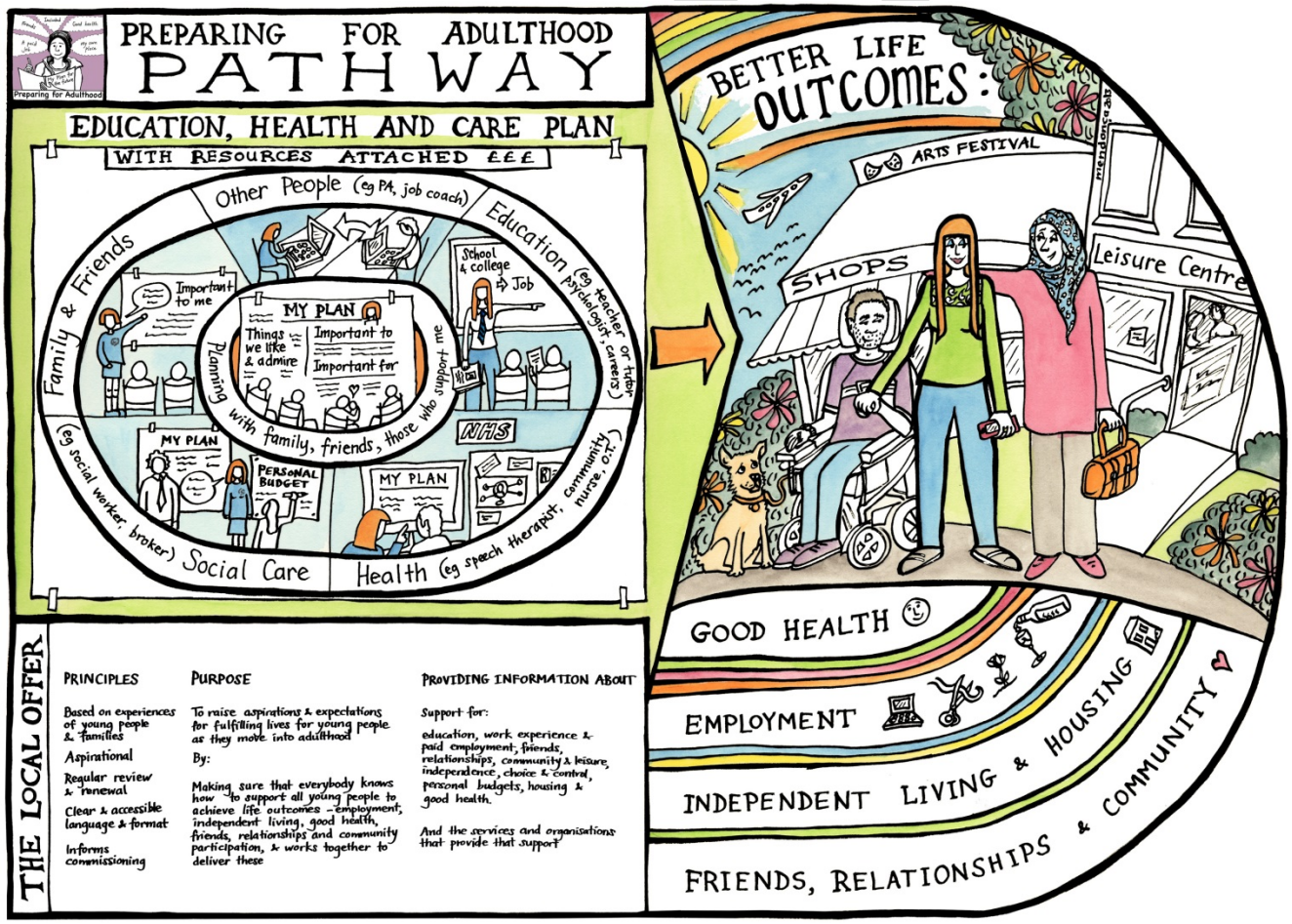
Sunderland Safeguarding Children Board

Sunderland City Council

Multi-agency preparing for adulthood protocol & pathway for Children and Young People with SEND

January 2018



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This graphic was produced as part of the Preparing for Adulthood Programme
www.preparingforadulthood.org.uk

Introduction and Background

Disabled children, young people and their parent(s)/carer(s) have repeatedly told statutory organisations that preparing for adulthood is a period in their lives that can be dreaded and where good practice in is not sufficiently well embedded. The Children and Families Act 2014 has brought about the most extensive changes to support for children and young people who have a special educational need and/or disability (SEND) for thirty years. The legislation delivers a clear message that agencies must work together to provide careful preparation, multi-agency planning and excellent communication to ensure that young people who have SEND get the support they need so they can move from child, to young person, to adult as seamlessly as possible.

Children looked after and those who are leaving care, particularly those with SEND, are known to be vulnerable during this period due to their previous life histories. The aim of this protocol is to ensure that leaving care is a process which is driven by a qualitative assessment process, ongoing support and assessment and the capacity of each child to develop the skills necessary to live independently where possible.

Partners across education, health and social care have a key role to play in helping all children and young people with a learning difficulty and/or disability (LDD) prepare well for adult life. This protocol sets out to address the roles, responsibilities and accountability for all partners whilst making sure the child, young person and their parent(s)/carer(s) are at the heart of the process.

This document acknowledges that this group of children and young people will have a broad range of needs and entitlements and require support from both Children's Services and a range of Adult Services. It is important to understand the different service frameworks covering this group of children and young adults and ensure there is clarity about their entitlements and the responsibilities for both of these.

We will use this protocol to ensure that a person centred, partnership approach to planning during this period is key to its success. The individual outcomes we aim to achieve with children and young people will enable them to take their place as adult citizens where their contribution to their local community is valued.

The term child is used in this document to describe individuals prior to their 18th birthday; the term young person is used to describe anyone aged between 18 and 25.

This protocol will be reviewed in January 2020.

Section 1

What is this protocol and who is it for?

This multi-agency preparing for adulthood protocol and pathway is for all children and young people with a learning difficulty and/or disability (LDD), their families/carer(s) and any professionals involved during this time. It should be read in conjunction with:

- the local authorities Education, Health and Care plan protocol and guidance
- Home to School Transport policy
- Personal Budgets policy
- Interface Protocol between Safeguarding Children and safeguarding Adults
- Children with disabilities policies and procedures
- Children looked after and leaving care policies and procedures
- Staying put policies and procedures
- Managing (Disability) Benefits for Children Looked After
- Adult services policies and procedures, including 'capacity and ordinary residence'.

A strategic preparing for adulthood protocol and pathway is needed in Sunderland to ensure services are brought together, with a clear and transparent commitment to make the preparing for adulthood process work for disabled children, young people and their families.

Developing a clear, strategic, multi-agency, agreed protocol and pathway on how local services work to meet the needs of disabled children and young people prepare for adulthood can transform the effectiveness of local support.

It is essential the protocol and pathway is multi-agency, is embedded in reality and is owned and understood by all those who have a part to play, including children, young people and their families.

It is well known that a recurring key challenge often leading to lack of continuity in provision of services during the preparing for adulthood years, stems from the different entitlement criteria and definitions between services available to children and those available to adults. This protocol will identify key milestones in the process and the roles and responsibilities of those involved, thus ensuring that a seamless process is achieved for disabled children and young people.

The Sunderland multi-agency preparing for adulthood protocol and pathway is aimed at children and young people with learning and/or physical disabilities or difficulties, aged 14 – 25 years who have an Education, Health and Care Plan (EHCP), Child in Need (CIN) Plan and Care or Pathway Plan. It is also for those who receive support at the SEN support level. The Special Educational Needs Coordinator (SENCO) role within school is key in leading this person centred transition planning, which is referred to in this protocol as the SEN Support Pathway.

For those children who are looked after, a leaving care assessment must be completed before

16 years of age and agreed once they become an eligible child, following this assessment a pathway plan must be developed from aged 16 alongside the child's EHCP. For any child who is likely to require ongoing support from adult social care aged 18, this is an ideal opportunity to carry out a transition assessment to determine their eligibility to receive support under the Care Act 2014 and generate an indicative budget.

Following a transition assessment, a small number of children with the most complex needs will require the involvement of adult social care once they reach the age of 18. In this situation an allocated worker from adult social care will become involved at the appropriate review stage of a young person's EHCP before their 18th birthday. Where a young person has an Education, Health and Care Plan in place it is referred to in this protocol as the EHCP Pathway.

The table below illustrates which pathway young people are likely to follow and includes all young people with an Education, Health and Care Plan, those receiving SEN Support and any child or young person who is 'looked after'.

