Salford Multi Agency Transition Policy and Process

Supporting Young People In Salford Transition from Childhood to Adult life

This policy and process sets out how Salford intend to work together to support all young people with additional needs move from childhood to Adult life. Salford intend where possible to support young people through mainstream services; where young people need a commissioned or specialist service, this will be developed to enable the young person to become independent and gain the skills for a successful adult life. The key to success will be measured by young people being in control of their own lives with an emphasis on young people being enabled to be active and contributing citizens. All agencies, organisations and professionals will use a strengths-based conversation model of assessment and support.

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1. What is the policy about?

The Salford Multi- Agency Transition Policy and Process primarily sets out the young person's expected journey to Adult life and the partnership working required between Salford Integrated Care Organisation, Salford SEN, Children's Social Care, Health, CAMHS, GMMH and ICB Locality.

The policy draws together all current national, regional, and local strategy and procedures to ensure that Salford is compliant with our statutory duties across children's and adult's legislation to ensure Salford achieve high quality and best practice for the young people we support.

The aim of the policy is to increase the quality of experiences and opportunities of young people moving from childhood to Adult life who have one or more difficulties which could include special education needs, disabilities, and mental health difficulties.

Young people experience a variety of transitions throughout their life from birth to early years and childhood into Adult life. Transitions are often defined as a process of psychological, social, and educational change at various points in time throughout the life course, and a young person's experience of these are significantly influenced by the context, environment, family, and relationships in their life.

Some young people with service, health, or care needs will often experience transitions across multiple services and systems, particularly when moving from childhood to Adult life. The more complex their need, the more challenging transitions can be for some young people.

Salford's Transitions Policy recognises these challenges and aims to make sure that service and processes are person centred and effectively co-ordinated through strong integrated governance arrangements support the best possible outcomes for young people transitioning between services and from childhood to Adult life.

Our Transitions Policy aims to deliver on Salford's 0-25 partnership vision which sets out that we want:

"All children and young people to achieve their full potential."

The Policy has been designed to enable people in Salford to 'Start Well, Live Well and Age Well', and our mission is to ensure:

Children and young people are supported to develop independence and transition smoothly and successfully between settings, across children's and adult systems and into Adult life

'Transitions' is recognised in the following Salford strategies as a key priority, including:

- Salford's All Age Mental Health Strategy
- Salford's Thrive Plan
- Salford's Education and Inclusion Strategy and Action Plan
- Salford's SEND Strategy

Our Policy recognises the difficulties that many young people and adults experience in transitioning across services and the ways in which we can help to support successful transitions. These principles underpin our approach around co-ordination and collaboration between services.

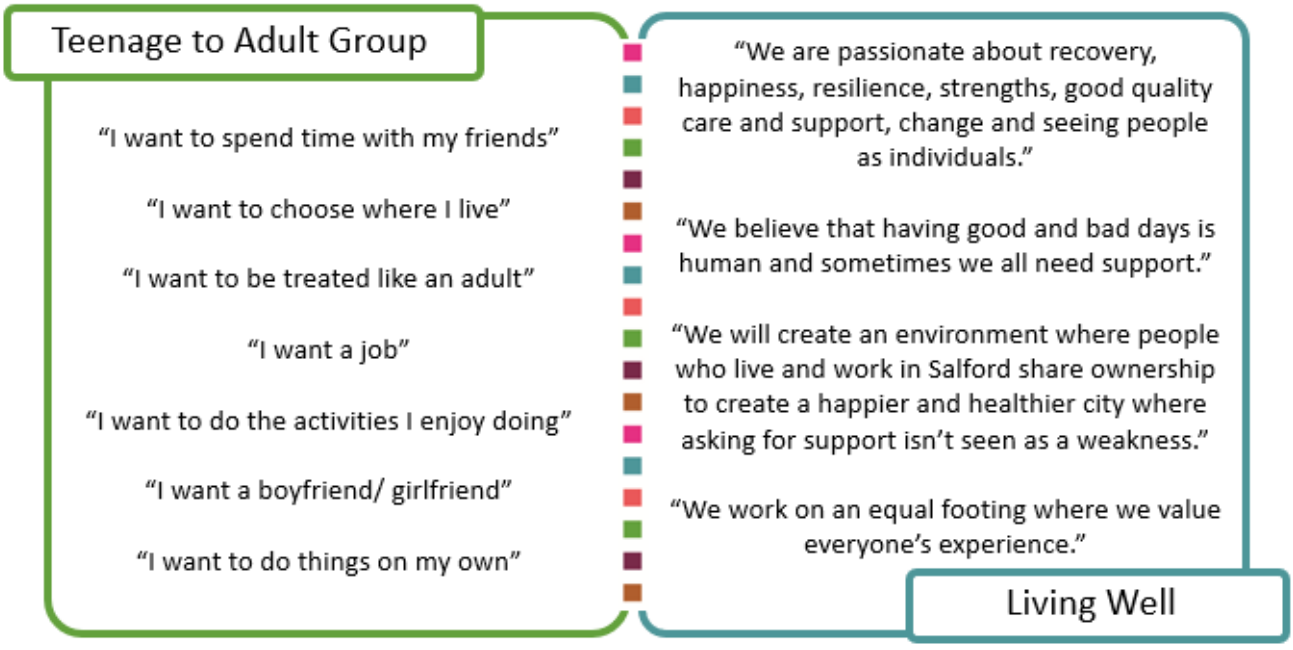
- Person-centred focus, involving the young person and their parents in decision making.
- Starting the transitions planning process early.
- Increased information about available options.
- More support for families.
- Dedicated transitions staff; and
- Appropriate training for staff.

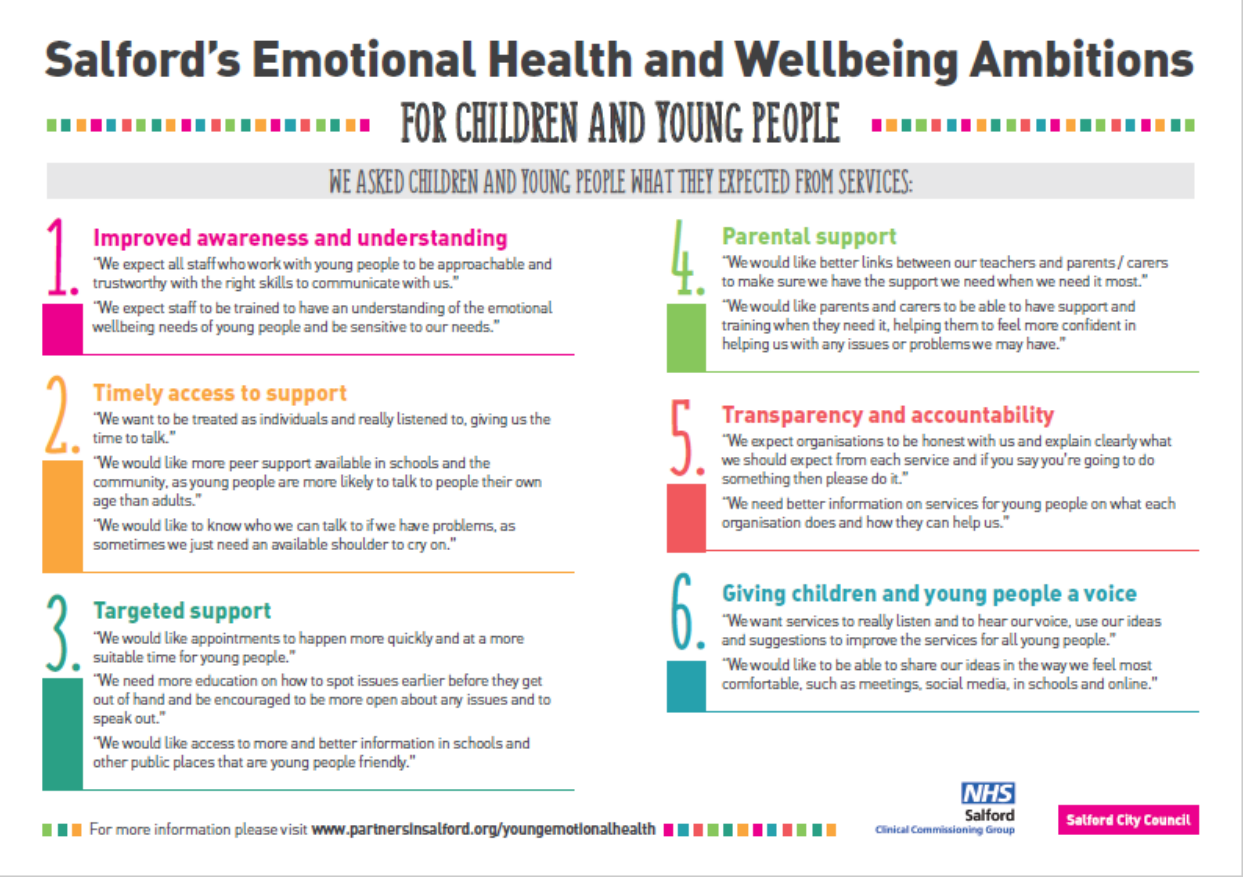
To achieve this Salford have developed:

- Salford's Growing Up and Preparing for Adult life Delivery Support Model
- Salford's 16- 25 Multi Agency Hub which enables clear concise cross organisation processes and systems, and ensures a golden thread, from strategic objectives to operational practice
- Specialist Transition Pathways
- A 16-25 Multi Agency Operational Framework and Preparing for Adulthood Practitioners guide

This Policy has been developed collaboratively through a multi-agency partnership and by listening to the voice (needs and wishes) of young people and adults in Salford. It aims to deliver on the 'we statements' developed by children, young people and adults in Salford who have lived experience of transitions between services (see below). We will ensure that our Transitions Policy and processes delivers on these expectations of services and supports the best possible experience of transition.

Teenage & Adult 'we statements' or expectations of services





There are a number of documents that should be read alongside this policy which are documented in section 9

If you have any concerns about the content of this document, please contact the author or advise the Document Control Administrator

2. Where will it be used?

2.1 This Policy intends to support the joint working across all agencies involved with supporting young people to transition to Adult life in Salford. Salford understand that transition for young people with additional needs can be difficult and complex and that it is important that support is provided to young people to prevent and delay them from requiring lifelong service. Salford are committed to continually developing strengths-based working and using the underlying principles of trauma informed care and the support sequence. The exact model used may differ between teams, however, to illustrate this for young people the THRIVE model has been adopted as the primary model.

This Policy is wide reaching, and its success requires the seamless joint working across a number of agencies. The policy intends to ensure that the following agencies/ departments across Children's and Adult Services work together and understand their role in the transition of young people to Adult life:

- Adult Social Care (Community Mental health teams, Integrated Care teams, Learning Disability Teams Transition Support Team, Sensory Team)
- Children's Social Care (Children with Disabilities team, LAC, Child in Need team, Early Help, Next Steps Leaving Care service)
- Children's and Adult safeguarding teams
- SEN Team
- CAMHS
- Children's Health (e.g., Allied health, Nursing)
- Continuing Health Care
- Adult Health teams (e.g. District nurses, allied health professionals, mental health)
- Children and Adults Commissioning

In implementing the policy lead agencies in transition should explore how they can increase the quality of experience of transition for young people and their families by jointly working with agencies and organisations in the following sectors:

- Education (e.g., schools, colleges, connexions)
- Housing
- Community and voluntary organisations
- Youth Services
- Procurement and Market Management
- Specialist support providers

- Health organisations
- Greater Manchester Police
- Children's Safeguarding Board
- Adult safeguarding board
- Primary mental health services

The above organisations should be involved in the operational implementation and strategic groups

2.2 This policy covers the following young people:

Getting Advice - Getting Help: Young People and Carers (14-25) who require advice help with some focused goals-based input

- Those who have an Education Health and Care Plan (EHCP)
- Those who would benefit from support in planning for adult life but do not have an EHCP plan (e.g., those with high functioning autism, social, emotional, mental health needs or ill health)

Getting More Help - Getting Risk Support: Young People (14-25) and Carers who require more extensive and specialised goal orientated help

- Those who are likely to meet the eligibility criteria for adult social care and have care and support needs as set out in the Care Act 2014
- Young people who currently receive services Under Section 17 of the Children Act 1989 because of disability
- Young People receiving services under The Chronically Sick & Disabled Persons Act 1970
- Young people who are supported under Section 20 and Section 31 of the Children Act 1989 who have an impairment or disability and are likely to require accommodation and support post 18
- Those with Continuing Healthcare needs
- Those with complex needs (e.g., learning disabilities, physical disabilities, mental health difficulties, ADHD, ASD, chronic medical conditions)
- Young Adults who are LAC or formally LAC, have an impairment or disability and are likely to have eligible needs under the Care Act, or be at risk of being a vulnerable adult, as per the Salford Vulnerable Adult Policy
- Carers of young people preparing for Adult life and young carers who are themselves preparing for Adult life.
- Young people supported under the Mental Health Act 1983
- Young people who have had significant trauma which is likely to affect there functioning as an adult.

