidence / self-esteem?</td>
</tr>
<tr>
<td>How does pupil cope with criticism?</td>
</tr>
<tr>
<td>How does pupil cope and what is best way to work?</td>
</tr>
<tr>
<td>• with adults</td>
</tr>
<tr>
<td>• with other young people</td>
</tr>
<tr>
<td>• In a group situation</td>
</tr>
<tr>
<td>How does pupil show initiative/decision-making?</td>
</tr>
<tr>
<td>Does pupil need support with change or in a new situation?</td>
</tr>
<tr>
<td>Can pupil respond effectively to instructions/advice:</td>
</tr>
<tr>
<td>What triggers anxiety or negative reaction?</td>
</tr>
<tr>
<td>How does pupil behave when anxious?</td>
</tr>
<tr>
<td>Are there any strategies to deal with this?</td>
</tr>
</tbody>
</table>

### Success Strategies

<table>
<thead>
<tr>
<th>Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>To help in situations with others</td>
</tr>
<tr>
<td>To motivate or keep on task</td>
</tr>
<tr>
<td>To use or avoid when upset</td>
</tr>
<tr>
<td>To manage anger</td>
</tr>
<tr>
<td>Does pupil respond to positive approaches/praise?</td>
</tr>
<tr>
<td>How should praise be given?</td>
</tr>
</tbody>
</table>

### Social Contacts and Friends

<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest in hobbies/clubs?</td>
</tr>
<tr>
<td>Support needed to access outside interests/develop friendships</td>
</tr>
<tr>
<td>Any difficulties which could result in social isolation?</td>
</tr>
</tbody>
</table>
### Health and Well-being Issues

**Physical Health**

- Dietary requirements or allergies to note:
- Supports needed with medication:
- Any personal care arrangements needed?
- Supports needed with moving and handling

**Emotional Health**

- Sexual awareness and relationship issues:

### Personal Safety issues

- Vulnerabilities/risk areas to note
- Actions to be taken to minimise risks

### Continuing Education and Career Options

- Pupil’s key strengths?
- Career/training/other opportunities being explored?

### The Future

- Pupil’s hopes for the future
- Other visits experienced/arranged
- Areas pupil wants to develop in
- Information provided on range of options
- NB - What key supports would be needed to enable pupil to access options?

### Any Other Information

- Is there any other relevant information not already covered?
Transition Planning - Community Paediatrician Involvement

At S3, approx age 15, Transition Planning will commence in schools to enable an action plan to be developed for those with co-ordinated support plans and other significant support needs.

All agencies who have involvement with the young person may be invited to participate in the Transition Planning meeting, following discussion with the family.

Regardless of whether attending or not, a medical report following the suggested draft generic template (attached) should be forwarded to the school co-ordinator no later than 2 weeks before the scheduled Transition meeting. Schools will provide at least 8 weeks notice of Transition Planning meetings.

Protocol:

1. School Co-ordinator will discuss with the pupil/family who should be invited to take part in the planning meeting
2. Invitations will be sent by school co-ordinator to all relevant parties asking for attendance at meeting and/or for summary report
3. Requests will be sent to the central Community Paediatric office for the relevant Community Paediatrician to compile a report and schedule their attendance at the Transition planning meeting if they feel this is appropriate (and if not appropriate or unable to, ensure apologies given)
4. Transition report will be written using agreed template and returned to school co-ordinator no later than 2 weeks before Transition meeting date to enable this to be shared with the young person and parents before meeting
5. Transition Action Plan will be compiled by School Co-ordinator after the meeting with actions and key responsible people noted, for circulation to all relevant parties
6. Any subsequent annual Transition Planning Review dates would be provided by the school and the Community Paediatrician would contribute appropriately as above

INFORMATION PROTOCOL – TRANSITION PLANNING

1. Why share Information?

If we share information on a Young Person (YP), we will inevitably gain a better, more complete picture of the needs of that YP and consequently be able to support them more effectively. Equally a YP should expect to be given access to all information held about him/her and also information that would help them to make choices about post-school life and to plan a good seamfree transition.

2. Obtaining Informed consent

Need to seek and record the informed consent of YP/parent or guardian to obtaining and sharing information with those involved with providing a service for the YP. This requires the professional to explain:

- what information is likely to be asked for/developed/kept
- how it would be stored and
- who it would be helpful to share it with and why
It would be acceptable for the School Co-ordinator responsible for Transition Planning to obtain and record the consent for the entire period of transition, providing it was made clear that YPs and their parents could withdraw consents if found necessary. It should be made clear that to fully support the YP, it would be expected to share relevant information with a range of professionals.

Other professionals have a responsibility in their dealing with the YP and parents, to check permission to share relevant information provided to them with others involved with the YP when appropriate.