	SEN Support Pathway (Universal and targeted support)	EHCP Pathway (Specialist and bespoke support)	Looked After Child (LAC) Pathway
Who is it for?	Young people who have needs that can be met through universal and targeted services available as part of Sunderland's Local Offer.	Young people who have an Education, Health and Care Plan and require specialist or bespoke services to meet their needs.	Children and young people who are 'looked after'. All children will have a Pathway Plan and some children will have an EHCP.
Who leads on it	Special Educational Needs Coordinator (SENCO)	Keyworker (Likely to be the child's Social Worker or someone designated as part of the EHCP process) The designated Keyworker role should be carried out by the most appropriate person to lead the planning process as the child or young person prepares for adulthood. This could be the Social Worker, the SENCO or someone else and may need to change at different stages. A decision should be made on an individual basis.	Next Steps Social Worker (SW) will lead from age 16 to 18 or if the case is open to the CDT, the allocated SW from this team would lead. Next Steps Personal Advisor (PA) will work alongside the allocated SW from age 17yrs 6mnths. The PA will take the lead role when the young person is aged between 18 to 21 or 25 if the young person remains in education.

If there is evidence following a person centred graduated approach to providing support for a child or young person, that they are following a pathway that does not meet their needs, an EHCP assessment may be requested, if successful they can be moved to the EHCP pathway. In order to receive adult social care services at the age of 18, an adult needs assessment will need to be undertaken by age 18 and Care Act 2014 eligibility criteria applied. If a transition assessment has been completed previously and an indicative budget identified, the information in this assessment should inform the adult needs assessment.

If a young person and/or their family believe they should be following a different pathway from the one they are following, they should make representation to the local authorities SEN department. Or if it is in regard to social care support for children a referral should be made via the Integrated Contact and Referral Team. For adult social care they should contact the local authority's customer service network to request an adult needs assessment. In addition, they may seek the support of an independent advocate to act on their behalf.

Section 2

What does good look like?

Preparing for adulthood can be an exciting time of new opportunities, choices and increasing independence. It can also be a time of great anxiety, confusion and uncertainty for children and their families as they move from familiar arrangements, services and people into the 'unknown'. For everyone involved it is a crucial time to think carefully about the child's adult life, what they want now and in the future.

Current policy and guidance which is summarised in Appendix 1 makes it clear that children and their families should play a central role, with planning starting early from year 9 (age 14) with the preparing for adulthood review and with all agencies working together. By listening to the child and their parents about what is important to them a person centred approach to planning can make a real difference to the outcomes that are achieved.

In discussion with families, disabled children and young people it is clear that good planning when preparing for adulthood involves:

- Opportunities to make choices and take risks throughout childhood;
- Good co-ordination and communication between the agencies responsible for services for children and adults;
- Effective participation by children, young people and their families within existing multi-agency preparing for adulthood planning systems;
- Adequate choices and opportunities at the point of school leaving and after for disabled young people;
- Good information available at the right time in an understandable format.

Some children and young people with a learning disability do not have sufficient understanding and communication skills to make their views known. In this situation it is essential that those working with them have the necessary skills to facilitate the involvement of the child or young person and their family to support them to make decisions. It is essential that workers have a thorough understanding of supported decision making and the Mental Capacity Act 2005 which applies to children aged 16 and above. A Mental Capacity Act Assessment should be completed with the child at age 16 only if there is reason to doubt they have the capacity to make a specific decision about their life. Referral for independent support or advocacy may also be appropriate, particularly when there is conflict between the young person's views and others involved.

Incorporating person centred planning into young peoples' everyday lives can make a genuine difference. Giving professionals involved in supporting a young person to prepare for adulthood

the tools for person centred planning can impact upon how they perform their job and provide job satisfaction. Person centred planning should not be seen as an 'add on', it should be an integral part of how planning takes place with disabled children and young people throughout the preparing for adulthood period.

Put simply it means you identify the following and use this information to develop plans and person centred outcomes that move the child or young person closer to their aspirations:

- What is important to the child or young person now and for the future, what are their aspirations?
- What is the child or young person's strengths and qualities, how do these strengths feature in planning for their future?
- What is working and not working from different perspectives? Do the outcomes set maintain what is working and address what is not?
- What does best support look like for the child or young person?

It is vital that the information collected through individual Education, Health and Care Plans informs a joint commissioning strategy. Many issues for individual young people can be resolved through joined up person centred planning that involves them and their family as equal partners. Planning that learns what is the best that can happen for the young person; and then works together locally to make this happen, will result in more young people and their families achieving successful outcomes in their adult lives.

From the year 9 preparing for adulthood review, the following areas should be a feature at all following reviews:

- Moving to further education or employment
- Independent living (independence at home or finding a place of your own)
- Being part of community and having friendships and relationships
- Good health and wellbeing
- Moving from a children's services framework to an adults framework

Identifying what is working and not working in these areas from different perspectives should develop a clear direction of travel and help the child or young person to discover and create the future they want. It should lead to fewer people entering traditional day services and should instead support young people in having paid work, having their own personal budget, employing their own support staff, enjoying full and healthy lives and being contributing members of their own community.

Section 3

Preparing for Adulthood timetable and key milestones –

This timetable is based on the annual school review process for all children. For those children and young people who have an EHCP, their EHCP will be reviewed at this stage each year and sometimes before if required. Every effort should be made to carry out the review of any other statutory plan's that a child or young person has in place in line with their EHCP review. Where this is not possible the responsible agency should make sure that the information collected at the review is consistent across all assessments and plans. These could include:

- Education, Health and Care Plan
- Care Plan
- Personal Education Plan
- Child in Need Assessment
- Health Assessment and Health Plan (Children Looked After)
- Leaving Care Assessment
- Pathway Plan
- Transition Assessment
- Adult Needs Assessment
- Social Care - Care and Support Plan
- (Associated Health Plans, including Continuing Care)

Year 9 (age 13/14)

This is the start of the formal preparing for adulthood process. The Year 9 preparing for adulthood review takes place at school and must include the formal beginning of transition planning. Children are supported in advance of the review in order for them to fully understand and maximise the potential opportunity of it so they are able to make an informed contribution. Preparation will take place to explore what is important to the child now and for the future, how to support them best and to find out what are their aspirations? It is also important that the child's parent(s)/carer(s) are supported to prepare for the review; this may be via a phone call, a preparation booklet or a meeting beforehand with an appropriate practitioner. There are a number of options available to children and their parent(s)/carer(s) to help them to prepare for a review; these include Independent support provided by Sunderland Carers Centre, the local authorities SEND Information Advice and Support service, the school SENCO or another professional or practitioner who knows the young person well.

For those children who have an EHCP or where statements of SEND are transferring to an EHCP, preparation for the review needs to include identifying what information is already available and what else is required in terms of assessments or plans. Who takes the key worker role should also be discussed and decided upon before the start of the process; the person who takes on this role may be different for individuals depending on their needs and circumstances and the child and their parents/carer(s) should be included in making this decision. The key worker role may also change as the child moves towards 18 and if they access new services or

additional support e.g. if a social worker is allocated. For the review to be successful, all those involved including professionals should be prepared to share information about what is working and not working from their perspective around the preparing for adulthood outcomes; moving to further education or employment, independent living, being part of community and being healthy.

The review is called by the school and must be attended by the child and their parent(s)/ carer(s) (or chosen representative), their keyworker, appropriate school staff, Connexions Personal Adviser and School Nurse, the Learning Disability Transition Nurse may also attend.

Where there is involvement from Children's Social Care the allocated worker should attend, or at the very least provide comprehensive information from the Child in Need Plan or Care Plan in regard to the outcomes that the child is aiming to achieve, what support is being provided to work towards these outcomes and what is working and not working from the workers perspective.

Where a child is looked after and requires a Personal Education Plan (PEP), the content of the plan should be co-terminus with information developed in the Education, Health and Care Plan. It is the responsibility of the Independent Review Officer (IRO) to make sure that all statutory assessments and plans are in place for any child who is looked after. The IRO will monitor the child's progress as they prepare for adulthood and ensure that all statutory leaving care duties are carried out.

If the child has an EHCP, a plan coordinator from the local authority will usually attend the review to support the facilitation of the meeting and make any amendments to the EHCP. The child and their parent(s)/carer(s) should be asked who else should be invited to the review and when it should take place.