This Policy only covers young people under 25 as it is specifically about the transition to Adult life and directing all organisations on how they are expected to work together to ensure a positive experience for young people and their families.

3. Why is it important?

3.1 Transition from children's to adult services is often challenging for the young person and their families as it combines a change of services and professionals at a time when they are also negotiating wider changes to their lives which can be difficult without the added complexity of disability, ill health, or trauma.

Historically transition has been described as feeling like a 'cliff edge' which can result in some young people reaching 18 who are already in receipt of support suddenly finding themselves without the care and support they need as an adult.

Equally, those who do not reach the threshold of adult services but do have additional needs are at risk of having poorer adult outcomes and life chances and of moving into crisis at a later stage of their lives.

For young people with additional needs who do not currently receive care and support from statutory services there is a risk that those working with the young person are not equipped with the skills and knowledge to provide the information, advice, and guidance required and ensure a transition plan is in place that supports young person's aspirations whilst developing the person's practical skills required for Adult life.

At the other end of the spectrum, where there are often lots of agencies and professionals involved with competing priorities and working under conflicting legislation and policy this

Therefore, it is important that a multi- agency policy and process is formalised which takes into account all legislation and local and national policy and guidance and provides agencies and professionals a shared set of standards with clear protocols to increase consistency and quality of transition to Adult life for young people, and where appropriate effective transfer to and from services.

3.2 It is widely accepted that the actual experience of transition and the operational and strategic development of transition can be problematic and for this reason there has been a focus nationally on transition over the last 10 years. This has accumulated in a comprehensive legislative framework across:

- **Part 3 Children and Families Act 2014 (SEND reforms)**
- **Part 1 The Care Act 2014**

These two pieces of legislation work together to ensure that all young people with additional needs and disabilities are supported to prepare for Adult life from 14- 25 regardless of whether they currently receive or will require a commissioned services post 18.

Part 3 of the Children and Families Act 2014 covers young people with special education needs and disabilities and introduces the SEND reforms for young people from 0-25 with a particular emphasis on preparing for Adult life at ages 14-25 in section 8.

The Care Act 2014 replaces a number of different pieces of legislation and is based on prevention and wellbeing principles for those likely to require care and support. Part 1 section 58-66 covers transition for children who may require care and support when they are an adult.

The Care Act 2014 has duties both to the individual with needs but also adult and young carers. The whole of the Care Act 2014 is relevant to young people over 18 however the specific section on transition sets out the duties the authority has for young people.

There is significant overlap between the two pieces of legislation which means they dovetail into each other and provide a firm basis for practice. Key themes are:

- A personalised outcome focused approach to preparing for Adult life
- Emphasis on enablement and prevention: Supporting young people using the wellbeing principles and strengths-based approaches to prevent long term reliance on services.
- A coordinated multi- agency approach, across education, health, social care, and other services, with a move towards joint commissioning and a tell us once ethos
- Transition evolution a slow and progressive journey from 14- 25 with no cliff hanger transition at 18
- New focus on Carers across Acts: 'family' transition rather than just the young person's transition.
- A real focus on co-production and the voice of the young person and family/carers.
- Both acts have person centred planning at the heart but entwine this into the statutory requirements.
- Emphasis on information, advice and guidance

Throughout this policy we will refer back to the statutory duties that the Acts place on the local authority and how Salford intends to meet these duties.

The Mental Capacity Act 2005

Underpinning these pieces of legislation is the Mental Capacity Act 2005. The Mental Capacity Act (MCA) comes into force when a young person is 16. The MCA starts with the assumption that everyone has capacity to make decisions unless proven otherwise. Capacity is decision specific. All young people should be supported to maximise their capacity to enable them to make decision about their own lives. Where a young person does not have capacity a best interest decision should be made as regards what we think is in their best interest. This should also reflect what we think they would choose, although it will not always be possible to follow the young person's

wishes. An unwise decision does not mean a person does not have capacity. Work around rights and responsibilities are vital when developing or supporting a young people's decision making

3.3 The Policy also aims to ensure we also adhere to:

- The Children's Act 1989
- The Mental Health Act 1983
- The Mental Capacity Act 2005
- The Leaving Care Act 2000
- The Human Rights Act 1998
- The Health and Social Care Act 2012
- The Equality Act 2010

The policy and process also intend to adhere to the relevant national policy and guidance:

- SEN code of practice 2014
- Preparing for Adult life
- Building Independence through planning for transition: a quick guide for practitioners supporting young people (SCIE & NICE guidance)
- Transition from Children's to Adult Services for young people using health or social care services.
- Strengths based social work
- 5 Year Forward View for Mental Heath
- NHS 10-year plan
- Transforming care
- Preparing for Adult life: The Role of the Social Worker

The policy stipulates how Salford intends to meet the statutory and best practice requirement for young people transitioning to adult life.

4. What's in this new version?

Salford has had a Joint Transition policy for 15 years. Over the last 3 years, there have been a number of work streams that have taken place to develop better multi-agency working. This new version includes:

- The 16- 25 Multi –Agency Hub: Operational and Strategic Infrastructure and framework
- Thrive model of working
- Increased emphasis on enablement and strengths-based approaches
- The role of the Transition Team
- Development of specialist transition pathways.

5. Policy and Procedure

This Policy has a large scope both for whom and what it covers. Salford acknowledges that young people with additional needs will require different levels of support depending on:

- Abilities/ difficulties
- Natural support
- Personal circumstance

This has led Salford to develop an overarching **Growing Up and Preparing for Adult life Delivery and Support Model** which is based on enabling young people to develop the skills and independence required for adult life. In order to deliver on the model and ensure we are compliant with legislation, policy, and best practice. Salford are embedding:

- The Multi-Agency Hub – Operational and Strategic infrastructure
- The Growing Up and Preparing for Adult life delivery and support model
- Specialist Transition Pathways

How we intend to embed this will be set out in the 16-25 Multi Agency Hub Operational Framework and Preparing for Adult life practitioners guide

5.1 The Multi- Agency Hub

The **Growing Up in Salford Preparing for Adult life Delivery Model** is underpinned by the operating infrastructure of the **16- 25 Multi-Agency Hub** which is a series of meetings over a four week cycle that support multi- agency working for young people 16-25 and enables Salford to develop, track, and monitor the transition of young people to Adult life and the success of transfer to and from services.

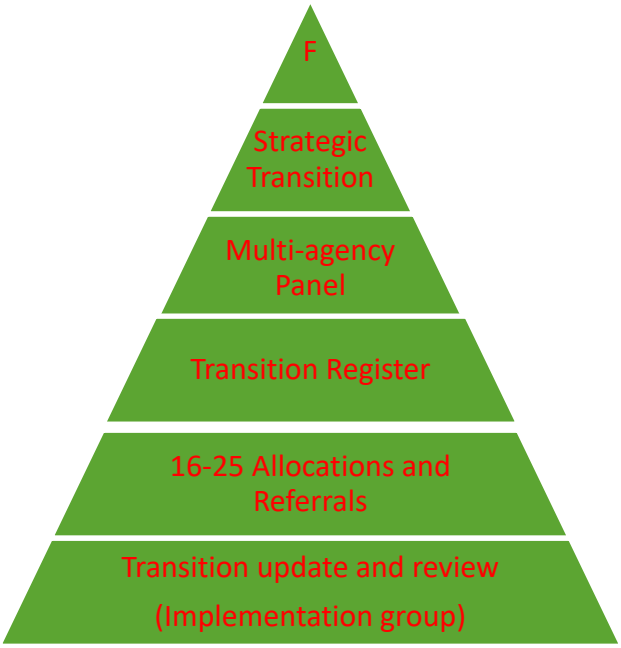
5.1a The Four Week Multi Agency Hub cycle

The 16-25 Multi- Agency Hub is an amalgamation of 5 distinct meetings that develop transition opportunities and tracks the progress of individual cases. It has 3 aims:

- Continue to learn and develop quality transitions for young people in Salford.
- To embed the multi- agency processes and system which enables successful multi- agency working
- To ensure a smooth transfer of transition cases from children's to adults across health and social care

The Multi – Agency hub works on a 4-week cycle and is managed by the Transition Support Team with the MAPS Coordinator leading on the administration of the hub.

The Multi – Agency Hub, has a comprehensive Terms of Reference and operating manual, which need to be read alongside this policy and process.



YPTransition@nca.nhs.uk: Central Communication point for Multi-Agency Hub

To enable the multi –agency hub to work effectively it needs to be co-ordinated. The MAPs Coordinator coordinates all queries and correspondence that filters into the Multi – Agency Hub. The administration of the hub is being integrated into the liquid logic system, however not all agencies will have access to Liquid Logic, therefore all correspondences and queries go through: YPTransition@nca.nhs.uk.

YPTransition outlook provides an email address and calendar that enables the Transition Support Team on behalf of the Multi- Agency Hub to:

- Have a central point where all work and queries come to and are recorded (this does not replace duty for any emergency work or safeguarding)
- Enables workflow to be tracked and recorded and reports created

All incoming emails are categorised into 11 query types:

- Query 1: PFA Action plan/ Minutes from Review
- Query 2 Information Advice and Guidance
- Query 3 EHCP Social Care Advice
- Query 4 Final EHCP
- Query 5 Initial Visit / MAM
- Query 6 Moving on Up Project
- Query 7 Invite to Review meeting
- Query 8 Multi –Agency Hub – Referral and allocation – Under 18
- Query 9 Multi –Agency Hub – Referral and allocation – Over 18
- Query 10 Multi - Agency Panel – Referral
- Query 11Cease EHCP Plan

All correspondence, emails, minutes, actions plans etc., are sent to and from the YPTransition inbox

1`	2	3	4		5	6	7	8	9	10
Date	Name of Worker/Manager	Name of Person/Client	P No.	Query Details	Link to Client Folder	Overview of case: date	MAPS Coordinator/ comments and actions	Transition Coordinator/ actions and comments	YPTransition weekly meeting; Actions/ whats been done	YPTransition Monthly meeting

Part 1: Transition Update and Review (implementation group)

All information is shared to YPTransition@nca.nhs.uk then distributed to the transition update and review list to keep everyone up to date.

The Transition Update and Review (implementation group) meeting takes place on week 1 of the cycle on a Tuesday. All teams/ organisations involved in the transition of young people who are SEND and or have a disability should send representation to these meetings so they can cascade information about what is new and upcoming or important as regards transition in Salford, Greater Manchester, and nationally. This representative should be operational and will become their organisations Transition Champion.

Minutes to the meeting should be distributed wide scale across Children's and Adults Services. The following organisations/ teams are required to nominate a Transition/Engagement Champion for their team who should attend the Transition Update and Review meeting:

- Children's Social Care (Early Help, Children with Disabilities, Next steps)
- Adult Social Care (Transition Support Team, Learning Disability Team, Integrated Care team)
- Connexions
- Raising Participation Team
- Employment
- Housing
- Community
- Education
- SEN
- Health (Diana Nurses, children's/ adults LDHP)
- CAMHS/AMS
- Salford Parent Voice
- TAG
- Youth service
- Local offer

The Transition Update and Review meetings aims to:

- Bring together all work stream across children's, adults, education, health, social care, and community which are currently being developed,/ in progress for young people 14-25 (both universal, targeted and commissioned)
- Identify potential gaps and develop and monitor transition projects which are then fed into the strategic group.
- Information Exchange: Opportunity to showcase work that is being done across the sector
- Develop a Multi - Agency Transition Business/Implementation Plan
- Agree multi-agency performance indicator's
- Link with the strategic groups
- Ensure cross- service training and information programs are delivered

Guest speakers will be invited to disseminate information about specific projects and new developments.

Where appropriate task and finish groups will be set up to develop key areas which may come out of this meeting and the strategic meetings.

16- 25 Multi –Agency Hub: 16-25 Referrals and Allocations

The 16- 25 Multi Agency hub: Allocation and Referrals currently coordinates, allocates, and monitors the following referrals/ transfers:

- Children's service to adult social care transfers (16-25)
- 18- 25 year old referrals to Adult Social Care

It is expected that the scope of the 16-25 **Multi Agency Hub: Allocations and Referrals** will extend to:

- New referrals for Education Health and Care Plans (16+)
- Children's to adult allied health referrals
- Children's nursing to adult nursing care
- CAMHS to AMHS/ LDMH
- Continuing Health Care

Who attends?

The Multi Agency Hub: Referral and Allocations meeting is a multi - agency operational management meeting. Representation is required from:

- Transition Support Team
- Integrated Care Team
- Adult Learning Disability Team
- Adult Community Mental Health Services

- Children with disabilities team
- Next Steps Leaving Care Team
- CAMHS
- Children Health
- Children's Allied Health
- Continuing Health Care

People who attend must have authority to make decisions around allocation to teams and allocations to budgets. This will enable joint decision making around cases but also identify where other services could potentially support the young person and their family.

