Practice Guidance

Transition Plan

This document is designed to support you in completing the Transition to Adulthood Plan Review Record (found in forms and documents) on Mosaic as part of the Transition Plan Review meetings. This document has guidance and prompts for most of the questions in this workflow, to ensure the questions can be answered accurately that represent the young person's aspirations and goals for their post-18 plan.

Section 1- Person Details

Some details automatically pull through from mosaic front screen

'Ordinary Residency Area'- This is the area the young person is from. If they are living out of county or in a different locality (mainly LAC) then this is the area they are originally from.

'Service User groups'- If there are any additional groups on the front screen to the primary one, copy and paste these into the text box

'Age of the young person when transition plan was completed'- This is important to put in to highlight the progression of the plan for a young person as they transition up to 18.

'Involved professionals & organisations'- Add all the names of professionals who are involved with the young person and put whether or not they attended the multi-disciplinary discussion. If they didn't it is important the plan is still sent to them and they are encouraged to attend future meetings.

'Referral to adult care'- Depending on the young person's need this has to be made by the time the young person is 16.5 years old at the latest. However, it may be highlighted through the transition plan discussions with adults that a referral is needed earlier due to the complexity of a young person's needs.

Section 2- Transition Plan

'Is the young person aware and involved in their post 18 planning?'- Drop down answer. Consider how involved the young person is in their future planning. Could they be more involved in their decision making? Do they need support to be involved and make decisions?

'Has a Mental Capacity Assessment been carried out?'- If 'no' is selected a text box will appear this is to add a reason why one hasn't. There may be a clear explanation in that one is not required but it is important to consider if there are any significant decisions the young person needs to be part of and if an MCA is needed. **Remember to always assume capacity unless proven otherwise.**

'Aspirationally what outcomes could this young person achieve in day to day living if enabled or supported in their adult life?'- In this text box outline a couple of bullet points that highlight what the young person's aspirations or goals are post 18 in their day-to-day life. This could be 'They want to live in supported living with minimal support' or 'They would like to be able to use public transport independently'. Look at the question mark next to the text box for things to consider as part of this question.

Aids and Adaptations and Maintenance Arrangements- For all the questions in this section they are all drop down answers, do discuss with the occupational therapists as part of your multi-disciplinary meetings to answer these**.**

'Aspirationally what outcomes could this young person achieve in education, training or employment if enabled or supported in their adult life?'- In this text box outline a couple of bullet points that highlight what the young person's aspirations or goals are post 18 in their education or employment. This could include 'They would like to attend college to carry out a course on agriculture' or 'They enjoy swimming and sensory play which they would like to have part of their daily routine'. Look at the question mark next to the text box for things to consider as part of this question.

Could the young person be supported to travel independently? - Travel training is something that is available to young people, it can be discussed with SEND possibly community connectors also to support a young person to use public transport independently.

'Aspirationally what outcomes could this young person post 18 to maintain and form social relationships?'- In this text box outline a couple of bullet points that highlight what the young person's aspirations or goals are post 18 to engage in the community and maintain family relationships. This could include 'They would like to see their family weekly both visiting them at their home and them visiting the family home' or 'They would like to keep in contact with a good friend from school once they have finished education by going to a day centre to do some activities'. Look at the question mark next to the text box for things to consider as part of this question.

'Has this young person previously had a Child at Risk of Exploitation toolkit completed?' - If you select 'yes' there will be further questions appear to gather more information about whether those risks are still present or not.

'Aspirationally, what could the young person achieve to optimise their health and wellbeing?'- In this text box outline a couple of bullet points that highlight what the young person's aspirations or goals are post 18 to manage their health and wellbeing. For example, 'The young person would like to be able to take their medication on their own with support of alarms/prompts' or 'The young person would like to continue managing and regulating their emotions with support'. Look at the question mark next to the text box for things to consider as part of this question.

Section 3- SMART Action Plan

The SMART action plan (whether it is in the CIN/CP/LAC plan) needs to consider actions over the next 6 month period that are specific to that individual's transition plan and the post 18 aspirations and goals, which you will have outlined in the 'aspiration' questions.

What do we want to achieve (outcome)	Actions (to achieve outcome)	By Whom?	By When?	How will we measure progress and success?	Impact of actions (outcomes achieved)
Joe to develop his skills in making a basic meal independently.	Parent/Carers to start with prompts and step by step to make a basic meal. Parent/Carers to be present but gradually build on him	Parent/Carers LCAMHS/school to support with phrase cards	Over the next 6 months develop a schedule for him to develop his independence skills.	Joe will have learnt how to cook a basic meal on his own.	

	becoming more independent. Using short phrases and reminder cards for Joe to remember each step.				
Joe to develop is community links and learn how to use public transport	Referral for travel training to develop his awareness and skills to navigate in the community.	SW to discuss with SEND worker to make referral for travel training.	Within next 2-3 weeks	Joe will be receiving travel training to learn more about using public transport	