The meeting should focus upon identifying the child's strength's and qualities and what the people who know them best like and admire about them. What is important to the child now and for the future (their aspirations), what is important for the child (including their assessed needs) what good support looks like and what is working and not working in their life. If the child is being supported via an SEN support plan, the same areas should be addressed and person centred outcomes should be identified that move the person closer to their aspirations, addressing what is not working in their life or maintaining what is working. If the child has an EHCP, the plan should be updated with clear person centred outcomes set for the next 12 months (some outcomes will have different timescales), that are specific and measurable. It is important that any EHCP takes an integrated approach to developing outcomes and for those children who have education, health and or social care elements to their plan; this should be reflected in the recording of outcomes in relation to these areas. Specific, measurable, achievable, relevant and timed (S.M.A.R.T) actions should be set to identify how these outcomes will be achieved.

The meeting should identify any health needs that the child may have and outcomes to maintain or improve health and wellbeing developed and agreed. If it is agreed that a health action plan

would be of benefit, the Learning Disability Transition Nurse takes responsibility for leading this. Where Social Care are involved, or if it is identified at the EHCP review stage that a child may require support from adult social care in the future, the multi-agency Transition Management Group will be informed that preparing for adulthood planning has begun, provided with early information and where there are potential health and social care complex commissioning issues to be addressed. The Transition Management Group is a multi-agency group, it meets monthly and a spread sheet is maintained to track cases where children are approaching the age of 18. The group provides information advice and guidance in regard to transition cases and identifies the appropriate adult service to respond to individual need.

Year 10 (14/15)

Each school is responsible for identifying EHCP review dates and the person in the school who will lead on this, E.g. the designated Teacher or SENCO. The school is responsible for circulating invitations to all key stakeholders. If a child has an EHCP, the plan and the PEP (if the child has one) is reviewed and provides further detail including education and complex health and social care issues to be addressed. It is the responsibility of the Key Worker to make sure this is communicated to the multi-agency Transition Management Group.

The child and their parent(s)/carer(s) should be supported to be at the centre of reviewing their plan, making changes and agreeing who will undertake what actions.

Sunderland's Local Offer should be accessed to help provide information about potential solutions and opportunities, and planning should be available for the child to explore post 16 options such as post school options, explore work and work experience such as Saturday jobs and identify potential opportunities to engage in their community.

If a child is looked after, they will require a Leaving Care Assessment of Need and a Pathway Plan on reaching their 16th birthday. The Leaving Care Assessment of Need should commence when the child reaches 15yrs and 6 months and should be completed immediately after their 16th birthday. The Pathway Plan should be completed by the time the child reaches 16yrs and 3 months.

If it is identified that support from adult social care is likely to be required once the child is aged 18, a request for a transition assessment should be made to the local authority. The request can be made by the child, a parent/carer or someone who knows the child well such as the SENCO. A request can be made at any stage before the child reaches 18 but it should be made at an appropriate time for the child and their parent(s)/carer(s), taking into consideration the child's complexity of need and circumstances. A transition assessment will use eligibility criteria set out in the Care Act 2014 to identify whether a child is likely to have eligible social care needs once they reach the age of 18. As well as determining eligible needs, a transition assessment should identify the indicative budget likely to be available to a child to meet their needs when they become 18.

Where a child is looked after, the transition assessment should focus on the needs of the child as a care leaver and take into account the move from the children's social care framework to a framework designed for adults.

If a child already receives a service from children's social care, it is important that the allocated worker carries out a transition assessment as part of the preparing for adulthood process (which begins at year 9) at an appropriate time; this should take place at the review stage of a child's EHCP if they have one.

Once a request for a transition assessment is received, the local authority must respond in writing if they do not feel that it is an appropriate time to carry out the transition assessment and identify when the assessment will be carried out.

Year 11 (15/16)

The school is responsible for identifying review dates and circulating invitations to all key stakeholders. If a child has an EHCP this is reviewed and provides further detail to plans including complex health and social care issues to be addressed; this is communicated to the Transition Management Group. Where the child is planning to leave school in the next academic year, an EHCP should identify whether the child is staying in full time education (e.g. at a College) starting an apprenticeship, supported internship or traineeship, moving into work, or volunteering for 20 hours or more a week while in part time education or training.

The annual review meeting in the final year at school should take place early in the academic year to enable updated agreed actions to be implemented before the child leaves school if they plan to do so. At the final review meeting within statutory education, the child and their parent(s)/carer(s) should be clear about the changes that will happen when the child has left school and about the options available to them.

If a child is 'looked-after' and the local authority has responsibility as the corporate parent, a Pathway Plan (see previous section for timescales) must be developed at this stage by the allocated worker from the relevant children's social care team (the Children's Disability team, the Next Steps team or Locality team). This plan should be developed with the EHCP if a child has one, clearly identifying outcomes in the preparing for adulthood areas of higher education or employment, independent living, being part of the community and being healthy. Outcomes need to be specific and measurable and clearly reflect what is important to the child and their parent(s)/carer(s). Outcomes should address what is not working or maintain what is working in their lives and move the child closer to their aspirations. Specific, measurable, achievable, relevant and timed (S.M.A.R.T) actions should be set to identify how outcomes will be met.

Once a child is aged 16, legislation in the Mental Capacity Act 2005 applies. Decisions about independent living, finances, further education and who provides care and support are particularly relevant for a child at this stage as they prepare for adulthood. Any plans being developed need to include how a child will be supported to make decisions about their life, the workers involved in supporting children must have a good understanding of the Mental Capacity

Act and how to apply it.

Other changes that may occur at age 16 include changes in a child's entitlements to welfare benefits. Information about benefit entitlement should be shared with the child and their parent(s)/carer(s) and signposting to where additional information can be found.
Where a child is looked after, please refer to the 'Managing (Disability) Benefits for LAC/Care Leavers' policy.

As part of the process a Transition Assessment to identify eligible needs for adult social care under the Care Act 2014, should be started before the child becomes 16yrs and 6mnths and should be completed by their 17th birthday.

Where the child is staying in education, the annual review of the EHCP will continue.

Year 12 (16/17)

The annual review for children who have left school for post-16 education is arranged by the education or training provider. The EHCP is reviewed providing further detail. All key stakeholders are requested to provide information regarding their involvement and are invited to attend the review.

Where the child has remained at school for tertiary education the Head Teacher is responsible for arranging the review.

This review is a critical stage in the transition process as the financial position of the child may change depending upon individual circumstances:

- The child may be eligible to claim Personal Independence Payment (PIP) in their own right;
- The child may be eligible to access Employment Support Allowance (ESA).

Given the potential complexity of these issues, the child should be supported to access the appropriate information to ensure they are in receipt of all benefits for which they are eligible. If a child lacks capacity to manage their finances, an appointee may need to be appointed to do this on the child's behalf.

The year 12 review will consider post 19 specialist provision where this has been identified as part of the person centred preparing for adulthood review. To ensure that appropriate further education options can be explored, it is important that the outcomes recorded for education are specific and measurable, reflecting what is important to the child and moving them closer to their aspirations.

Where the child moves onto further education or training, where possible the Connexions Personal Advisor should continue to support the child in their new learning environment for

continuity of support. Where this is not possible an alternative supporter should be identified, this could be a Social Worker, the leaving care Personal Adviser or an Advocate.

Where it is identified that a child may require support from adult social care to live independently when they become an adult, the local authority has a duty to carry out a transition assessment which identifies eligibility for support at 18 under the Care Act 2014. The transition assessment should identify the needs the child has in relation to living independently, including the support they will require to do so. If the child has an EHCP and or a Pathway Plan, planning for independent living should be a key focus and housing solutions explored in good time. Finding an appropriate housing solution and the right support will take time, so it is essential that planning takes place at an early stage and information and support continues to be provided to the child and their parent(s)/carer(s) as they approach 18.

Where a child is looked after, they should be supported to join the housing needs register within 3 months of their 16th birthday, or within 3 months of becoming looked after if this happens after their 16th birthday.

The Transition Management Group will be informed about children who will require support to live independently as they approach 18. Each case will be discussed at the group with decisions being made about the appropriate way forward, which teams will be involved and to ensure that the allocated worker has placed the child's name onto the commissioning intentions database (CID).

The adult accommodation forum meets regularly to discuss the cases on the CID, the forum then investigate housing solutions, working with commissioning and alongside the allocated worker from social care.