Transition: Referring Young People the 16-18 to the 16-25 Multi – Agency Hub

The 16-25 Multi- Agency Hub: Transition Referrals and Allocations (16-18) meeting intends to ensure that all young people who are likely to have eligible needs as per the Care Act 2014 have a timely and well managed transition. The Hub also understands that there are cases where young people do not fall under the Care Act 2014 but do require support to transition to Adult life. These cases should also be referred to the hub

Where a young person has complex needs or has a package of care it is expected that the Transition Support Team are made aware of them from 14. The young person will be put on to the transition tracker. A decision will then be made about adult services input.

A referral to the Multi- Agency Hub can be made by any agency. Young people and families can also self-refer. A referral to the Multi-Agency Hub should be made before the young person's 16th birthday if:

- The young person currently has commissioned services
- The young person is likely to be eligible for commissioned service post 18, although they do not have them now
- The young person has a disability, impairment or ill health and is looked after, and is likely to require care and support post 18
- The young person has complex health needs
- The young person is supported by more than one agency and the Transition to Adult life is likely to be complex
- There are concerns regards the young person transition to Adult life

Where a person is known to services it is expected those referrals to the **Multi- Agency Hub: Referrals and Allocations** are at least 28 days before their 16th Birthday. However the hub does accept late referrals because it accepts young people's circumstances can change or the young person can become known to children's services late. These cases follow the same process as young people at 16 but timescales will differ. In these cases if the transition assessment is not complete by their 18 birthday a joint decision between children and adults will be made about who will pay for the existing service until the new service is agreed/ in place.

Transition Form Part 1: The start of the Transition Assessment (Under 18)

A Transition form part 1 (TFP1) should be completed before the young person 16th birthday, and sent via Liquid Logic and/ or to YPTransition@nca.nhs.uk

The Transition Form Part 1 is the first part of the transition assessment and gives an overview of the young person's life now. The TFP1 has the following sections in it:

- Overview of Transition Process
- Personal information/ One Page Profile/ who is in the person life now
- Living Arrangements/ family dynamics
- Education
- Health: General: Specialist: behaviour
- Developing Independence
- Current provision
- Recommendations

This should be completed by the young person's social worker (if they have one) or the engagement lead. It should be completed collaboratively with the young person, family, and all those working with young person. Where there is more than one team/ agency working with the young person it is best practice to complete the Transition Form Part 1 as a Multi-Professional group. This can be done as a Multi- Agency Meeting (MAM)

The young person and family should where possible know and consent to a referral to the 16-25 Multi- Agency Hub

The Referral and Allocation Process 16-18

Once a Transition Form Part 1 has been completed the referral needs to be sent to the Multi – Agency hub via liquid logic and/or the YPTransition email. The referral is then processed:

Initial Referral (Transition form part 1 TfP1)	•Transition form part 1 is completed by the childrens worker on behalf of the young person before but no earlier than 3 month prior to their16th birthday •Transition Form Part 1 to be signed off by a Children's Team manager then sent to TRANSTION TRAY and YPTransition@nca.nhs.uk •All referrals to be received by week 2 of the Multi Agency hub cycle to ensure they are presented at the next 16-25 Multi Agency Hub
YPTransition process Referral	•Referral added to weekly spreadsheet •Email sent to referrer accepting refferal and stating what will happen next •Add to MAH- allocation and refferral cribsheet • Add to Transition Tracker / budget pressure sheet • Transition Support Team arrange initial contact • All documentation to be sent out to panel members one week before the meeting (week 4)
Presented at 16-25 Multi Agency Hub: Referral and Allocation Panel	•Children's and adult operational managers meet every month on week one of multi agency hub cycle. •Young Person's worker/team present young person to panel •Transition Support Team feedback on informaiton gathered from initial contacts/ fact find • Discussions recorded by the Multi Agency Panel Coordinator on the Allocaion and refferal crib sheet
Multi Agency Refferral and Allocation: Agree actions	•The Multi- Agency Operational Management Team: • Agrees next steps for cases • Agree Engagement lead/ lead agency • Agree Budget holder • Agree if they need to be added to the 16-25 MultiAgency Young People Risk System (MAYAR) •agree offer
YPTransition process referral and allocation	•Update multi agency hub crib sheet and send out to panel members • Allocate Transition Social Worker / lead from Transiiton Support Team where appropriate •Update Liquid Logic (allocated worker, TfP1: decision and actions , upload activities , allocated worker, transfer from TRANSITION TRAY) • Update Transition Tracker / MAYARS • Add to transition register • Send letter to young person and family stating the outcome of meeting and what to expect next
YPTransition: feedback to referrer and adult allocated workers	• Email, current worker, referrer, managers , and allocated adult worker set email which states key informaiton of young person, and what needs to happen next • Provide TfP1 and any other relevant paperwork (ensure it is encrypted) • Send invite calenders to all working with person to the relevant Transition Register Meetings

The Referral and Allocation Process 18-25

Not all young people from 16-25 can be case managed by the Transition Support Team. However it is important that referrals of young people come through a central point to ensure:

- Young people are supported by the right team
- Where there are issues they can be picked up quickly
- We can understand the needs and gaps for young people aged 16-25.
- Children's services may have historic knowledge of this young person which can support in decision making.

In order to achieve this the 16-25 Multi-Agency hub should be made aware of all referral of young people who are 18- 25 to Adult Services and where it is felt beneficial to do so, should be should be presented at the 16- 25 Multi- Agency Hub.

A 16-25 Multi-Agency Panel referral form should be completed and sent to the Liquid logic transition team tray and/or YPTransition@nca.nhs.uk

This meeting takes place at the same time as the 16-18 referrals and allocation meeting and has the same multi agency operational panel.

Referrals 18-25:

Referral can come from a number of agencies which include:

- The Contact Team
- Health services
- SEN Team (where people are finishing education
- Education and Training establishments (concerns raised in EHCP meetings)
- Adult Social Care teams
- Housing
- Safeguarding teams

At the meeting:

The format before, during, and after the meeting follows the same format as for those under 18.

- Each case is presented
- Discussion takes place to agree:
  1. What the issues are and how the needs of the person can best be met by which team
  2. Where appropriate agree lead team and case management team
  3. Where the Transition Support Team case manages the case, agree the budget holding team

In most cases it is expected that the Budget Holding team will case manage the case, it will only be in certain special cases that the Transition Support Team will lead on the cases of young people 19+

If it is likely that the young person has eligible needs under Section 13 of the Care Act 2014, an assessment should be completed under Section 9 and where appropriate a Care and Support Plan developed under Section 25 of the Care Act 2014 developed.

The assessment should aim to be completed within 28 days of the referral from the 16-25 Multi – Agency Hub

16-18 Transition Register

The **Transition Register** happens on week 3 of the Multi –Agency Hub cycle. It aims to ensure that all transition cases are kept on track and that those working with young people are supported. It currently monitors young people who have assessed social care needs but the scope can be widened.

Young people are presented by their core team every 3 month to the children's and adults panel of experts. The experts include:

- Head of service Learning Disability, Transition and sensory team
- Principle manager
- Transition coordinator
- Children with Disability Manager
- Next Steps manager
- Complex Needs Advanced Practitioner
- District Nurse lead
- Transition health need
- SEN lead
- Other as required

Aim is:

- To ensure all elements of Transition are completed
- To monitor performance indicators
- To provide advice and guidance
- To provide expert social work input, guidance, reflection, and supervision
- Update Transition Tracker
- To keep on top of budget pressures attached to individuals and ensure they are being addressed
- Agree if the case needs to be taken to the Multi Agency Panel/ risk register/ funding panel

Young people will be presented in blocks quarterly:

- Young people who are 16-17
- Young people who are 17-18
- Young people who are 18-19

The meeting is split into two sections.

Section 1: Information for performance indicators – unpick any issues

that may be affecting the delivering on performance indicators

Section 2: Case discussion

Information and performance indicators are recorded on the transition register crib sheets.

Actions and activities agreed at the meeting should be recorded on Care first/liquid logic

The MAPS co-ordinator will send out the Transition Register crib sheet to the panel members of 16-25 Multi-Agency referral and allocation team.

The Transition coordinator will update the Transition Tracker

Information will be provided quarterly to the Strategic Transition Focus Group, in a quarterly and annual report.

16-25 Multi – Agency Panel

The 16-25 Multi –Agency Panel Core Group meets virtually every 4 weeks on week 1 of the 16-25 Multi –Agency Hub cycle. The panel is made up of a core group of senior managers across children's / adults:

- **Education**
- **Health**
- **Social care**
- **Commissioners**
- **Housing**
- **Community**
- **Safeguarding**

The Core Panel is expected to have high levels of knowledge and influence and be able to draw in the right support from the right areas when required.

'Experts' are invited based on the cases being presented.

This meeting has 2 key aims:

- **Part 1:** To manage the Multi Agency Young People Risk System (MAYARS)
- **Part 2:** To provide senior level advice, guidance, support and decision making for complex cases

The Multi Agency Young People Risk System will be held by the Transition Coordinator, and aims to bridge the gap between the children's and adults risk registers, but also to capture specific transitional risks. It will be expected that the MAPS Coordinator gets regular updates from workers. A person will be identified to go on the risk register if:

- They are currently/ formerly looked after or on the edge of care.
- They have complex health or behaviour needs.
- They have mental health needs which are at risk of not being met.
- It is unclear which team should support the person
- There are safeguarding concerns
- It is unclear what package of support they will require/ now or in the future
- There is difficultly putting a package of support together.
- High cost placements
- They are at risk of falling through the gaps

The Core Panel will review the ***Multi Agency Young Person Risk System,*** and monitor the cases. They will provide feedback to case workers where appropriate. Where it is felt it would be beneficial

the young person may be highlighted to be discussed in more depth with 'experts' at the multi-agency panel.

Part 2 sets out to support frontline staff working with complex cases whereby a senior decision needs to be made or it is not clear what needs to happen next. Cases will be diverse but generally cases will come to this meeting if:

- They are high risk/ high cost
- Significant safeguarding concerns
- Requires a commissioning decision
- Accountability/ governance
- Development of something new is required
- What is required does not currently exist or is not available in Salford
- Where there are disputes about where a case should sit, and who should do what
- Funding issues

It is expected that before a case comes to the Multi Agency Panel, the following will have been completed:

- Assessments completed
- Initial Multi Agency Meeting to resolve issues has taken place
- Where appropriate an CTER/CTR has taken place

Where appropriate a situation will be escalated and decisions can be made which are outside our usual commissioning/ operational arrangements. Depending on the issues where possible the relevant senior managers/ decision makers will attend the Panel.

Aim:

- Manage risk /link to adult risk register
- Link to relevant funding panels
- Provide expert advice/ decision making for complex cases
- Feed into the Strategic Planning Group

How:

- Each case is given a 20 minute slot
- Young people are 'presented' by their core team
- Discussion – action plans developed

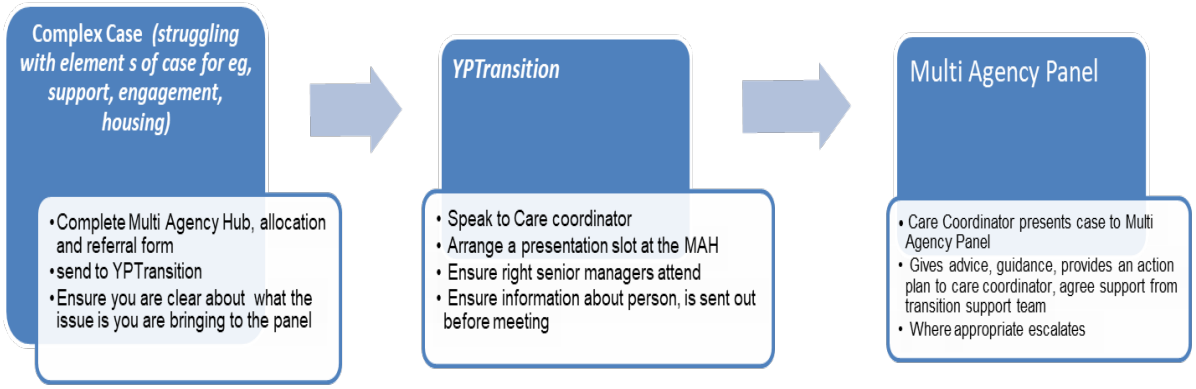
Where there is a crisis situation, a 'Virtual Multi Agency Panel' will take place. This will take place within 48 hours.

All discussions and decision will be recorded.

A link person will sit on the under 18 Multi Agency Panel/ risk register and the Learning disability risk register. A representative from the Transition Support Team will sit on the complex safeguarding panel.

It is Salford aspiration that eventually there will be an all age risk register and that work the MAYARS is a temporary option to bridge the gap from children and adults, and to highlight risks that are transitional in nature.

Diagram showing the process for referring a case to the Multi- agency panel



Multi – Agency Strategic Transition: The Strategic Transition Focus Group

In order for Transition to be successful it is important that there is a link between the strategic and the operational teams with a two way process of information and development.