3. Assembling information
- need to identify what information is legitimately required relating to the YP to maximise support and discuss how this should be gathered and presented
- also need to identify what other sources of information would help the YP in making choices and decisions about their post-school life and ensure this is obtained. Any needs identified at Planning meetings to seek additional information should be noted against a responsible person for action
- agreement on use of report templates to simplify the reporting process
- having reports copied in advance of the Transition Planning meeting so that YPs and their families and others have the chance to read and absorb these
- information packs should always be seen as fluid and able to be updated, amended and altered according to new needs or opportunities. These should be distributed to YPs and their families at the start of Transition Planning and opportunities given to discuss their content

4. Storage of information
   Any information obtained about the YP would be stored securely either in a file or on computer.
   Access to information would be restricted to only those with permission for this.

5. Transfer of information
   - Decisions on sharing information during Transition Planning can be made with families at the outset
   - Other decisions to be made on where summary information should be passed to help simplify the transition from school or other children's services to adult services
   - Where communication passports have been developed these should (with appropriate consent) be transferred to relevant next settings
   - Profiles – where identified as needed, a summary of relevant information should be passed to post-school settings after discussion with young person and agreement on sharing. These profiles could be developed with the YP by an agreed person such as Home Link Worker, Local Area Co-ordinator, Learning Support Assistant, teacher, nurse, member of social work team or anyone who knows the YP well. A proforma template is available for this purpose, which can be modified to suit.

September 2006
Transition Planning - consent to share information form

Young Person’s Name

Address:  

Date of birth  Tel No  

The information that you or your family give to those who provide support for you sometimes needs to be shared with others who support you.

It is important that you know about the sort of information that is gathered and held about you and that you agree who can see it.

If you change your mind about who can see information held about you, you should speak to someone who knows you well (like your learning support teacher or social worker).

By signing here, you are giving your consent. This means that you are happy for all the people who are helping to plan your transition (that is, move) to life after school, to hold and share information about you.

I understand that information will be held about me only if it is needed to ensure I am given the right support.

I give my consent to hold and share information about me when it is needed.

I understand that I can say if I have changed my mind about this.

Signed

Print name  Date

Sign here only if parent/guardian signs on behalf of the young person:  

Print name  Date

Add any comments if conditions apply regarding consent to share information


Transition Protocol from CAMHS to Adult Mental Health Services

1. 6 months before client’s 18th birthday, CAMHS worker to consider options for future care needs.
   - Do they need to transfer to Adult Mental Health services?
   - Can their needs be met by and outside agency or support system?
   - What are the clients/families/GP/other professionals’ views?
   - Has an appropriate risk assessment been carried out?

2. If thought that client requires adult mental health service, CAMHS caseholder consults with Transition MHW about transition pathway, and makes plans to attend appropriate CMHT allocation meeting to discuss the needs of the client. For Looked After young people, the process needs to link with the statutory looked after children review and leaving care planning process.
   - Plans need to be holistic, seamless and inclusive.

3. Not less than 3 months before client’s 18th birthday and joint decision for handover been agreed, CAMHS worker refers to CMHT team leader, in writing (TRANSITION NOTICE FORM). Thereafter planning is to be carried out in ‘face to face’ meetings, involving the client/family (where appropriate) at all times.

4. CMHT team leader to allocate CMHT worker to work with CAMHS worker to plan transition to Adult Mental Health service and prepare for the eventual hand-over.
   - The CMHT team leader should respond to the CAMHS worker with a name and contact number of the proposed team member within 4 weeks of the transition notice.

5. At this point an ICP planning date should be negotiated and agreed with the individual, family (where appropriate), CAMHS worker, CMHT worker and other relevant support services.

6. An ICP meeting should be held at least 6 weeks prior to the 18th birthday to promote the communications between the teams and allow for all interested parties to meet and share concerns, anxieties and formulate a plan of care that could reflect the changing needs of the client and the family. It is the responsibility of the CAMHS worker and the proposed new CMHT team member to establish an effective channel of communication that allows for the containment of any anxieties that a transition may cause. Consider a period of joint-working to enable the services to ‘dove-tail’ and to avoid an abrupt ending (i.e. to promote the concept of a seamless service). Again, for looked after young people, the process is to include the relevant looked after care worker and young people leaving care worker.

7. The Consultant responsibility remains with the CAMHS consultant until an agreed date of hand-over that meets the needs of the client. However, joint working between CAMHS and Adult Mental Health clinicians will enable a seamless transition. In practice when a client is under the adult services, the care can often be co-ordinated by a social worker, CPN, OT etc. and not necessarily by the Consultant Psychiatrist. If the CAMHS consultant holds a case (with no other worker involved) that requires transfer then they should also use the Transition notice to alert the CMHT and liaise with the new allocated team member from the Adult Mental Health service on how to organise an ICP to transfer the care.

8. The CAMHS worker should continue to assume responsibility for the co-ordination of the client’s care plan until the handover has been completed at the final ICP meeting. This enables a clear sense of responsibility within the period of joint-working, allowing for the sharing of skills and practises between services, and the development of new relationships.