Where a child has significant health needs, an application for continuing healthcare (CHC) should be considered, a continuing healthcare checklist can be completed as part of the EHCP review process to check whether an application for CHC is appropriate. The child and their parent(s)/carer(s) should be involved in completing the checklist with the relevant professionals involved including the Social Worker, Transition Nurse, SENCO and those people who know the child best. More information about continuing healthcare and the CHC checklist can be found on the NHS choices website

Year 13 (17/18)

Where the child or young person remains within a school setting, review arrangements are as set out previously. Children's social care teams will begin the transfer process to adult social care, providing background information about the case and updates to the Transition Management Group. A transition assessment will have been completed with all children where it is assessed that children require care and support from adult social care post 18. This assessment will be shared with the Transition Management Group who will oversee the transfer process and ensure that the appropriate assessments and plans are in place.
Prior to a child becoming 18 the Transition Management Group will have identified the relevant

adult social care team who will undertake an Adult Needs Assessment (ANA), it is likely that information captured in the transition assessment will remain valid unless there has been a significant change to the child's care and support needs or their circumstances. Once the ANA has been completed, a person centred Care and Support Plan will be developed to identify the outcomes that the young person aims to achieve and how their social care needs will be met. If the young person has an EHCP and/or Care Plan or Pathway Plan, the Care and Support Plan will be heavily influenced by the comprehensive person centred framework and plans that have been in development for a considerable time. If a young person has an Education, Health and Care Plan, it is anticipated that this plan will become the young person's care and support plan as they reach 18.

Looked after children who are supported by the Children's Disability Team, will remain the responsibility of this team until they reach the age of 18, at which time the same process stated above will take place to ensure that the relevant adult social care team is identified. When the child reaches the age of 17yrs and 6mnths a Personal Adviser will work alongside the allocated social worker from the Children's Disability Team. Once the young person reaches 18, their Personal Adviser will work alongside the allocated Social Worker from the relevant adult social care team until the young person is aged 21 or 25 if they remain in education.

Looked after children who are supported by the Next Steps team under 'Planning Transition to Adulthood for Care Leavers 2010' (revised 2015) legislation, will remain the responsibility of the Next Steps team until the young person reaches the age of 21 and in some cases if the young person remains in education until 25. A representative from the Next Steps team is a member of the Transition Management Group to ensure good communication with adult social care teams and robust transition arrangements for children and young people who are leaving care.

As previously stated, any assessments and plans undertaken with the young person and their parent(s)/carer(s) should be completed as part of the EHCP process for those young people who have an Education, Health and Care Plan.

Where the young person is to receive support from adult social care, a referral to the Benefits Assessment Team is made by the allocated worker from adult social care to complete a full benefits check to make sure the young person is receiving the benefit's they are entitled to. A financial assessment is carried out to determine the level of financial contribution the young person may need to make to the services they receive as an adult.

Year 14 (18/19)

If a young person has an EHCP, the final school review takes place which updates the now very comprehensive plan. By this stage the plan should be well defined with significant detail about how the young person will move into adulthood with commissioning arrangements in place and health and social care needs fully addressed. Once authorised at the Resources Commissioning Panel, the EHCP will identify what further education provision the young person will access the following year if this is what has been planned. If a young person is in receipt of

support from adult social care, it is essential at this stage that the EHCP clearly identifies opportunities for education and social care to provide the best possible solutions including the use of a personal budget, to enable young people to work towards their aspirations.

For those young people who are supported via an SEN Support Plan, at this stage the plan should clearly identify what universal and targeted support is available to access within Sunderland's Local Offer, making sure that the young person has the same opportunities to reach their potential as their peers. Information should be provided to the young person and their parent(s)/carer(s) about how to access a social care assessment and support if it is required in the future.

Age 19 - 25

For those young people who have an EHCP and who are remaining in education or training, the EHCP retains its statutory status and is reviewed as a minimum every 12 months. The plan should continue to evidence that educational progress continues to be made towards long term aspirations and the outcomes set out in the plan. The review continues to be a multi-agency review and where adult social care is involved the allocated worker must continue to provide information and attend the EHCP review when invited. Once the young person leaves education the EHCP is no longer a statutory plan but where health or social care elements of the plan remain, the plan should continue as the young person's Care and Support Plan under Care Act 2014 legislation.

Connexions continue to provide advice and guidance up to age 25 and young people who were looked after and are care leavers, are entitled to ongoing support from the Next Steps team under the Planning Transition to Adulthood for Care Leavers framework 2010 (revised 2015) .

Section 4

Preparing for Adulthood Pathways –

The following transition pathways identify the roles and responsibilities for the teams and professionals involved the key tasks that need to be completed and the timescales.

There are three pathways –

- **SEN Support Pathway:** Children and young people who have an SEN support plan but not an EHCP.
- **EHCP Pathway:** Children and young people who have an Education, Health and Care Plan. This may include looked after children who also have a Pathway Plan.
- **LAC and Leaving Care Pathway:** Children and young people who are looked after and those who are leaving care. This may include children and young people who have an EHCP as well as a Pathway Plan.

SEN Support Pathway

Timescale	SENCO	Connexions	Transition Management Group	Other aspects to be considered
Age 14	Complete year 9 preparing for adulthood review. Alert the TMG re any cases where the child may require ongoing support from social care as an adult.	Engagement /contact Young person/family before the year 9 review Complete preparing for adulthood documentation (negotiation with school) Attend preparing for adulthood review	After receiving a referral, if appropriate record track and monitor using the TMG spread sheet. Provide information and guidance where appropriate.	The Local Offer should be used to support any transition planning from age 14.
Age 15	Complete annual school review.			
Age 16	Complete annual school review. Alert the TMG re any cases where the child may require ongoing support from social care as an adult.	Engagement with the child prior to their review. Attend the annual review	After receiving a referral, if appropriate record track and monitor using the TMG spread sheet. Provide information and guidance where appropriate.	The Mental Capacity Act 2005 applies from age 16. Identify whether the child is staying in full time education. Entitlements to welfare benefits change at age 16.

Timescale	SENCO	Connexions	Transition Management Group	Other aspects to be considered
Age 17	Complete annual school review. Alert the TMG re any cases where the child may require ongoing support from social care as an adult.	SEN Support students will either be in a college or Work Based Learning Work undertaken depends on individual needs and circumstances of the young person		
Age 18	If the child remains in education complete annual school review.			

EHCP Pathway

Timescale	SENCO	SW – Children's services – CDT, Locality teams	SW – Next Steps Team - Personal Adviser	Transition Management Group (TMG)	SW – Adult Social Care	Other aspects to be considered
Age 14	Complete year 9 preparing for adulthood EHCP review. Alert the TMG re any cases where the child may require ongoing support from social care as an adult.	Attend EHCP preparing for adulthood review if child is in receipt of support. Review care plan as part of EHCP review where possible. Alert the TMG re any cases where the child may require ongoing support from social care as an adult.		After receiving a referral, record track and monitor using the TMG spread sheet.		Key worker role to be designated if not assigned already. Decisions need to be made about who will support the child and their parents/carers to prepare for the EHCP review. The Local Offer should be used to support any transition planning from age 14.

Timescale	SENCO	SW – Children's services	SW – Next Steps Team - Personal Adviser	Transition Management Group (TMG)	SW – Adult Social Care	Other aspects to be considered
Age 15	Complete EHCP review – invite all key stakeholders	Attend EHCP review if child is receiving support.				If a young person is looked after, a Pathway Plan will need to be developed alongside the EHCP (see LAC Pathway)
Age 16	Complete EHCP review – invite all key stakeholders Contribute to Transition assessment and Pathway Plan if appropriate	Attend EHCP review if child is in receipt of support. Complete Transition Assessment to determine eligibility for adult social care and support post 18. Alert the TMG if not already done.	Attend EHCP review if child is in receipt of support. Complete Transition Assessment to determine eligibility for adult social care. Alert the TMG if the child will require ongoing support from adult social care.	Track and monitor cases. Identify the appropriate adult team to allocate a worker if appropriate at this stage.	Depending on complexity of the case allocate a worker from the appropriate team and attend EHCP review if child is to receive support at 18.	The Mental Capacity Act 2005 applies from age 16. Identify whether the child is staying in full time education. Entitlements to welfare benefits change at age 16. Any housing needs post 18 should be identified.