As Transition is multi- faceted it is important that strategically there is a focus on all areas individually whilst ensuring the areas are brought together into one plan.

As part of the Multi-Agency Hub. The key areas area are:

- Social Care Commissioning
- Health/ Mental Health
- Education/ Employment/ SEND
- Housing / community/ third sector

It is expected that there is information throughput from the Transition Update and Reviews meeting and vice versa which will develop the strategic and operational themes.

The Strategic Transition Focus Group will meet every quarter and should link in with the wider strategic themes across Salford but with a focus on people under 25.

The Strategic Transition Focus Group will pick up issues that are being presented in the multi-agency panel to ensure that resolutions to issues are incorporated into practice or where issues/ gaps continue there is strategic oversight.

The Strategic Transition focus group will agree an annual strategic transition plan.

Depending on the strategic themes, a number of strategic task finish groups will be develop to continually review, evaluate and improve transition

Strategic Social Care Commissioning and Budget Forecasting

It is important that Children and Adults Social Care Services work together to ensure:

- An early intervention and prevention model is developed by children's services which aligns with the work of adults to prevent on-going or long-term needs for service whilst ensuing families and young people are supported enough to prevent crisis.
- From 14+ children's and adults need to work closely to ensure that young people's support can where appropriate continue post 18 and where appropriate follows the enablement model.
- Where a new service for someone over 16 is required children and adults should jointly develop and agree, and where appropriate adopt an in-reach model from adults
- Ensure stringent budget forecasting and strategic planning to ensure where possible cost avoidance is achieved, unexpected costs are prevented, and ensure the services available in adults meet the needs of the young people coming through are high quality and provide value for money.
- To ensure the budget forecasting and strategic planning links to the other 3 strategic themes
- Ensure links to Salford Project 29
- Risk registers/ CETR

To achieve this representation is required form both children's and adults in these key areas:

- Social Care
- Operational leads
- Commissioning managers
- 16-25 Multi Agency Panel members
- SEN
- Health
- Finance
- Procurement and Market Management

Children's services must ensure they inform the appropriate senior manager is adult services of any new potential budget pressures.

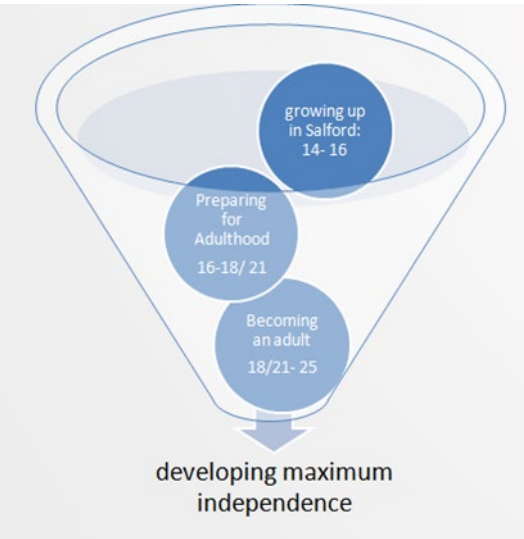
Any young person who has a change in presenting need, which may impact on their transition to Adult life, or the services required post 18 must be highlighted the Transition Coordinator and a Multi-Agency Meeting set up, to assess whether adult services can in reach in to ensure minimisation of moves and or disruption of service.

A five year demographic overview of all young people transitioning to adult services will be developed and updated annually and the Transition Team will develop an annual report on the current trends, gaps and risk.

A member of Adult Social Care will sit on the children's Disability Resource Panel.

Salford's Growing Up In Salford, Preparing for Adult life Delivery Model

Primarily Salford wants to support young people to have a positive transition to adult life which is led by the young person themselves. To achieve this Salford see transition to Adult life in three distinct stages



Stage 1: Growing up in Salford 14-16:

Young Person and Family are starting to be supported to think about the future. Begin supporting young person to think about what they might want to do at college and what skills they might need to develop. Start to have Preparing for Adult Outcomes within their EHCP plan/ review process

Stage 2: Preparing for Adult life 16-18

Continuing to look at skill development. Start to ensure young person has things in place to support with adult life (i.e., bank accounts, benefits, transition to college, transition to adult service (health and social care)

Stage 3: Becoming an adult 18-25: Support young person to exit education, developing meaningful activity during the day (including employment). Build young person's skills to enable them to become more independent and develop self-determination and autonomy.

The Engagement Lead

Transition is complex and multi-faceted and can feel for young people and families that they are falling off a cliff. Therefore, it is important that we support staff and the natural support working with young person to develop their skills to support the young person on their journey to Adult life. In order to do this each young person coming through transition will be assigned a person who will be their 'engagement lead'

The engagement lead role is based on a 'keyworker' role and aims to help the young person navigate through transition and identify where they can access support and develop skills. Depending on the needs and circumstances of the young person an engagement lead could be:

- The young person
- A family member
- School/ SENCO/ Teaching assistant
- A member of staff from Youth Service
- TAG
- Early help worker
- Youth worker
- Social worker
- Health worker
- Housing worker

The engagement lead role reflects the approach that is expected to be taken by anyone who is working with young person regardless of their profession or background. It is based on a strengths based person centred model and brings together the core expectations of all agencies involved with young people:

- To support young people to access mainstream service where possible
- To use person centred approaches
- To be outcome focused
- To work on a person strengths and build a person resilience
- To support the person to develop skills and independence

The Engagement Lead will:

- Coordinate the Young Person's transition
- Ensure that the Young Person has a PfA action plan, that is outcome focused
- Be able to signpost young person/ family services and information that may be able to assist the Young Person's transition
- Where necessary make relevant referrals
- Support young person to make transitional visits to new opportunities (education, health, social care)
- Be trained in the use of the support sequence.
- Will act as a one point of contact for the young person and their family- where appropriate and agreed.
- Where there are issues will set up a Multi Agency Meeting (MAMS)

Who will take the engagement lead role for a young person should be decided at the beginning of the transition process and should be the person who is most involved in supporting the young person. As the young person goes through their journey, the engagement lead may change this should be agreed by the young person and their family.

The Transition Team will develop training and active learning sessions around the Engagement lead role/approach 4 times a year (every quarter).

The Preparing for Adult life Action Plan (PfA action plan)

The Preparing for Adult life Action Plan (PfA action plan) aims to support the Young Person, their Family, and those working with the Young Person to develop a plan to support the person get ready for Adult life. The PfA action plan should cover the areas set out in the Preparing for Adult life pathway and the Keys to Citizenship

- Independent living and home
- Community, friendships and relationships
- Health
- Employment
- Money
- Support
- Future goals
- Choice and control

The Preparing for Adult life action plan should

- Start at the Year 9 Preparing for Adult life Transition review, for all young people who have an EHCP
- Should be reviewed and updated at least annually
- Should be co-produced and sent to the young person and their family

- Should ensure that skills for independence are developed, including managing and understanding their own condition where relevant
- It should be clear what the young person and family should expect during the transition period and clarify the roles and responsibilities of the people working with the young person

There is no set format for the PfA action and different organisations may have their own versions and gather information for them in different ways. However, where there is more than one agency involved a decision should be made regards who is leading on the PfA action plan, and that agency should take responsibility for ensuring it is completed, distributed, and reviewed.

A young person should only have one coordinated PfA action plan- not a number of action plans from different organisations. PfA may be created in PHSE, EHCP review, MAM meetings, Young People plans, Pathway plans, CAMHs/YAMHS Transition Plan and Booklet, and as part of the initial contact from the Transition Support Team.

Where appropriate a young person may be supported to complete an Outcome Star.

The Multi Agency Meeting (MAMS)

The Multi Agency Meeting (mam) is any meeting where a young person and their supporters are supported to review their situation and develop an action plan. A Multi- agency meeting can be:

- A LAC review
- AN ECHP review
- A young person meeting
- A person centred review

There are a number of specific transition Multi Agency Meetings, which focus specifically on transition and are person centred in format. This includes:

- The citizenship review
- The support sequence meeting

More information about Multi- Agency Meetings and their formats, and when they should be used are set out in the 16-25 Operating Framework and the Preparing for Adult Practitioner guide.

When a Multi-Agency Meeting is set up for a young person, which is specifically around transition the MAP coordinator should be informed so it can be recorded.

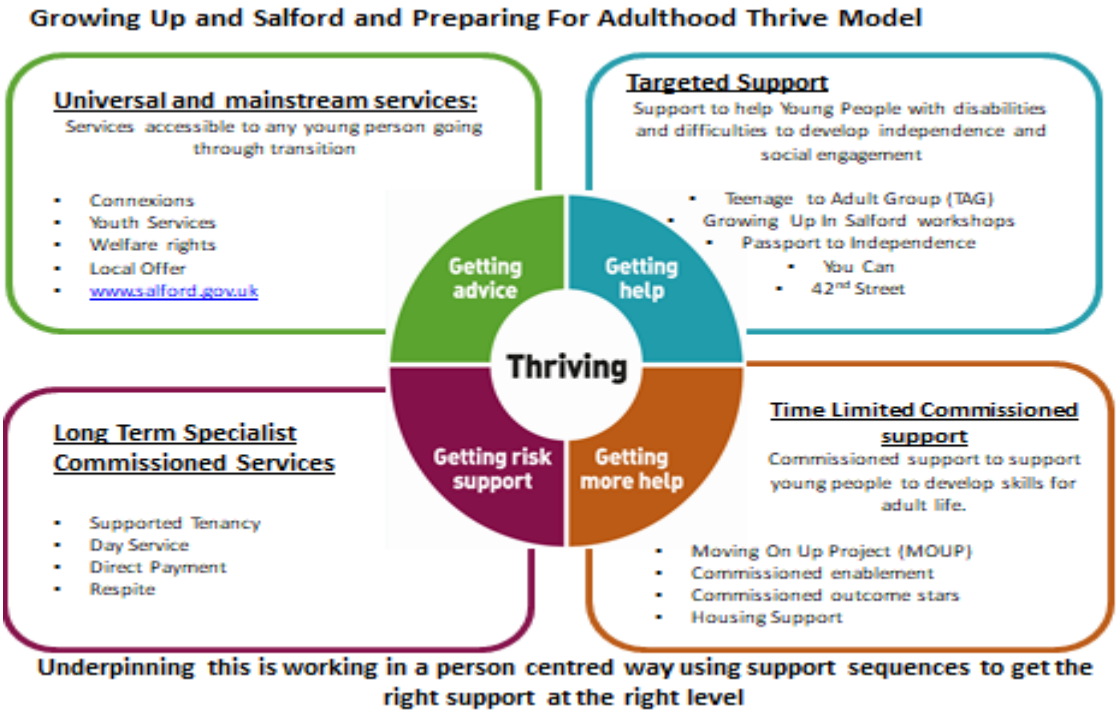
Growing Up In Salford and Preparing for Adult life Thrive Model: The Right Support at the Right Level

In line with the Children and Families Act 2014, The Care Act 2014, and strengths based working. Salford wants to support young people to be active and valued citizens of their community and to support young people to use the resources which are available to them.

To achieve this Salford wants to develop the early intervention and prevention model to enable young people to ‘get a life, not just a service’. This means ensuring that support is available early and that the Engagement Lead is aware of what is available and how the young person such be supported

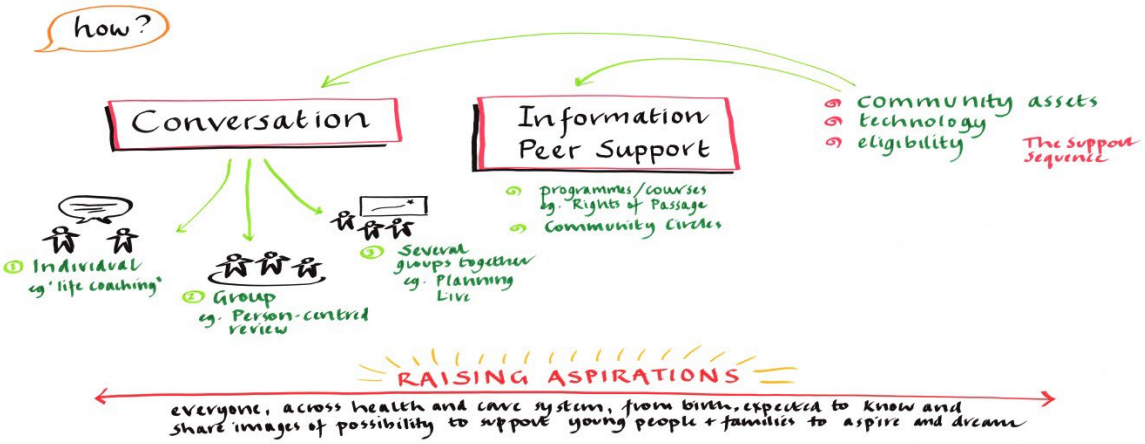
Salford recognises that Young People with additional needs may require support and direction to meet their true potential. Salford is committed to using strength based models which aims to increase the Young Person independence as they grow up so they can achieve the adult life they aspire to.