9. All agencies should be aware of the Child Protection needs of the individual. Ensure established links with Child Protection staff.
10. Should the client experience a crisis/relapse in this period then the CAMHS worker would continue to assume responsibility until the situation is assessed as being more stable. This should not exclude joint working for the client but gives a clear sense of clinical responsibility in a difficult period. Best practise indicates that transitions are most effective in terms of engagement in future care when the individual is experiencing a settled period in their mental health. Thus, it is advisable to avoid a hand-over of care when a client is unable to contribute in their usual way to the process.

11. This protocol will be subject to an audit process to ensure that any particular difficulties in practise can be identified and problem solved.

**TAP18**

Integrated Care Pathway for Young People in Transition from CAMHS to Adult Mental Health Services

**Aged 17+ Years**

Assessment of future needs by CAMHS worker

Is Client involved with other agencies?

- Yes
  - Should other agencies be involved?
    - Yes
      - Make appropriate referrals
    - No
      - Is Follow-up required in order to supervise prescribed medication?
        - Yes
          - Refer to adult psychiatrist
        - No
          - No

- No
  - Will mental health needs require ongoing support?
    - Yes
      - Refer to adult psychiatrist
    - No
      - No

Arrange review with client, other service providers, GP, transition MHW and Family/carers if appropriate

**>3 months before 18th birthday**

Planning meeting with all involved including Transition MHW

Joint meeting convened with all involved. Transition date agreed. Interim care plan completed and given to all parties inc client

Period of joint working if appropriate

Discharge letter and care plan from CAMHS to GP and other parties

Final handover from CAMHS to Adult Services, inc transfer to consultant Psychiatrist
Appendix B – Legislation and Policy Framework

“A Scottish Executive Review of Speech and Language Therapy, Physiotherapy and Occupational Therapy for Children and Speech and Language Therapy for Adults with Learning Disabilities and Autistic Spectrum Disorder”

“A Scottish Framework for Nursing in Schools”, Scottish Executive

“Access to primary care services in Scotland (2001)”

“Administration of Medicines in Schools 2001”, Scottish Executive Guidance

“Adults with Incapacity (Scotland) Act 2000”

“Age of Legal Capacity (Scotland) Act 1991”

“Better Behaviour – Better Learning”, Scottish Executive

“Care Management in Community Care”. Scottish Executive, 2004

“Carers (Recognition & Services) Act (1995)

“Children (Scotland) Act 1995”

“Children Act 1989”

“Children and Young Persons Act 1969”

“Code of Additional Support Needs Mediation Practice”, Govan Law Centre Education Law Unit.

“Community Care (Direct Payments) Act 1996”

“Community Care and Health (Scotland) Act 2002”


“Designed to Care (1997)”

“Disability Discrimination Act 1995 (as extended 2001”

“Disability Discrimination Act 2005”

“Don’t give it, don’t take it”, Scottish Executive

“Education (Additional Support for Learning) (Scotland) Act 2004”

“Education (Disability Strategies and Pupils’ Records) (Scotland) Act 2002”

“Fair for all (2001)”

“Five National Priorities in Education”, Scottish Executive

“For Scotland’s Children”, Scottish Executive

“Framework for Mental Health Services (1997)”

“Freedom of Information Act 2000”

“Guidelines for the practice of mediation”, Scottish Mediation Network

“Happy, safe and achieving their potential”, The National Review of Guidance 2004

“Housing (Scotland) Act 1987”

“How good is our school?” Her Majesty’s Inspector of Education

“Human Rights Act (2000)”
Appendix B – Legislation and Policy Framework (cont)

“Implementing Inclusiveness, Realising Potential. The Beattie Committee Report”, Scottish Executive
“Improving the Life Chances of Disabled People (2005)”
“Integrated Early Years Strategy”, Scottish Executive
“It’s everyone’s job to make sure I’m alright”, Scottish Executive
“Learning with care – The Education of Children Looked After Away from Home by Local Authorities”, Scottish Executive
“Making the connections (2002)”
“Mental Health (Care and Treatment) (Scotland) Act 2003”
“Moving On from School to College“, Her Majesty’s Inspectorate of Education
“NHS and Community Care Act 1990”
“Nursing for Health (2000)”
“Partnership Matters: A guide to Local Authorities, NHS Boards and Voluntary Organisations on Supporting Students with Additional Needs in Further Education”, Scottish Executive
“Patient focus and public involvement (2001)”
“Protecting Children and Young People – Framework for standards”, Scottish Executive
“Protection of Children (Scotland) Act 2003 (& Police (Scotland) Act 1997)”
“Review of Care Management in Scotland”, K Stalker and I Campbell, Scottish Executive, 2002
“Riddell Report – Advisory Committee: Report into the Education of Children with Severe Low Incidence Disabilities (1999)”
“School Education (Ministerial Powers and Independent Schools) (Scotland) Act 2004”
“Social Inclusion: Opening the door to a better Scotland (1999)”
“Special Educational Needs and Disability Act 2001”
“Success for All”, Scottish Executive
“The Same As You? A Review of Services for People with Learning Disabilities (2000)”
For further information contact:

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Lochside Road
Dumfries
DG2 ODY

tel 01387 254979