Timescale	SENCO	SW – Children's services	SW – Next Steps Team - Personal Adviser	Transition Management Group (TMG)	SW – Adult Social Care	Other aspects to be considered
Age 17	If the child remains in education, complete EHCP review inviting all key stakeholders.	Attend EHCP review if child is receiving support.	Attend EHCP review if child is receiving support.	Identify the appropriate adult team to allocate a worker.	Allocate a worker from the appropriate adult team. Attend EHCP review if child is in receipt of support. Complete Adult Needs Assessment including indicative budget. Develop Care and Support Plan alongside EHCP.	EHCP should identify whether the child is eligible to receive support from adult social care. The well-developed EHCP should influence the care and Support Plan.
Age 18	If the child remains in education, complete EHCP review inviting all key stakeholders.		Attend EHCP review if child is receiving support.		Put Care and Support in place as set out within care and support plan and EHCP. Attend EHCP review if child is receiving support.	

LAC and Leaving Care Pathway

Timescale	SENCO or Designated Teacher	Independent Reviewing Officer (IRO)	SW – Children's Disability Team	SW – Next Steps Team (Personal Adviser from 18)	Transition Management Group	SW – Adult Social Care	Other aspects to be considered
Age 14	Complete year 9 preparing for adulthood EHCP review.	Ensure the Preparing for Adulthood review takes place for those young people who have EHCP Ensure that Transition Assessment has commenced where required	Attend EHCP preparing for adulthood review. Review care plan as part of EHCP review where possible. Alert the TMG re any cases where the child may require ongoing support from social care as an adult.		After receiving a referral, record track and monitor using the TMG spread sheet.		Virtual School responsibilities to be considered PEP will need to be completed alongside EHCP.

Timescale	SENCO or Designated Teacher	Independent Reviewing Officer (IRO)	SW – Children's Disability Team	SW – Next Steps Team (Personal Adviser from 18)	Transition Management Group	SW – Adult Social Care	Other aspects to be considered
Age 15	Complete EHCP review – invite all key stakeholders	Ensure Leaving Care assessment commenced where required Ensure that National Insurance number has been applied for where required Ensure welfare benefit enquiry (ESA) has been made and all relevant applications made where appropriate Ensure professional	Support a young person to apply for a National Insurance number and other welfare benefits they may be entitled to when they reach the age of 16. Alert the TMG re any cases where the child may require ongoing support from social care as an adult if not already done.				

		viability meeting has taken place re staying put/ shared lives					
Timescale	**SENCO or Designated Teacher**	**Independent Reviewing Officer (IRO)**	**SW – Children's Disability Team**	**SW – Next Steps Team (Personal Adviser from 18)**	**Transition Management Group**	**SW – Adult Social Care**	**Other aspects to be considered**
Age 16	Complete EHCP review – invite all key stakeholders Contribute to Leaving Care Assessment, Transition Assessment and Pathway Plan if appropriate.	Ensure capacity has been considered Review Pathway Plan every six months Ensure Education bursary is in place Ensure housing needs have been considered and relevant	Complete a Mental Capacity Assessment (decision specific) If the young person lacks capacity, convene a 'Best Interests' meeting (consider Deprivation of Liberty Safeguarding) Complete a Leaving Care Assessment	Complete a Mental Capacity Assessment (decision specific) If the young person lacks capacity, convene a 'Best Interests' meeting (consider Deprivation of Liberty Safeguarding) Complete a Leaving Care Assessment	Track and monitor cases. Identify the appropriate adult team to allocate a worker if appropriate at this stage.	Contribute to Leaving Care Assessment, Transition Assessment and Pathway Plan if appropriate. Attend planning meetings if appropriate.	The Mental Capacity Act 2005 applies from age 16. Identify whether the child is staying in full time education. Entitlements to welfare benefits change at age 16. Consideration should be given to 'Staying Put' and 'Shared Lives' policy

		applications made	Complete Transition Assessment Complete Pathway Plan by 16yrs 3 mnths alongside the EHCP.	Complete Transition Assessment Complete Pathway Plan by 16yrs 3 mnths alongside the EHCP.			
Timescale	**SENCO or Designated Teacher**	**Independent Reviewing Officer (IRO)**	**SW – Children's Disability Team**	**SW – Next Steps Team (Personal Adviser from 18)**	**Transition Management Group**	**SW – Adult Social Care**	**Other aspects to be considered**
Age 17	If the child remains in education, complete EHCP review inviting all key stakeholders.	Ensure Next Steps Personal Adviser is introduced Where appropriate ensure that Adult Social Worker is introduced to complete Adult Needs Assessment	Review Pathway Plan alongside EHCP. Continue the review process every 6 months. Introduce Personal Adviser at 17 yrs 6 mnths.	Review Pathway Plan alongside EHCP. Continue the review process every 6 months. Introduce Personal Adviser at 17 yrs 6 mnths.	Identify the appropriate adult team to allocate a worker.	Attend planning meetings if appropriate. Allocate a worker from the appropriate adult team. Attend EHCP review if child is in receipt of support. Complete Adult Needs Assessment	If a child is placed out of area particular consideration should be given to 'Staying Put' and 'Shared Lives' policy to ensure that accommodation and support arrangements post 18 can be planned for.

						including indicative budget. Develop Care and Support Plan alongside EHCP.	
Timescale	**SENCO or Designated Teacher**	**Independent Reviewing Officer (IRO)**	**SW – Children's Disability Team**	**SW – Next Steps Team (Personal Adviser from 18)**	**Transition Management Group**	**SW – Adult Social Care**	**Other aspects to be considered**
Age 18	If the child remains in education, complete EHCP review inviting all key stakeholders.	Chair final looked after review Review the first Pathway Plan following 18th birthday		The Personal Adviser ensures that all leaving care duties are discharged up to the age of 21 or 25, if in further education. Review Pathway Plan every 6 months Take part in review of EHCP every 12 months		Put Care and Support Plan into practice alongside EHCP. Attend EHCP review if child is receiving support.	

Appendices

Appendix 1 - Legal Framework

The Children Act 1989 remains the general legal framework for young people in and leaving care. Subsequent legislation sought to amend and supplement its provision.

The Children (Leaving Care) Act 2000 and the associated Regulations and Guidance was designed to improve the life chances of young people leaving care and details important entitlements in both support and finance. (This has now been superseded by volume 3 of the Children Act 1989 (see below).

The Children Act 1989 Guidance and Regulations, Volume 3: Planning Transition to Adulthood for Care Leavers (January 2015) includes The Care Leavers (England) Regulations 2010 and stands as the most current guidance. It was implemented in April 2011 and is addressed to local authorities and their staff, lead members and Commissioners of services to ensure care leavers are given the same level of care and support that their peers would expect from a reasonable parent and that they are provided with the opportunities and chances needed to help them move successfully to adulthood.

The Children and Young Person Act 2008 provides a particular focus on young people in care and those making the transition from care to adulthood.
The Children Act 1989 Guidance and Regulations, Volume 2: Care Planning, Placement and Case Review, Regulations and Guidance 2015) the framework for the provision of services to children looked after and for the development of leaving care assessments, pathway plans and preparation for adulthood.

The Children and Families Act 2014 seeks to improve services for vulnerable children and support strong families. It underpins wider reforms to ensure that all children and young people can succeed, no matter what their background and sets out the requirement for each local authority to have a Staying Put policy.
The Staying Put requirements apply to children placed in foster care is aimed at ensuring that care leavers experience a transition from care to independence and adulthood in a similar manner to that which most young people experience, and is based on need and not on age alone. The Act also introduces the biggest reforms to support for children and young people with special educational needs and disabilities for 30 years. The reforms include an Education, Health and Care Plan (EHCP) that replaces the Statement of special educational needs, Personal budgets for children, a requirement for joint commissioning across education, health and social care and a requirement for each local authority to publish a local offer.

The Care Act 2014 sets out the framework for the provision of services to ‘vulnerable adults’ and sets out a framework that defines each adults ‘Ordinary Resident’.

The Mental Capacity Act 2005 generally only applies to people aged 16 or over and provides a statutory framework to empower and protect people who may lack capacity to make some decisions for themselves, for example, people with dementia, learning

disabilities, mental health problems, stroke or head injuries, who may lack capacity to make certain decisions.

Sunderland's Local Offer provides information about the services and support available for disabled young people in Sunderland in a central accessible place.

There has also been **significant case law** that the Local Authority has to be mindful of in undertaking their statutory duties and obligations to CIC and Care Leavers (and those who are 'vulnerable' adults and also become adult service users).

G v Southwark (2009)
Considers how local authorities respond and support homeless 16 and 17-year old young people.

J v London Borough of Sutton (2007)
J challenged the Borough of Sutton to provide her with leaving care services as a 'relevant child' under the Children (Leaving Care) Act 2000.

J v Caerphilly County Borough Council (2004)
J challenged in relation to the local authority's responsibility when assessing care leavers and drawing up Pathway Plans.