In order to achieve this Salford have developed the ***Growing Up in Salford and Preparing for adult Thrive Model***, which demonstrates to young people and practitioners how they may be supported depending on their needs.



Having a Conversation and using the Support Sequence

When supporting a young person to plan and develop skills for Adult life it is expected that all people working with young people develop a meaningful conversation style and use the support sequence. The support sequence firstly finds out what is important to the young person now and in the future and supports the young person to develop their own goals (outcomes). It then looks at how we can best support the young person to achieve these.

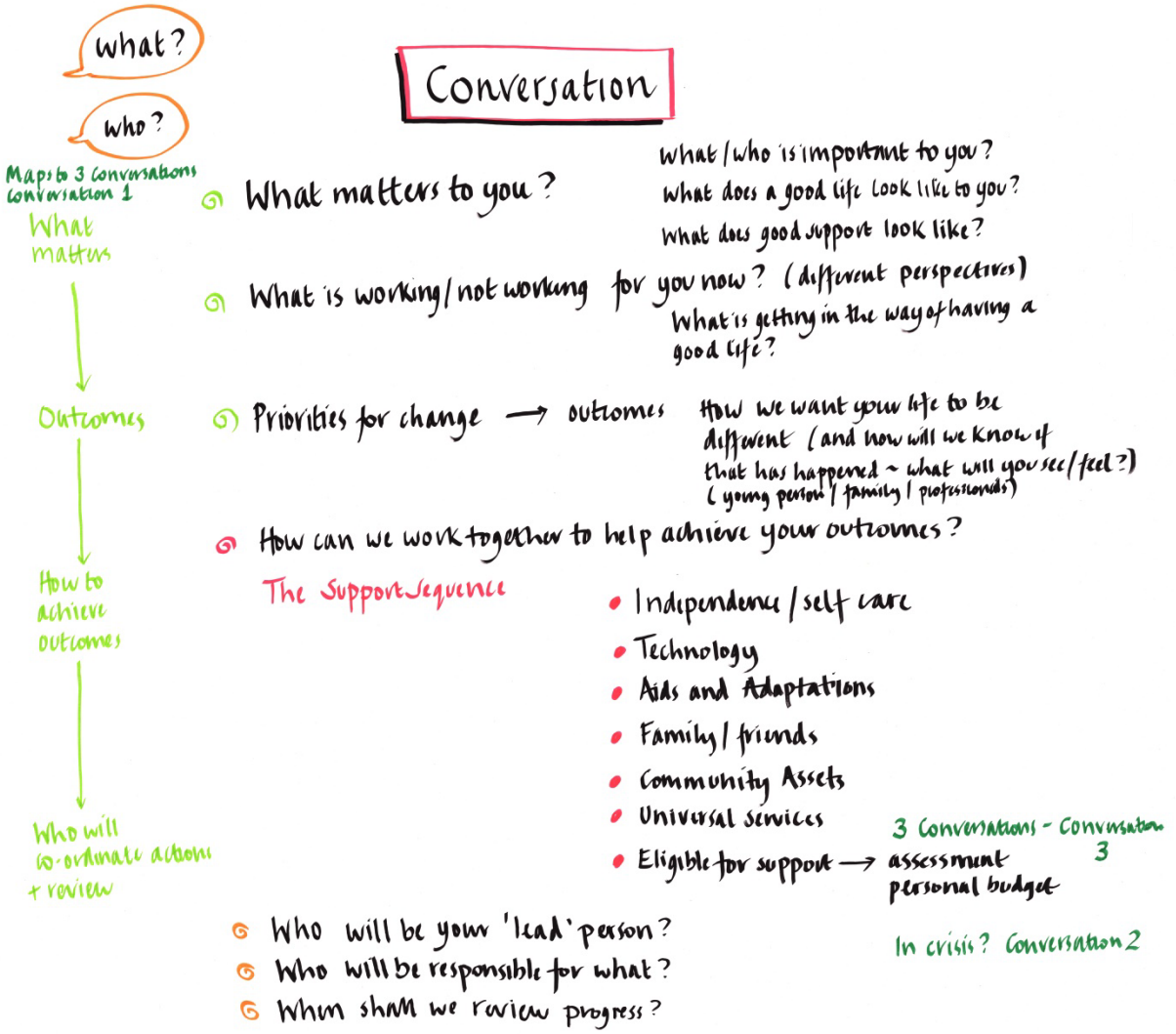


The Engagement Lead should support the young person, families, and those working with the young person to look at how the young person can be supported:

- What can the young person do for themselves/ can we develop the young person's skills so they can do it themselves?

- Is there any technology, aides or adaptations that can help the young person achieve their outcome/
- What natural support do they have available, what can they provide/ do they need to build up their networks, how can we support this
- What is available in the community
- What paid support does a person require

Salford expects that paid support is only used when it has been found that a young person is unable to meet their outcomes through the different types of support available.



Growing up In Salford 14-16 Stage

Although a life-long approach should be adopted for supporting young people to develop the skills required for adult life, from a transition perspective within this document we start the transition to Adult life from age 14.

The phase from 14-16 has been developed as the ***Growing Up in Salford*** stage where young people should be supported to start to think about their future aspirations, post 16 education, training options, and developing the skills they need to develop for Adult life.

At this point it is not about having a clear vision of exactly what the young person's life will look like but more about starting to get the young person to think about the near future and what skills they want to develop.

What this looks like will vary from person to person depending on personal circumstance needs and aspirations. For most young people this stage will be very much about moving from school to further education and thinking about what needs to happen to enable this.

The 16-25 Multi-Agency Operational Framework and Preparing for Adult life Practitioner guide has lots of useful resources to support to fully support young people through this stage.

When supporting Young People all practitioner should be made aware and have good working knowledge of:

- The Local Offer
- Growing up In Salford booklet/ Preparing for Adult life directory

Thrive Directory https://www.partnersinsalford.org/media/1432/directory-covid-version-july-2020v2.pdf

Stage 1: Growing up In Salford: Getting Advice/ Getting Help

The Children and Families Act 2014 and SEND code of Practice establishes that transition for young people with SEN and or an EHCP should start in Year 9.

It is expected that the educational establishment should lead on the dissemination of transition information to young people and that young people are enabled to explore the preparing for Adult life (PfA) outcomes through both curriculum activities and extracurricular activities. The PfA outcomes are nationally agreed and broadly cover:

- ***Education and Employment***
- ***Independent living***
- ***Community inclusion***
- ***Health***

To enrich young people's experiences, it is expected that schools should partnership with employment services, businesses, housing agencies, disability organisations etc.

Each young person should have an engagement lead that supports the young person and family to navigate through transition and supports signposting, taster session, visits etc.

Where there are no other organisations involved with the young person this should be a member of the school staff or family member. Where there are other organisations involved decisions about the best person to be the engagement lead should take place at the EHCP annual review.

It is expected that as a minimum in Salford all education establishments working with young people with SEN and or disabilities will offer the following:

- Careers advice
- Information, advice and guidance around preparing for Adult life
- Tailored support to transition from one educational establishment to the next
- Reasonable adjustments to support young people with learning, exams etc.

Salford is aware that a lot of young people with an EHCP attend mainstream school and do not always have the infrastructure to develop robust systems for preparing for Adult life. Salford therefore provides workshops, training, and advice around what's available for young people and developing person centred preparing for Adult life outcomes.

Training for engagement leads will take place 4 times a year and will link to the locality and neighbourhood model. This will be led by the Transition Support Team.

The Transition Support Team will ensure the following will be available for all young people, families, engagement leads, and SENC0s

- The Growing Up In Salford Booklet (what you need to know and do as you grow up)
- Understanding the Care Act 2014 and Mental Capacity Act 2005
- Preparing for Adult life Action Plan
- Checklist to independence
- YPtransition@nca.nhs.uk – information given
- Training on what's available
- Growing up In Salford Workshops
- Passport to Independence
- The Preparing for Adult life Road show

These are currently held with the Transition Support team and can be accessed via: YPTransition@nca.nhs.uk but we aim by 2023 for these to be on the:

- Salford Local Offer: Preparing for Adult life
- Partners in Salford
- My City life
- WUUT

Information on all of the above will be sent to all SENCOs in Salford through the SEN team at the beginning of each academic year.

Young People, families, and SENCOs can also get information from the Local Offer/ Preparing for Adult life pages and the Thrive directory.

Young people and families can also contact the SIASS team for information, advice, support, and guidance.

The Transition Support Team will work closely with Salford's Parents Voice to ensure information about transition is disseminated to all families across Salford.

Information about what is available in Transition and new developments will be discussed at the Transition update and review group. This group should have transition champions that attend. There will be a wider distribution list to those doing engagement lead roles across Salford who will receive the minutes in the form of a newsletter to ensure they keep up to date with what is available for young people in Salford.

If young people, families, engagement leads, or SENCOs have any questioned around Transition they can email query to YPTransition@nca.nhs.uk

The EHCP Preparing For Adult life Annual Review

Where young people have an EHCP from Yr. 9 it is expected that the EHCP annual review will incorporate the Preparing for Adult life review, outcome planning, and PfA action plan. For each year thereafter the preparing for Adult life review, outcomes, and PfA action plans should be reviewed at the annual EHCP review and more frequently if required.

The Preparing for Adult life Review is led by the educational establishment and should ensure that:

- Young people and families have opportunity to prepare for the review beforehand
- All organisations working with a young person should be invited to the review and given at least 2 week notice.
- A preparing for Adult life action plan is completed that relates to the PfA outcomes, aspirations of young person, and skill development (including options) and maximising decision making.
- There should be particular attention made to post 16 education and training, and how to ensure a smooth transition to the next educational establishment
- At the initial PfA review an engagement lead should be agreed and reviewed each year thereafter.

It is best practice in Salford that a holistic person centred approach to reviews is adhered to. Best practice states that:

- Yr. 9 Preparing for Adult life review should be an Important To and For Review
- Yr. 10 Preparing for Adult life review should be a Citizenship Review or Working Not Working Review
- A support sequence review should take place on the year the young person is leaving education.
- All reviews should establish holistic SMART outcomes with all involved supporting the young person to look how they can achieve their outcomes
- The action plan from the review should look at how the person may meet the outcomes (i.e., visits to colleges, signposting to youth clubs, getting a bank account etc)

The 16-25 Multi Agency Operational Manual and Preparing for Adult life Practitioner's guide provides information on the different types of reviews available and templates for the reviews.

Growing up In Salford 14-16: Getting more help/ Getting risk support

If at the Preparing for Adult hood Transition Review or throughout the year there are concerns needs are unmet then a 16-25 Multi- Agency Meeting (MAM) should be convened.

From the MAM a PfA action plan should be agreed and a decision should also be made regards:

- Whether the case needs to go the 0-18 Multi-Agency Panel
- 0-18 Risk register
- The 16-18 Multi-Agency Hub to be informed regards the young person and whether adult service representation/ assessment is required.

Where a young person doesn't currently receive social care services but it is felt likely that they may require services post 18 information should be given about how to self- refer to services or a decision made at the EHCP review/ MAM for a professional to make a referral to the 16-18 Multi-agency hub allocation and referral meeting. (referral to 16-25 Multi Agency Hub: Allocation and referral meeting.)

Where a young person is currently in receipt of services or has more than one organisation working with them a referral should be made using the Transition form part 1 to the 16-18 Multi-Agency Hub This should be completed by the social worker/ engagement lead and if more than one organisation is involved it can be done jointly.

A referral to adult services should be made, no later than 28 days before their 16th birthday but no early than 15 years and ¾, unless the young person has:

- Complex health/ social care needs
- High risks (e.g. breakdown, risk to self or others)
- High cost placement
- Accommodation needs
- Presented at the under 18 MAPS

In which case adult services should be made aware from 14.

For young people where they receive commissioned services:

- A representative from the social care team should be at the Preparing for Adult life /Keys to Citizenship review and should fully participate in the development of preparing for Adult life outcomes.
- Discussion should take place about how current commissioned support can be used to support the young person obtain their outcomes. (i.e. using support to learn skills and develop independence)
- Young people and Families should also be supported to explore how having a personal budget may support them better to combine resources from education, health and social care to obtain their outcomes

When young people from 14+ are discussed at funding panels, a representative from adult services must be invited and attend.

Stage 2 Preparing for Adult life 16-18

Once a young person with additional needs reaches Yr. 11 and becomes 16 Salford move to the Preparing for Adult life stage of our policy and process.

Decision Making

The Mental Capacity Act 2005 (MCA) applies to anyone aged 16 and over who is unable to make some or all decisions for themselves. This has to be because of a disturbance or impairment of the person's mind or brain. It does not cover situations in which the young person is struggling to make decisions for other reasons (e.g. undue influence/ age/lack of experience).

The MCA starts with the assumption that everyone has capacity to make decisions unless proven otherwise after all practicable steps have been taken to support the person to make the decision.