P v Cheshire West and Chester Council (2014)
Considered the circumstances where a person is deprived of his liberty by virtue of the complete and effective control exercised over his life by those looking after him.
The judgement identified that to determine whether a person (without the mental capacity to consent to the arrangements) is being deprived of their liberty, the following 'acid test' should be applied:

Is the person subject to continuous supervision and control?

All of these factors are necessary. You should seek legal advice if intensive levels of support are being provided to any person as part of a package of care or treatment.

Is the person free to leave?

The focus is not on the person's ability to express a desire to leave, but on what those with control over their care arrangements would do if they sought to leave.

Appendix 2 - Roles & Responsibilities

Schools

Most disabled young people receive their education in one of the authority's 17 mainstream secondary schools. There are also 4 secondary special schools in Sunderland that can accommodate disabled children and young people.

Schools carry the responsibility to co-ordinate the formal transition process and are well placed to bring together other key agencies and work with young people to ensure their views are at the heart of the process.

The Head Teacher has responsibility for implementing the transition process including liaison with the Health, Social Care, SEN team and Connexions.

Special Educational Needs Co-ordinator (SENCO)

Every school has an appointed SENCO who is a teacher with additional responsibility to record and update information with regard to the young person's special educational needs, whether or not they have a statement of SEN. They liaise with parents and relevant professionals in other agencies, arrange educational facilities and resources and advise the teaching team ensuring that individual educational plans are in place. They monitor the young person's progress in educational settings, arranging formal reviews as required and provide information about a young person's educational needs to key staff in further education meetings.

Connexions

Connexions Personal Advisors work with children and young people with SEN aged 13 to 16 who have SEN in mainstream schools and those aged 13-19 in special schools. They can also work with young people who have SEN up to the age of 25.

Arrangements for the work of Personal Advisors differ in every school, but contact generally starts with the child in Year 9 including the content of preparing for adulthood reviews for those children with EHC plans. The role of the Personal Advisers thereafter is to meet with the child or young person regularly to find out their views and aspirations about the future, and planning the transition into post 16 options.

The Personal Advisors work in partnership with the child or young person and their family, the school and other key agencies involved and help the child/ young person to explore their options. This can include applications and visits to colleges or work based learning providers, and may involve support to keep the child or young person engaged in education, college, or work based learning.

This support could continue up to the age of 25 but for those towards the upper end of the age range, this may often involve referral on their behalf with organisations that have been identified as offering specialist help such as Disability Employment Advisers.

Connexions Personal Advisor – provides information, advice and guidance for children and young people who have a disability aged from 13 to 25 years. They attend and contribute to the annual review and transition planning meetings in schools from Year 9 (age 14). They offer young people and their parents advice about post-school and post- education options and liaising with others who have agreed to carry out actions, but are not responsible for arranging the specific provisions of other agencies.
The Connexions PA provides the young person and their family with information about the transition years, key contacts, support that is available and what good transition looks like.

Special Educational Needs (SEN) Team

The SEN team is a small unit of SEN Officers that are responsible for the assessments and placement reviews of children with special educational needs.

The Team collates information/documentation from parents and professional staff in education, social care and health on pupils whose special educational needs are being formally assessed by the local authority. They consider that advice against agreed guidance, and if appropriate issue an Education, Health and Care plan.

The Team is responsible for ensuring that the support specified in an Education, Health and Care plan is provided in school and for arranging alternative specialist placements. Eligibility for support with home to school transport is determined using the eligibility criteria set out in the Home to School Transport policy.

The Team works with schools to annually review Education, Health and Care plans.

Sunderland Virtual School

The Virtual School has a truly cross agency approach, liaising with CYPS, YOS, Next Steps, Connexions, schools and providers. The Virtual School monitor the educational progress of those young people in full time education who are 16-18 years old and support transitions from Year 11 to post 16 provisions in consultation with other agencies.

Other aspects of the team include:

- Supporting the transition from Statement to EHCP, and the application for EHCPs, in all school years, including Year 11 and post 16.

- Holding regular planned meetings with Connexions, Next Steps and learning providers to ensure learning and emotional needs are known and catered for.
- The team acts as a central partner in ensuring education pathways for children and young people.
- The team represents the LAC /leaving care young person at PEP and disciplinary meetings.
- The team monitors the 16-18 year olds who are not in education, employment or training, finding provisions that deliver courses they are interested in.
- The team support and monitor retention, engagement and attainment in education and training through many ways, including meetings and individual support.
- The team ensure the young person has a say in their future, and that their views are listened to and acted on, including as they transfer to adulthood
- The team raises awareness of Bursaries and financial support amongst providers and carers.
- The team has a role in referring safeguarding issues and ensuring that social care is aware.
- The Virtual School Head sits on the External Placements Panel to ensure educational needs are still met when a child moves out of the area.
- The team source advice and guidance on providers through links with Virtual Schools in other Local Authorities.

Independent Review Officer (IRO)

Disabled children and young people who are in receipt of more than 75 overnight stays (Regulation 48, Short Break Care Planning), or who are in the care of the local authority either accommodated S20 or via a Court Order have an allocated IRO whose role is to oversee the Care Plan within the looked after review process and reflect the child/young person voice.

The IRO will chair looked after review meetings within 3 month of the first episode of care, for children and young people involved in short break stays, then subsequently on a 6 monthly basis, unless there is a need to bring a meeting forward. For children and young people who are accommodated via S20 or a Court Order an initial looked after review will be held within 20 working days , then within 3 month and subsequently 6 monthly, unless there is a need to bring a meeting forward.

In all cases open to an IRO, the IRO will make a recommendation for a Transition Assessment when the child reaches the age of 14 years and will monitor the progression of the recommendation. The IRO will oversee the local authority Care Plan, Personal Education Plan, Health Plan.

When the young person reaches the age of 15 years the IRO will make a recommendation re the need for a Leaving Care Assessment which will go on to inform the Pathway Plan, this will then be reviewed by the IRO.

The IRO will remain involved with all children and young people accommodated by the LA until they reach their 18th birthday.

Children's Social Care – Children's Disability Team

The Children's Disability Team work with children from birth up to the age of 18 where the child has one or more of the following:

- a substantial physical disability
- a severe communication disability (including autistic spectrum disorder)
- a severe learning disability

The Children's Disability Team provides a range of opportunities and provisions for disabled children and their families.

The Children's Disability Team provides the care management and assessment function for disabled children in the transition years up to the age of 18.

Social Worker – Social Workers cover a range of roles including child protection and acting as a parent for children in looked after in care, in addition to enabling families to access a range of support services. Where appropriate, they will attend the annual transition planning meetings (from age 14) in school and organise provision to meet the care needs of the child and their family. The Social Workers based within the Children's Disability Team are responsible for providing information from the child's Care Plan, Leaving Care Assessment and Pathway Plan (if they have one) to the Transition Management Group and liaising with Social Workers in Adult Services so that a smooth transfer takes place at age 18.

Advocate – disabled children may have access to an advocate to act on their behalf. Where this need is identified it is arranged by the Social Worker within Services for Disabled Children or Adult Social Care if the young person is over 18.

Children's Social Care – Locality Teams

Social Worker – Social Workers cover a range of roles including child protection, in addition to enabling families to access a range of support services. Where appropriate, they will attend the annual transition planning meetings (from age 14) in school and organise provision to meet the care needs of the child and their family. The Social Workers based within the Locality Teams are responsible for providing information from the child's Care Plan, Leaving Care Assessment and Pathway Plan (if they have one) to the Transition Management Group and liaising with Social Workers in Adult Services so that a smooth transfer takes place at age 18.

Where a child is deemed a child in Need the responsibility for their care and support is transferred to the appropriate adult team on their 18th birthday.

Leaving Care Personal Adviser – Next Steps Team

All eligible, relevant and former relevant young people eligible for leaving care services will be appointed a Personal Adviser ("PA") who will fulfil a key role in providing the right support to them as they make the transition to adulthood.

The young person's allocated social worker (from 16 – 18) can undertake the role of the child's PA up until the young person attains 18 years of age. From 18 years of age a PA will be allocated to the young person within the Next Steps team. The transfer of support from the social worker to the PA will take place in a planned and managed way.

A PA will be allocated up until the age of 21 (or 24 in further education).

A PA has the following functions in relation to the relevant child or former relevant child for whom they are appointed:

- to provide advice (including practical advice) and support, where applicable, to participate in the assessment and the preparation of the pathway plan;
- to participate in reviews of the pathway plan;
- to liaise with the responsible authority in the implementation of the pathway plan;
- to co-ordinate the provision of services, and to take reasonable steps;
- to ensure that the child makes use of such services and that they are
- appropriate to the child's needs;
- to remain informed about the relevant child's or former relevant child's progress and wellbeing;
- to keep a written record of contacts with, and of services provided to, the relevant or former relevant child.

In addition, where accommodation is provided to a relevant child or former relevant child by the responsible authority under section 23B or section 24B, the PA must visit the relevant child or former relevant child at that accommodation every two months.

The functions of the PA for an eligible child are:

- provide the young person with advice and support (this will include direct practical help to prepare them for the time when they move or cease to be looked after and also emotional support);

- liaise with the responsible authority about the provision of services (this function may be carried out by the personal adviser working as a member of a social work or a specialist leaving care team; it will also involve liaising and negotiating with the full range of services that make up the local authority's services, e.g. education and housing services);

- co-ordinate the provision of services, ensuring that these are responsive to the young person's needs and that s/he is able to access and make constructive use of them;

- remain informed about the young person's progress and keep in touch with him/her – visiting at no less than the statutory intervals; and maintain a record of their involvement with the young person, monitoring the effectiveness of services in preparing the young person for a time when s/he will move to greater independence or when s/he ceases to be looked after.

The role of the PA is to ensure that transition planning for disabled young people leaving care is timely, efficient and involves all relevant professionals.

Missing Sexually Exploited and Trafficked Intelligence Group – (MSET)

The MSET Intelligence Group is a multi-agency operational group working under the arrangements of the Sunderland Safeguarding Children Board and alongside the wider partnerships across Sunderland. The group reports directly to the MSET Sub Committee which in turn reports to the Safeguarding Board itself.

The purpose of the group is to -

- Consider individual children and adults who are open to the Next Steps Team, who are at significant risk from going missing, being sexually exploited and/or trafficked.
- Share information in order to inform risk assessment and consider actions in support of the Care Plan
- Identify linked cases, emerging trends/hotspots and offenders
- Identify areas of good practice and training needs
- Report to the MSET Sub Committee

The MSET group meets monthly to discuss new cases and review any existing cases.

Transition Management Group – (TMG)

Sunderland's Transition Management Group is a multi-agency group that meets monthly to discuss cases where young people are approaching adulthood and likely to require on-going support into their adult lives. Adult Social Care, Health and Education are represented at the group. The group tracks cases as young people move towards

the age of 18 ensuring that the appropriate adult teams are aware of the young person and understand their needs and aspirations. Each case is discussed to identify the progress made in developing plans, ensuring assessments have been completed and that appropriate teams are involved.

The TMG also aims to provide information, advice and guidance to the teams and workers involved with the young person as they approach 18 to support good transition planning.

Where Social Care are involved, or if it is identified at the Education, Health and Care plan (EHC plan) review stage that a child may require support from adult social care in the future, the TMG will be informed that preparing for adulthood planning has begun, be provided with early information and where there are potential health and social care complex commissioning issues to be addressed.

The Transition Management Group is also informed about children who will require support to live independently as they approach 18. Each case is discussed at the group with decisions being made about the appropriate way forward, which teams will be involved and to ensure that the allocated worker has placed the child's name onto the commissioning intentions database (CID).

Adult Social Care - Learning Disability Team

The two Learning Disability Care Management & Assessment Teams in the city are split geographically, one covering the east of the city and the other covering the west. The teams support adults who have a learning disability and include Social Workers and Assessment and Reviewing Officers.

The primary functions of the team are those set out under the framework of the Care Act 2014. These involve the main functions of assessment of need; care and support planning; implementation of care and support plans; reviewing and monitoring of adults with a learning disability age range 18 onwards, with full participation of their carers as appropriate.

A number of questions will be asked by the worker involved and information collected to help establish if the young person is eligible to receive support as an adult.

Following an adult needs assessment, if the person is eligible to receive support, a worker from the Learning Disabilities Team will meet with the person and their carers/family. This could happen just once or a number of times. Information is collected and written down. Any information given during an assessment will be held in confidence; this means permission will be asked before the information is discussed with anyone.

Adult Social Care - Mental Health Team

The Local Authority Mental Health Team works across a diverse range of mental disorders and situations providing a range of interventions in accordance with very differing legal requirements. Typically the person who is being referred has a diagnosis: for example, schizophrenia, psychosis, bi-polar disorder, manic depression, depression, anxiety, obsessional compulsive disorder, korsakovs, personality disorder, aspergers (as well as younger people with a dementia and people who have a 'complex' dementia). People with any of these diagnoses would be dealt with by the Mental Health Service.

Where the person is described as suffering from a dementia, has a learning disability, brain injury, huntingtons etc., the person would need to be redirected to the service area responsible i.e. Adult Social Care Locality Team or Learning Disabilities. For people with drug and alcohol issues the local authority has transferred responsibility to the specialist services commissioned from Northumberland Tyne & Wear Mental Health Trust.

The Local Authority Mental Health Service is comprised of two teams (two Team Managers, Two Senior Practitioners, Ten Full Time Social Work staff, Four Part Time and Four Assessment and Review Officers working across the two teams). Work is currently divided among the teams on a predominantly geographic basis. While the majority of work relates to people who are currently resident in Sunderland a number of people require substantial interventions and are not currently in the Sunderland area being placed in various forensic and private hospital facilities across the North of England and as far South as Rampton Hospital.

Most staff time is spent seeing service users and their carers to undertake assessments, potentially advising and/or arranging services to meet identified need, review any existing care being provided. This work may range from arranging home care packages aimed at supporting the person to live in the community to assessments which result in admission to residential care. An increasingly significant component of any assessment or involvement is the Mental Capacity Act which can require the involvement of the Court of Protection and those assessments and roles are frequently time consuming and procedurally complex. As well as the more general responsibilities covered by the Care Act, staff also undertake the following specific duties and responsibilities:

i). Social Workers who are also employed as Approved Mental Health Professionals (AMHPs) undertake duty responsibilities in order to meet the local authority statutory responsibilities under the Mental Health Act. As AMHPs, staff work generically across all ages and service areas. Full time AMHPs are on the MHA Duty rota an average of ten days every thirteen weeks. If asked to undertake a MHA assessment this is frequently a full day's work and often longer. Some of the work is on a more planned basis such as referrals for an AMHP to undertake an assessment for a Community Treatment Order and this is covered by an additional separate rota.

ii). Office Duty is undertaken by all staff and is predominantly involved with

responding to telephone calls in relation to existing service users when the allocated worker is not available or other situations that arise.

iii). NTW and Initial Response Team Duty involves staff from the Mental Health Team working into the IRT meeting first thing every morning and thereafter attending various wards across the hospital. A number of staff are based in the South Community Treatment Team based at Doxford Park. This role is intended to pick up any referrals on service users who may have social care needs and to advise NTW staff regarding potential options.

iv). A number of staff are qualified as Best Interest Assessors and have responsibilities under the MCA Deprivation of Liberty Safeguards.

Adult Social Care - Locality Teams

The statutory responsibilities, as defined in the Care Act 2014, for people over the age of 18 with physical disabilities and those over the age of 65 years are provided by five locality based teams. These are based in the North, East, West, Washington and Coalfield's localities respectively. The teams are integrated with health practitioners and co-located.

Each team is made up of a combination of Assessment & Review Officers (ARO's) and qualified Social Workers (SW's). The appropriate locality team will be identified by home address and staff allocated following a triage of presenting issues or alternatively sign-posted to other sources of support more suited to their needs.

Staff will complete an Adult Needs Assessment to determine 'eligibility' for support using the criteria set out in the Care Act 2014 and its respective guidance. The assessment will take place in person and may involve repeated visits and communication dependent upon the complexity of the case. Information gathered will be retained and shared with other agencies, subject to the consent of the relevant person(s), in order to identify the best tailored solutions to the presenting needs. The allocated worker will facilitate the identification of resources most suitable to meet the identified needs and seek the agreement and input of the service user, carers or other relevant parties in finalising an agreed Support Plan. Support is then put in place and reviewed annually as a minimum.

In situations where eligibility has not been established staff will offer advice and guidance to the referrer to access independent support, where appropriate.

Occupational Therapy

The Occupational Therapy and Wheelchair Service is based within Health, Housing and Adult Services and provides a service to both children and adults. The service will take referrals to undertake an assessment to promote independence and assist with practical management of disability issues.