There are a number of critical decisions young people will need to make during this time which may include decisions around:

- Education and Employment
- Care and Support
- Accommodation / where they live
- Money/ finance
- Accessing health care / maintain health
- Relationships – (including contact with family, sexual relationships etc.)

Capacity is decision and time specific. Like all young people, young people with additional needs will have a number of factors that can affect their capacity to make decisions. These may include, age, experiences, peers, family, understanding the impact of the decision, and lack of opportunities in past to make decisions. Young people also often learn from their mistakes. People working with young people should not assume that young people do not have capacity to make a decision or that difficulties in making decision are due to an impairment of their mind and brain. All young people should be supported to maximise their capacity to enable them to make informed decisions decision about their own lives. To enable this working with young people need to think about how they develop a young person ability to make decision, including learning by experience and ensuring information is given in a format that the young person understands.

Supporting young people to make informed decisions is the responsibility of all people working with young people, not just the responsibility of adult services. Before a Mental Capacity Assessment is carried out, regards a particular decision, there should be evidence that work has been done with the young person to maximise their understanding. This will form the basis of the capacity assessment. Just because a young person makes what other think is bad decision, does not mean they lack capacity.

Where young people appear to be struggling with understanding the impact of certain decision, it is important to eliminate any factors that might be impacting on their decision making, as the Mental Capacity Act 2005 is only to be used if capacity to make the decision is because of an impairment of their mind and brain. Work around rights and responsibilities are vital when developing young people's decision making abilities.

The ***Preparing for Adult life practitioner guide*** provides information on developing young people's ability to make informed decisions.

Making Decisions Around Education:

After compulsory school age, (end of Yr.11) the right to make requests and decisions under the Children and Families Act 2014 applies to the young person directly rather than the young person's parents, if the young person has the capacity to make the decision in question.

Parents/ carers/ family members can still make decisions or act on behalf of the young person, provided the young person is able to consent to this and is happy for them to do so.

Generally it is expected that the young person's parents are still involved in the young person's education and the Local Authority should continue to involve the parents.

Making Decisions Around Social Care and Health:

As regards Social Care and Health decisions should be based on the young person's needs and wishes, however this does not mean that families and carers should not be involved and consulted. Work needs to be done with both the young person and the family around decision making and involvement. If a young person has the capacity to make a decision they can only decide between the options that are available. However, the Young Person cannot insist on parents or professionals doing something where there is no assessed need.

It is important to consult with both young people and families when developing an assessment either for an EHC plan or Transition Assessment, to ensure we fully understand the needs of young person. However if a young person has capacity, they have the ultimate decision about what provision they will accept, and how they wish to be supported.

Where the family are also the main carers they also have rights especially if they have eligible needs resulting from their caring role. This can cause some tensions (for example if a young person says they do not want commissioned support but a family member needs a break from their caring role or are unable to continue with their caring role.) In these situations a young person should be supported to think about how their needs can be met in a way that makes sense to them or to understand the impact of the caring role on the family member. Carers should be offered a carers assessment. This is not dependent on the person they care for being eligible or in receipt of care and support from services. Carers should be supported to access and be informed of the services available at Gaddum carers centre.

Where a young person and a family member disagree it may be useful to involve an advocate or an independent supporter. Work should be carried out to support young people and families to understand each other's point of view.

Advocacy:

Where a young person does not have a relevant person to advocate for them (or they are not happy for a particular person advocating for them e.g. a parent), they should be asked if they would like a referral for an SIASS advocate (for decisions relating to education), or a Care Act Advocate (for social care decisions), or If the young person would have substantial difficulty in engaging with the transition assessment process for social care then they are entitled to a Care Act advocate if there is no other person who can support them.

There may also be a statutory right to advocacy in other situations e.g. if the young person needs serious medical treatment or a change of accommodation and there is no-one to support them

other than paid staff. If this is the case then the young person is entitled to support from an Independent Mental Capacity Advocate.

When a Young Person is assessed as not having capacity to make a specific decision:

Where a young person has been assessed as not having capacity a best interest decision should be made about what is in their 'best interests' following section 4 of the MCA. This should reflect the best idea of what the young person would like, and what they would choose if they had capacity. As well as focusing on the young person's views the decision should take account of the views of parents and other family members, and professionals (including foster carers) supporting the young person. The decision should also identify how the young person can be supported in a way that imposes the least restriction on their rights and freedoms.

It is very important to identify who the best interest's decision maker should be in any situation. If the young person lacks capacity and the decision falls within the 'zone' of parental responsibility then the decision can be taken by a parent. If the decision falls outside the zone of parental responsibility then the decision should be taken by the professional who is proposing the support plan (social worker, educational professional, GP etc).

If the young person presently lacks the capacity to make the decision in question then consideration should be given to whether they can be supported to develop the necessary capacity. This could be around finances, relationships, accommodation, engagement in sexual activity etc.

If there are any disputes around capacity or best interests then these should be resolved by local mediation wherever possible. If the dispute cannot be resolved then the decision-maker should take legal advice on whether an application needs to be made to the Court of Protection.

Some decisions involve imposing a level of restriction on the young person in their best interests that amounts to an interference with their rights under Article 5 of the European Convention, i.e. a 'deprivation of liberty'. This can only be authorised by the Court of Protection once the young person has turned 16. This also applies to young people who are subject to care orders.

[NOTE: The law in this area is developing rapidly and this guidance will need to be kept under regular review. It will need to refer to LPS once we have a timetable for its introduction.]

Stage 2: Preparing For Adult life 16- 25 Getting Advice/ Getting Help

All support as set out in Growing up in Salford level 1 and 2 should continue. However action plans need to start to reflect the transition into adult life including practical steps like ensuring young people have bank accounts and are in receipt of the right benefits etc.

The keys to citizenship framework supports with the development Preparing for Adulthood plans. At the Preparing for Adulthood stage there is a strong emphasis on enablement.

All young people will be able to **Get Advice** via:

- TAG group
- The annual Preparing For Adult life Road Show
- Get information from YPTransition@srft.nhs.uk
- Salford Local Offer

- Support from SIASS team
- The Salford Preparing for Adult life Directory

Young people should start to be able to **Get Help** by being offered practical support towards developing skills, such as:

- ADHD/ASD self- management courses
- Apprenticeships/ internships
- Skill development course (through TAG)
- Travel Training
- Moving On Up Passport to Independence Coaches
- Access to passport to independence courses
- Outcome stars
- Preparing for Adult life workshops at educational establishments.

There should also be the development of social circles and community activities to prevent social exclusion when young people leave education.

Educational establishments and all other people working with young people should be supporting young people develop the skills they need for Adult life. Colleges should link this into their curriculum and should also be working to develop innovative pathways into employment.

Support for mental health and wellbeing is set out in the Thrive Directory;

https://www.partnersinsalford.org/media/1432/directory-covid-version-july-2020v2.pdf

The offer at this stage should be developed through the Transition Update and Review Group. Information on supporting young people to access mainstream service and develop PfA plans is set out in the Preparing for Adult life Practitioner guidance

Stage 2: Preparing for Adult life 16-18 Getting more help/ Getting risk support

For some young people with SEN/ disabilities/ health conditions/ trauma/ mental health and wellbeing difficulties, they may require extra support to enable them to meet their preparing for Adult life outcomes and transition positively to adult life.

Where a young person currently:

- Has an allocated children's worker (i.e. CWD team/ Next Steps)
- Is in receipt of commissioned services (including accommodation)

They should be presented at: The 16-25 Multi- Agency Hub. This will not result in an automatic allocation to an adult team but it will agree the best course of action for the young person and ensure a smooth transition to Adult life.

It may not always be clear what the Young Person's actual needs are or what are the best team/ person/ course of action to help or support. Where practitioners working with young people are concerned about the young person's transition to Adult life for example where a young person:

- Has 2 or more services currently involved with them
- Has associated safeguarding concerns
- Is it high risk of becoming a vulnerable adult but not expected to meet the criteria for Adult Social Care or Community Mental Health Teams

These cases should be presented initially at the 16-25 Multi-Agency Hub where advice and guidance can be provided and where appropriate relevant referrals made. This will also enable a central understanding of high risk groups, demographics, and gaps in provision.

Where there is more than one agency involved with the young person a multi-agency meeting should take place no later than 17th birthday and a final joint Multi Agency Meeting across children and adult should be done within 3 months of the young person's 18th Birthday. Timing of meetings should be based on when it would provide the most significant benefit.

If at the MAM it is believed the young person is at significant risk during transition the case should be escalated to the Multi – Agency Panel and added to the Multi Agency Young Person's Risk Register, as soon as risk are identified.

Young People may require targeted or long term support in a number of areas which include:

- Social Care Support
- Health
- Mental Health and Wellbeing
- Risk management/ safeguarding
- Leaving care

Where there is to be more than one adult service involved. Adult Service will agree who is the lead agency/ lead worker. The lead agency have the responsibility to coordinate partners and ensure that a smooth holistic transition take place and to escalate any issues to the 16-25 Multi-Agency Panel.

From referral from children's services to agreeing whether an adult service is required there is a clear transition process that sets out what should happen by when regardless of what Adult Service has been agreed. This forms the basis of the transition Performance indicators.

The Salford Transition Performance indicators expect that:

- Children's Services should refer young people who are **getting more help** or **getting risk support** to adult services within 28 days of their 16th birthday or within 28 days of it being identified they may require adult services post 18.
- Adult Services will complete an initial contact within 28 days of the young person birthday or within 28 days of the referral (whichever comes first).
- In line with best practice it is expected that where an initial visit is required it will take place with the children's workers and the young person's family. Where more than one agency is involved the initial visit may be conducted as a Multi- Agency Meeting if deemed

appropriate. This should take place as soon as possible but no later than 3 months after referral. This will depend on the age of the young person when referred to adult services.

- All young people referred to Adult Services should be supported to coproduce a preparing for Adult life action plan within 3 months of their 16th birthday (or sooner if referred after their 16th birthday). Young People, Families, Practitioners, organisations, and services should all work together to develop a holistic outcome focused plan that minimising risk, meets needs, and promotes wellbeing. This should set out:
    1) What is expected from the young person and family
    2) What the young person and family can expect from adult services
    3) A plan to develop independence.
- Where a young person requires a full assessment (whether this is health, social care, or mental health) this should be completed and agreed before they are 17 ½
- Where a young person requires support post 18 from any adult service the plan should be complete no later than 17 ¾

How each Children/ Adult Service area will operationalize this is set out in the corresponding specialist Pathways.

Transition Performance Indicators will be reported on a quarterly basis and be presented to the Head of service for Learning Disability, Transition and sensory. This will help identify risk, demographics, underperformance, and gaps and enable the development of the annual strategic transition themes.

Enablement and Engagement: Preventing Long term need for commissioned services

Salford have adopted a strengths based enablement and engagement approach to supporting young people with emphasis on targeted support to reduce the need for long term commissioned services.

All Practitioner working with young people should work based on the principles of prevention and delay. Where services are involved, they should work with young people to identify key areas of development and work with young person to develop through their PfA action plan not only how they will meet needs but also support that aims to develop young people skills, resilience, and emotional and physical wellbeing.

Areas of development should be identified with the young person before they turn 18 in preparation for adult life.

Health, Education, Mental Health, and Social Care should provide and update their enablement offer using the principles of Thrive. Information about enablement services will be distributed to front line practitioners.

The ethos for young people should be around how we can prevent or delay people from requiring long term services, rather than what services are available for young people.

It is important that regardless of what a young person's need is they are supported to understand their needs, how it impacts on them, and how they can reduce the impact.

Early identification of young people who may require Care and Support Post 18- who currently do not have service provision

Salford recognise that there are lots of young people in Salford with significant needs, whose needs are currently being met by families, education, and communities, but who may have needs for care and support post 18. Many of these young people are either not known to the Children with Disabilities Team or are cases that are closed. We also have an increasing number of young people who are known to the Looked After Children (LAC) team and Child in Need team (CIN) and the Child Protection team who may require support from adult services post 18.

Salford's Transition Team will liaise with Salford's SEN team to develop lists of young people who are 16 and are in specialist provision or are higher needs learners.

Salford Adult Services will ensure all these young people have a representative from Adult Services at their Preparing for Adult life Keys to Citizenship annual Review. If those working with the young person think this will be of significant benefit to the young person and where they think it is likely they may have a need for care and support post 18. The age in which adult services will attend reviews will depend on the needs of the young person and whether this is timely. This may be their final year in education.

Salford can meet their duties under Care Act 2014 for a Transition Assessment by attending the Preparing for adult and keys to citizenship annual review and ensuring it is documented that a proportionate assessment of need has been made and recommendations have been fed back. The initial visit or your circumstance form will be used in these circumstances, with the minutes to review uploaded to documentum. The action plan from the review will be the preparing for adult life action plan.

Any recommendation or provision provided, even if this is at **Getting Advice**/ **Getting help** should be added to H2 section of the young person's EHCP.

The SEN team will liaise with Transition team in October each year to establish who will be or likely to be leaving education and hence their EHCP ceasing and whether they are likely to require Adult Social care Provision. The EHCP reviews should be take place before Christmas and have where appropriate have a representative from Adult Service attend who can advise on whether the case needs to go to the 16-25 multi-agency hub for allocation.

The Transition Support Team will also liaise directly with children's social care team to identify young people who may require adult service

All this information will form part of the 5-year demographic plan that will be developed. This will attempt to identify all groups not just those who are currently in receipt of service.

Salford's 16- 18 Specialist Pathway's Getting more help/Getting risk support

Salford recognises that all young people's needs are different and may be met in different ways and by a number of different agencies.

There is also always a risk that young people may fall through the net if all services and pathways are criteria led. However Salford also recognises that it's important that services think about how they support people in transition and how they work together.

The specialist pathways therefore do not set out the young person journey but instead dictate what is expected as a minimum from the service involved.

Young People may be supported by more than one service, and therefore it is imperative the lead transition agency sets out how the different agencies will work together to avoid duplication and ensure a holistic approach to transition and planning

Development of the young person's journey will be developed through the 16-25 Multi Agency Operational Manual and Practitioner guide. This will be evaluated and co-produced by young people.

Pathway One: Salford Transition to Adult Social Care

Salford understands the complexities of transition and the impact of the significant change on both young people and their families. Therefore, Salford has an established Transition Support Team who jointly works with the Children's team to lead on the Transition to Adult Social Care.

The Transition Team sits within Adult Services but in reaches into children's service. In most cases the Transition Team will work with all young under 18 who are likely to have eligible needs under the Care Act 2014 except where they have a severe and enduring mental illness or needs can be best met by the Community Mental Health teams (see Pathway 3)

The aim of this service is not only to complete the transition to adult services and ensure that young people are not without care and support, but also to develop relationships and partnerships with young people and their families to ensure young people's voices are heard.

The model is strengths based and aims where possible to develop young people's skills and prevent and delay long term commissioned services.

Statutory responsibility regards commissioning care /safeguarding remains with Children Services till the young person is 18.

Transition and The Care Act 2014

There are statutory duties set out in Part 1 section 58-66 of the Care Act 2014 as regards the Transition to adult services/ care and support. These sections set out:

- Assessment of Care and support
- Assessment of carers needs (including young carers)
- Continuation of services

The Care Act 2014 Part 1 section 58, states that a young person is entitled to an assessment of need where it is likely they may have needs for care and support after becoming 18 and there is significant benefit to the young person. This is regardless of whether a young person currently receives services from Children's Services under Section 17 of the Children Act 1989.

The Care Act 2014 is clear about our statutory duties:

- Local authorities have a duty to assess young people, carers, and young carers where it is expected they will have eligible needs and it will be of significant benefit to the young person, adult carer, and or young carer
- The assessment should be timely and proportionate to the needs of the young

person

- The local authority should actively seek out young people who may require adult care and support even where they are currently not using services, especially where it is believed education are currently meeting the individual's needs (with particular reference to Autism/ADHD and complex need)
- The young person, carer, or young carer must give consent to the assessment if They are able to do so. Where they refuse an assessment should only take place if there is concern that a young person may be at risk of abuse or neglect
- The young person, family/ carers, and other people who are important should be fully involved in the assessment processes. Person centred approaches should be used and young people should be supported to think of positive outcomes they wish to achieve
- Families should where possible be supported to continue or start to work.
- If a commissioned service is required a care and support plan should be completed. Where a person has an EHCP the outcomes and provision set out in the care and support plan should be added to the EHCP. EHCP should be the main document used by all services, it should be clear in the EHC plan how adults' services will support young person, with particularly reference to developing skills and preventing the development of needs later, and long term reliance on commissioned services.
- Where a commissioned service is not required or where their needs are not Eligible needs, the young person and the family should in writing be given details of the outcome of assessment and signposted to other services/ organisations that can help.
- Where a young person is receiving a service from children's services this needs to continue until the assessment is complete and needs have been identified. No one should be without service. Where a service will cease as it is not deemed appropriate or the young person does not have eligible needs the young person must be supported to transition from their current service using a phased approach.

Eligibility Under the Care Act 2014

In order to have commissioned services under the Care Act, 3 conditions must be met:

- ***Condition 1:*** The person needs must arise from a physical or mental impairment or illness.
- ***Condition 2:*** The person must be unable to achieve 2 or more of the Care Act outcomes:
    1) Manage and maintain nutrition
    2) Maintain personal hygiene
    3) Manage toilet needs
    4) Being appropriately clothes
    5) Be able to make use of their home safety
    6) Maintain a habitable home environment
    7) Develop/ maintain family and other personal relationships
    8) Access/ engage in work, training, education or volunteering
    9) Make use of community service
    10) Carry out caring responsibilities for a child
- ***Condition 3***: As a consequence, there is a significant impact on the person's wellbeing

Salford Response to Care Act 2014 Duties

The Care Act states that transition planning should be timely and proportionate and take place when there will be significant benefit.

Salford recognise that transition can be difficult and aims to use the period between16-18 to develop strong and trusting relationship's with young people and their families.

Salford understand that the best transition is no transition or a seamless transition, so children and adults work closely from 16+ to ensure any decision made can be continued into adult services. Although the Care Act states work should begin when it would be of significant benefit, Salford endeavour to:

- Have an initial contact with the young person 28 days after their 16 birthday or the referral, depending on which comes first
- Have met and develop a preparing for adult life action plan within 3 months
- Have completed the Independence Led Assessment by the time the young person is 17 ½
- Where required have completed the support plan by the time the young person is 17 ¾

The young person and family will meet with the adult worker individually on a number of occasions throughout the transition period,

Consent:

Young People have to consent to an adult assessment of need. Section 58.3 states that the consent condition is met if:

a) The young person has capacity or is competent to consent to the needs assessment being carried out, and does consent
b) The young person lacks capacity or is not competent to consent, but the authority is satisfied it is the young person best interest

Where a young person has capacity and refuses an assessment, but the young person is at risk or at likely risk of significant harm or experiencing or is at risk of abuse or neglect, and assessment should be carried out.

Young people have a right to request and refuse an adult social care assessment; however, any young person wanting adult social care commissioned services will need to have an adult assessment of need, and therefore need to understand the significance of refusing an assessment.

The Transition Assessment and Eligibility:

Salford will assess all young people coming through transition where it is deemed to provide significant benefit. If Salford refuse to complete an assessment. Salford will provide a response in letter format which provide:

a) Written reasons for the decision
b) Information and advice about what can be done to prevent or delay the development by the young person of needs for care and support in the future

Any young person who currently has a commissioned service, and meets condition 1 of the Care Act Eligibility, will be supported to take part in an adult assessment of need.

The Care Act states that a Transition Assessment should be completed for all those where is felt it will provide significant benefit, this should be proportionate to the needs of the young person. Salford has developed a comprehensive Transition Assessment, which is made up of a number of documents, across a number of agencies. When completing a transition assessment, Salford will involve:

- The young person
- The family
- Those who know the young person well.

The Transition Assessment will document:

- Why the young person has requested and assessment, and the young person wishes and outcomes they want to achieve in their day-to-day life
- The needs the young person has and the impact of their needs on their wellbeing, and the likelihood of them having these needs post 18. Thought will be given on how to prevent or delay these needs post 18.
- Whether and to what extent the provision of care and support could contribute to the young person outcomes.

Depending on the needs of the individual, will depend what parts of the Transition assessment is completed. This is set out in the Preparing for Adult practitioner guide. Below is the basic transition assessment.

TfP2: The Preparing for Adult life checklist and plan:

There are lots of things that young people and their families need to think about as they prepare for Adult life, which may not be captured on the adult social care assessment. The Preparing for Adult life checklist ensures that young people and families are made aware of changes and supported to think about benefits, banking, where they will live etc.

The Preparing for Adult life action plan, set out the transition plan and ensures young people know what to expect, when.

Statutory Adult Social Care Assessment:

Salford currently uses the Independence Led Assessment as the Adult Social Care assessment which identifies needs as set out the Care Act 2014. In line with the ethos of 'tell us once' with the consent of the young person, the adult worker should gather information from different sources to inform the initial assessment.

The assessment should be strengths focused with emphasis on supporting young person to be as independent as possible and should where possible direct young people and families to opportunities to support them to meet their outcomes.

Although the Social Care Assessment (SCA) does not need to be completed before the young person is 17 ½, a young person must be informed of whether they are likely to be eligible for commissioned service post 18. Therefore, an initial ILA may need to be completed to establish likely hood of eligibility, them updated nearer to their 18th Birthday. The initial ILA should focus on prevention and delay of long-term service, and how to develop independence. The plan on how to do this will be documented in the PfA action plan.

Where a young person is likely not to be eligible for service post 18, but is currently in receipt of service the SCA should be completed earlier to provide opportunity for the Young person to appeal the decision, and where necessary work with young person, family and children's services to exit out of current provision.

Young people should be formally informed of the decision around eligibility via a letter.

Carers Assessment:

Families' members are entitled to a carers assessment

Care and Support Planning:

Where a young person has eligible need, a young person should be supported to develop a care and support plan as set out in section 25 of the Care Act 2014. A young person and the family must be made aware of all of their options on how care and support can be provided.

The support plan should highlight the young person's strengths, natural support and also wider opportunities to enable young person or prevent and delay they use of long-term services.

Continuation of Care

Salford endeavour to ensure all young people's assessment, support planning and transfer to adult services is completed on or before their 18 birthday. However, where this is not the case Salford will ensure there is no break in service for the young person.

Where a young person has a disability or impairment or there are serious concerns regards the young person's wellbeing post 18, and they are currently in receipt of a commissioned service, they must not be without service whilst:

- an adult assessment is taking place,
- a support is being developed.
- Where a young person is not eligible under section 13 of the care act, a young person must be supported safety to transition out of their current provision. No service should just stop without a planned process

Where a young person is currently in receipt of a service commissioned service and the service is required to temporarily continue into adult life, children's service will continue to pay for the service and adult service will complete a back transfer. This will be agreed at the Strategic Social Care commissioning and budget forecasting meeting.

Where a young person is referred late to adult services, and there is a significant budget pressure attached to the young person. A meeting will take place between the head of services of the relevant children and adults' team, to agree who will pay for the interim 3 months after the young person 18th birthday, whilst assessment and support planning is completed. This decision making will be recorded.

To ensure funding can be agreed, and prevent service discontinuation, the adult worker should go to the Adult Social Care Resource Panel to request temporary funding for the case, if a decision about who will pay has not yet been made.

Families and Advocates.

Young people may choose for parents to advocate on their behalf, for example, dealing with correspondence, attending meetings making appointment etc. If this is what the young person wants this should be supported but it should also be clear how the young person want information relaying back to them. When providing any information to young people, it should be accessible to them and support from either SIASS, independent supporter or advocate should be available.

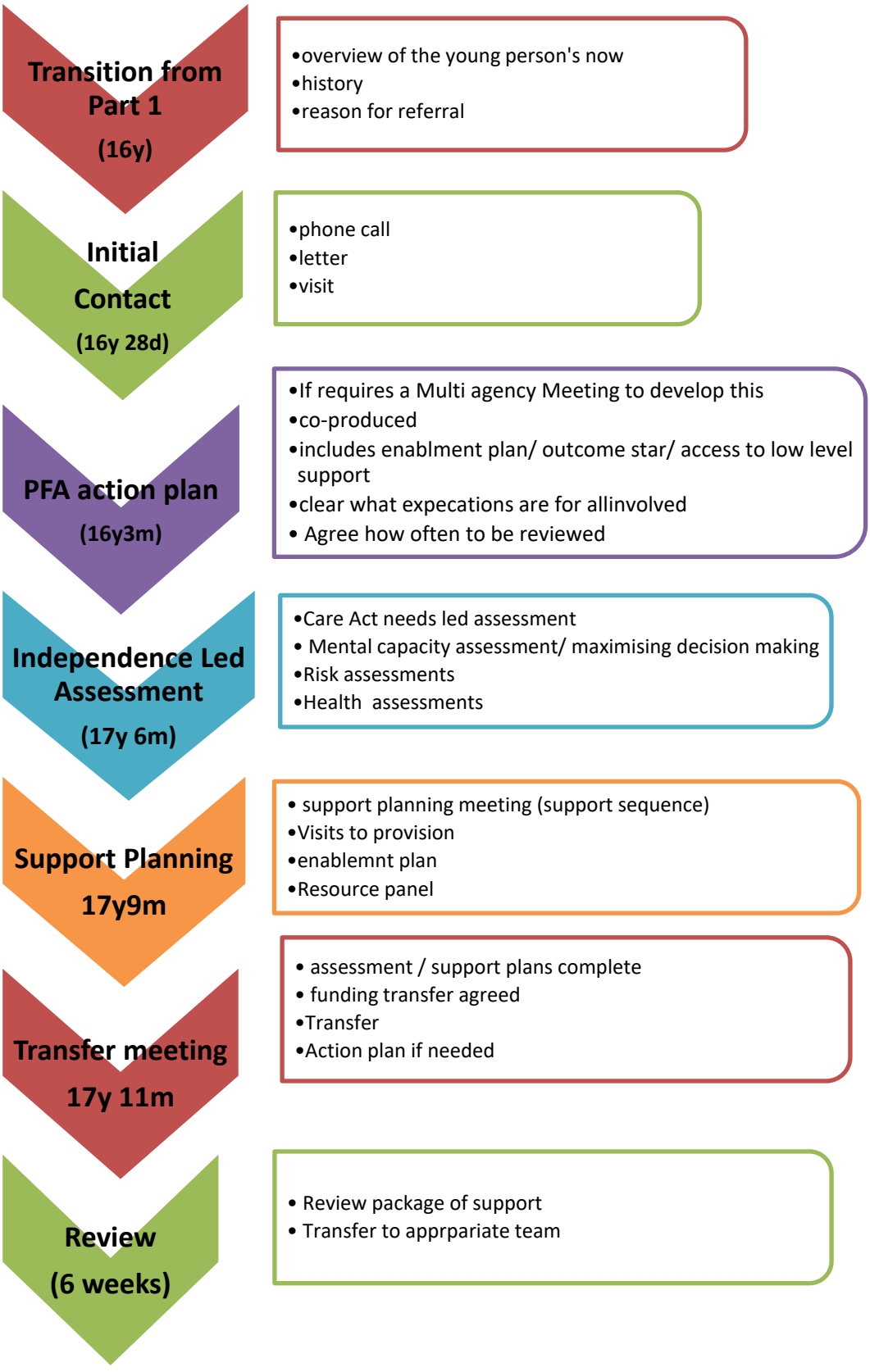
Where a young person has a care and support plan, and the family are the main provider of support, they should have access to this plan.

Where a family no longer provides support for a young person. The young person should be consulted with about how they would like their family to be involved. This should include clarity on

what is ok to be shared and what is not. Where a young person does not want family to be told information, they should where possible be supported to explain this to family. A decision-making agreement should be completed

Where not speaking to family may cause significant risk or harm to a young person (i.e. They have gone missing) the young person's wishes will be overridden.

Young People 16-18 Social Care Pathway



Young People who are looked after or formally looked after pathway

Pathway 2: People Leaving Care

The pathway below shows what work will happen when the young person is 16 – 18. This process sets out how Salford will support young people who are looked after and have additional need as set out in the Care Act 2014, Leaving Care Act 2000 & The Children Act 1989 guidance and regulations: Volume 3: Planning transition to adulthood for care leavers (2010)

Transfer from Children's Services to Adults Services

Before 16th Birthday	Complete Transition Form Part 1 (TFP!) to start the Transition process. Presented at Multi-Agency Hub:	Overview of Young Person Reason for Referral
16 Year 28 Days	Initial contact made by YP Transition on behalf of the Multi-Agency Hub	Phone call to Young Person / Family Arrange Initial Visit / MAM Send letter providing overview of what will happen
+ 28 Days	Initial visit and / or Multi-Agency Meeting (MAM)	Introduce Team / process Gathering information Start of Assessment PfA Action Plan Provide information (PfA Pack)
=/+ 28 Days	Initial assessment by Transition Support Team / Adults	Review all current information / Assessment What needs to happen to support transition? Likelihood of eligibility post 18
16 Years 6 Months	Preparing for Adulthood (PfA) checklist and Action Plan Agree engagement lead	What needs to happen by who, by when? Skill development Agree how regularly and how it will be reviewed
16 Years 6 month 17 Years 6 month	Implementing Preparing for Adulthood Action Plan	Support decision making MCA / Best Interest (BI) (if required) Increasing independence Visits / Options appraisal
17 Year 6 Months	Agree Adult Social Care Assessment	Review and update the initial assessment Agree eligibility and whether ongoing support is required

Continuing Health Care Pathway

Transitional Safeguarding Pathway

Transitional safeguarding is an emerging concept which aims to develop a fluid and appropriate response to safeguarding and supporting young people to develop the skills they need to keep them safe and build resilience self-efficacy and self-esteem.(Holmes, Smale 2018) Salford are aware that many adolescence and young adult will have significant complex needs but may not meet the threshold or criteria for certain services and statutory functions post 18. This is a particular risk as a young person turns 18, when there are significant differences and criteria for support especially within social care, safeguarding legislation and mental health services.

In recognising this, Salford is not advocating too paternalistically over support and protect young people but acknowledges that risk does not evaporate at 18; in fact, this can increase due to the lack of support systems, and lead to lifelong difficulties and poorer outcomes, with risk of over reliance on services later on in life for the young person. (Holmes, Smale 2018) Salford understands the importance of adolescence and the need for those working with young people to support the young person to develop the hard and soft skills for Adult life, based on trauma informed care.

Where it is felt a young person will require support post 18 Salford want to develop different options for young people depending on need. Salford do not want to build dependency on statutory services, and see the principles of the Multi-Agency Transition policy and process give an opportunity to work differently with young people, ensuring they have a stable base and where required have an engagement lead who will continue to work with the young person and connect them new community and support networks as they become young adults.

Where young people are being supported within the children's safeguarding framework pre-18, Salford, where appropriate want to ensure a smooth transition either to adult safeguarding, or to other support networks.

Referrers to utilise Pathway 1. **Young People 16-18 Social Care Pathway to refer to adult social care for direction.**

Mental Health Pathway (14)

The Transition is a process in which individual cases are transferred from Children's Services to Adult Services. Pathway three is designed for the childrens mental health worker to refer to the transition team when the young person is 16 years old.

The aim of the Mental Health Transition Pathway is to ensure that any young person who has a potential Mental Health need is allocated to the correct team. Where a young person has low level mental health needs (which are not their primary need) and is eligible for social care support, this Pathway aims to ensure they are signposted to relevant low level mental health support and social care support.

Pathway 3: ***The Mental Health Transition Pathway***

The pathway below shows what work will happen when the young person is 17 – 18. This process sets out how Salford transition young people to Adult Social Care: Salford's response and approach to the statutory duties that are set out in the Care Act 2014 in supporting young people with additional needs.

Transfer from Children's Services to Adults Services

Around 17th Birthday	Complete Transition Form Part 1 (TFP1) to start the Transition process. Presented at Multi-Agency Hub:	Overview of Young Person Reason for Referral ie – CAMHS to AMHS Mental Health Adults Champion to oversee the case and agree actions.
17 Year or 28 Days after referral	Initial contact made by childrens team to inform YP of the referral	Phone call to Young Person / Family The MH lead, will have core responsibilities to ensure the smooth transition of young people to the Adult Mental Health, and ensure clear communication with the Transition Coordinator.
=/+ 28 Days	Initial assessment by Transition Support Team / Adults if adult social care is required, Preparing for Adulthood (PfA) lead by MH	Review all current information / Assessment What needs to happen to support transition? Likelihood of eligibility post 18
17 Years 6 Months	Preparing for Adulthood (PfA) checklist and Action Plan Agree engagement lead Agree next steps in transition	What needs to happen by who, by when? Skill development or full assessment Update CAMHS MH tracker
17 Years 8 Months	Support Planning if required PfA action plan checked	Support Plan Adult Social Care (ASC) funding panel (If required) Care Brokerage/Charging assessment

Stage 3: Becoming and Adult life 18-25

Support available for young people who are 16-18 should be available to young who are 18-25.

Salford is aware that young people go through a number of transitions, and that transition to adult life does not start or end at 18.

Salford want to ensure that young people over 18 but under 25 who find themselves having difficulties, or needing some help have access to the same advice, help, and support as young people who were known to service before their 18th birthday.

Becoming and Adult life 18-25: Getting Advice/ Getting Help

Many young people with additional needs will not finish education 18. Salford are aware that education provides a great deal of structure, routine and support to young people, and that some young people who have never needed support may know require some advice and help. This can often be very short term.

In September each Year the SEN team and the Transition Support team will work together to identify who will be leaving education and whose EHCP will cease. From this list they will establish who may require some additional support to access support in the local community.

The transition support team will work with young people leaving education, both on an individual and group level to develop preparing for adult life action plan. Priority will be made to:

- Young people at Salford College Eccles foundation unit
- Chatsworth College
- Chatsworth Futures
- Oakwood High School
- Independent Specialist college
- Young people identified by the SEN team as being higher needs learner, who are at risk of social isolation

Opportunities will be mapped at the Transition Implementation and Review Group.

From this work the Transition Support team will be able to identify who may require support from Adult Services.

Becoming and Adult life 18-25: Getting more help/ Getting risk support

Young people who are over 18, who are not being referred directly from an educational establishment or other service already involved, should in the first instance go through the usual routes for all people over 18:

- Adult Social Care- contact team
- Mental Health – GP

6. Roles and Responsibilities

Transition Support Team

The Transition Team sits under the head of service for LD, transition and sensory within Adults services of:

Principal Manager (this is not solely for Transition team

- Advanced Practitioner: Social Worker:
- Social workers (2)
- Transition Coordinator:
- Multi Agency Panel Coordinator: Coordinates multi, agency hub and leads on dissemination of information advice and guidance

The role of the transition team is written into the Salford health and social care service specification.

In regards of the Children and Families Act 2014 and Care Act 2014, specific duties of this team are:

Getting Advice/ Getting help

- Provide and update information about transition
- Deliver Preparing for Adult life events
- Manage the Teenage to Adult Group
- Passport to Independence
- Develop and deliver training plan for Person Centred planning, reviews and preparing for adult life
- Manage the YPTransition information email
- Support young people to complete preparing for adult action plans
- Complete social care advice for young people 18+ and in certain circumstances 16+
- Signpost young people to level 1 and 2 services and organisations

Getting more help/ getting risk support

- Ensure the early identification of young people
- Administer the Multi – Agency Hub
- Lead on the operational function of Transition (transfer from one team to another, highlight budget pressures, manage risk)

- Manage the database of young people
- Ensure representation at where appropriate EHCP annual reviews
- Ensure young people get a transition assessment
- Ensure young people where eligible have a person-centred care and support plan, that dovetails where appropriate into their EHCP
- Develop a commissioning strategy based on the needs of young people as set out in their EHCP, preparing for adult action plans, transition assessments and care and support plan
- Develop pathways

7. Monitoring Effectiveness

Complete the following:

- Key standards: state the benchmarks, targets or key performance indicators that will be used, for example 'MANCHEWS scores on admission will be recorded in case notes for 100% children admitted to the children's ward', '100% staff will have completed annual hand hygiene training by the end of the financial year'.

- Method(s)*: state how compliance to these will be monitored, e.g., clinical audit, spot checks, direct observation, competency assessments, review of training attendance.

- Team responsible for monitoring: state which team/personnel will carry this out.

- Frequency of monitoring: state how often compliance will be checked, e.g., once every two years, quarterly, continually.

- Process for reviewing results and ensuring improvements in performance: state how will you report back and ensure action is taken if required, e.g., 'monthly compliance dashboards will be shared with the teams involved and reported up through the care organisation governance committee'.

*If clinical audit is an appropriate method of monitoring inclusion of an audit tool in the appendix is encouraged. Clinical audits must be registered with the Clinical Audit Department. Where evidence of non-compliance with the policy is to be monitored through submission of adverse incident reports (DATIX) a description of how this data will be collected, collated and reported should be provided in this section.

8. References and Supporting Documents

References

Insert list of references here: Suggested format: Surname, initials. (Year of publication). 'Title of the publication'. Organisation/Publisher and Place of Publication.

E.g., Department of Health, (2008). 'NHS Brand Guidelines for Acute Trusts'. Crown Copyright, London.

9.2 Related SRFT/PAT documents

List any Trust policies/guidelines that relate to this document: Include the document title and reference numbers. Please state whether related documents are SRFT, PAT or joint Northern Care Alliance documents.

9.3 Acknowledgement of sources

Insert here or delete this section if not applicable. If you have used or paraphrased content, such as ideas, text, images or flowcharts, from other people's/organisation's work please acknowledge here e.g., 'Images courtesy of NHS Photo library, Crown Copyright 2005', 'Legal advice provided by Weightmans Limited Liability Partnership Reg. No. OC326117, India Buildings, Water Street, Liverpool'. NB: you must check copyright permissions as some organisations will not permit use of their work without express permission. Library Services can advise.

[1] http://www.salfordccg.nhs.uk/salford-locality-plan (Accessed 01.04.2019)
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Crisis Care Pathway Pocket Guide, viewed 30/8/19
https://www.penninecare.nhs.uk/application/files/9315/6137/1592/childrens-crisis-care-pathway-summary-final-april-2018.pdf
[1] Salford City Partnership, viewed 30/8/19, https://www.partnersinsalford.org/media/1260/crisis-care-pathway-presentation-oct-18.pdf
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[1] NHS North West, https://www.england.nhs.uk/north-west/gmec-clinical-networks/our-networks/mental-health/adhd-services-across-greater-manchester/