Occupational therapists may recommend the provision of specialist equipment for the young person, or alternatively they may be supported to access grant funding in order to make structural alterations to the family home or the young person's own home. The Occupational Therapy Service will work with the Home Improvement Agency and Community Equipment Services in order to do this.

Wheelchair assessors may recommend the provision of equipment that enables mobility while also making sure that the young person's postural needs are cared for. Wheelchair assessors will work with a range of service providers, including Community Equipment Services and the Regional Rehabilitation Engineering Mobility Service in order to do this.

Benefits and Assessment Team

The Benefits and Assessment Team are responsible for providing benefits advice to Sunderland City Council customers. Its service is provided free of charge and it can give general advice on benefit and charging matters over the telephone and specific advice to customers in relation to their ongoing claims or financial assessments. The team arranges home visits to all new customers receiving potentially chargeable services e.g. adult social care.

Sunderland Clinical Commissioning Group (CCG)

NHS Sunderland Clinical Commissioning Group (CCG) is the statutory health body responsible for the planning and buying of local NHS care and services to meet the needs of the local community.

It is made up from a partnership of 51 GP practices, split into five localities, Coalfield, Sunderland North, Sunderland East, Sunderland West and Washington, and together we are responsible for a local population of approx. 281,500.

Working as a clinical commissioning group (CCG) we deliver high quality care, using the most appropriate methods and cost effective resources, to improve healthcare provision for the people of Sunderland and reduce disparities in health and social care. By using effective clinical decision-making we can make a real impact on the health, wellbeing and life expectancy of our patients.

What are clinical commissioning groups? -

Clinical commissioning groups (CCG) are made up of doctors, nurses and other health professionals, supported by experienced health service managers. Local GP practices work alongside specialist healthcare professionals, combining expertise and experience to improve healthcare services and benefit the people of Sunderland.

General Practitioner (GP) – this is the family doctor providing continuing medical care/psychological support for the young person and their family in the community. The

GP provides diagnosis and day to day care for urgent and ongoing medical needs, refers to specialist health and other services as required and maintains the medical link with the young person and their family throughout the transition process. From the age of 18, every adult is entitled to an annual health check with their GP; this can link with secondary healthcare providers as appropriate.

Northumberland, Tyne & Wear NHS Foundation Trust

Service users with mental ill health and/or learning disabilities often require services that no one discipline or agency can meet in isolation. It is therefore important that a system of effective care co-ordination is in place across services and that this system fully supports the effective and appropriate transition of the person between services.

Patients will be transferred between services on the basis of need and not solely on the grounds of having a specific diagnosis or having attained a certain age.

Decisions about transitions of care from one service area to another must therefore:

- Respond to individual clinical need, rather than rigid age or clinical criteria
- Incorporate and respect service user and carer views and wishes
- Arise from clinical needs identified through assessment undertaken within the framework of Care Co- ordination/Single Assessment
- Be supported by the development of a clear care plan and where appropriate, risk management plan

Community learning disability nurse – assess, plan, implement and evaluate nursing care. They do this in collaboration with the young person and their family and with other members of the multi-disciplinary team. They have a role in promoting health, assisting people to achieve optimum health.

The Learning Disabilities Community Treatment Team provides a range of specialist therapeutic interventions to people with a learning disability and support to mainstream health services to ensure they are accessible to people with a learning disability.

Ensuring that people who require learning disability specialist services and experience mental health and/or challenging behavior have their overall health needs maintained in the community.

The service is provided by a multi-disciplinary approach including Nursing, Psychiatry, Psychology, Physiotherapy, Occupational Therapy and (SALT) Speech and Language Therapy.

The Nursing and Multi-disciplinary teams are based at Monkwearmouth Hospital.

Allied Health Professionals (include clinical psychologist, occupational therapist, physiotherapist and speech & language therapist) – all of these professionals are usually based in health teams, work with the young person and their family throughout the transition years and often work with school staff to support the young person maximise their emotional and physical health and communication skills. They also provide support in the provision of orthotic appliances.

City Hospitals Sunderland NHS Foundation Trust

The vision for City Hospitals Sunderland NHS Foundation Trust has 4 key strands.

- Adopting a 'streams of care' approach to service models and service delivery
- The acute service provider of choice for Sunderland and North Easington communities
- Offering the clear alternative acute provider of choice for other local communities
- Focusing on strong patient/user/carer involvement in modernising care pathways and improving patient journeys.

Paediatric Community Nurses - City Hospitals NHS Trust provides a range of specialists and children's community nursing. The teams are based at the Niall Quinn Centre within the Children's Outpatient Department at Sunderland Royal Hospital. The team of children's nurses provides a generic service with additional specialisms in endocrinology, cystic fibrosis, respiratory and allergy, children with complex needs, epilepsy, gastro-enterology, diabetes.

Children are referred to the service if they have a nursing need that requires some intervention at home following admission to hospital, or if they have a long term nursing need. Many of the specialist nurses run nurse led clinics.

Children are referred to the services via referrals from paediatricians, GPs, and ward staff. The services are available during office hours although this can be more flexible depending upon the needs of the child.

There is also a Paediatric disability team which is led by Paediatric disability Consultants. They run 'transition handover clinics' within Portland Academy, where the care of the young person is handed over to a Consultant in neurorehabilitation within Adult Services provided by the Trust. Transition nurse specialists are included

wherever possible in all of the paediatric disability clinics at Portland, which gives them the opportunity to get to know families and proactively support transition planning from an early stage.
In 2008 the Trust, in partnership with Northumberland Tyne & Wear and commissioned by South of Tyne & Wear NHS Trust developed the role of a Learning Disability Acute Liaison Nurse. This role has had a major positive impact upon how services are delivered to people with learning disabilities when using City Hospital's services.

In 2009 the Trust, in partnership with Northumberland Tyne & Wear and commissioned by South of Tyne & Wear NHS Trust developed the role of Learning Disability Transitions Nurse Specialist.

Paediatrician – this Doctor specialises in the medical needs of children and young people and is usually based in hospital (Sunderland Royal Hospital). The Paediatrician provides diagnosis and medical care for young people with medical conditions, illnesses or disabilities, advises the young person and their family about the implications of the medical conditions and how to manage their own needs including health promotion. They also support the family in managing the young person's medical needs.

Specialist Doctors - are involved in different aspects of management including assessment and diagnosis, symptom management control of disease progression and prevention of complications. Young people with neuro-disabilities or complex needs may require support from neurologists with expertise in rarer neurological conditions, rehabilitative medicine specialists and palliative care physicians.

Learning Disability Transition Nurse

- The main purpose of the role is to:

- Co-ordinate health transition planning for young people with learning disabilities in Sunderland.

- Ensure the process of health transition planning is person centred and any health inequalities are acted upon to ensure equality of access to all health services.

- Correlate information from individual health transition plans to inform adult healthcare provision of potential service gaps.

- Contribute to the development of a comprehensive range of healthcare provision that meets the needs of all young people with a learning disability.

The LD Transition Nurse has responsibility for working with young people with a

learning disability and additional complex health care needs and their families to create person centred health care plans, provide advice, guidance and supervision to other healthcare practitioners in relation to good health transition planning, contribute to all aspects of multi-disciplinary practice and clinical intervention and contribute to continuing healthcare assessment process in order to determine eligibility criteria. The LD Transition Nurse is not responsible for meeting the day to day health needs of the young person, this responsibility remains with the relevant health care professionals.

Appendix 3 - Glossary of Terms

Advocacy	A process in which an independent person (an advocate) helps another person to express their views and wishes. Advocacy for children and young people has been defined as 'speaking up' for them. It aims to empower them and make sure that their views are heard and their rights are respected for example, when planning care.
Adult Needs Assessment (ANA)	An assessment to determine eligible social care needs for adults under Care Act 2014 legislation. The ANA will determine an indicative personal budget.
Adult Accommodation Forum	The forum is a multi-agency group that meets to discuss housing and support requirements for young people and adults who require some support from adult social care to live independently. The forum also discusses the housing and support needs of children who have a learning and or physical disability or autism as they prepare to move into adulthood.
Care Plan	A document that sets out the actions to be taken to meet the child's needs and records the person responsible for taking each identified action. The local authority is responsible for ensuring that it is regularly reviewed and that the identified actions happen.
Care and Support Plan	The plan that sets out how an adult with eligible social care needs will use their personal budget to access care and support to meet their assessed needs and what this will cost.
Corporate parents	A term used to describe the responsibility of any local authority as 'corporate parents' to all the children and young people who are in the care of that local authority (children and young people who are 'looked after' or 'in care'). A 'corporate parent' has a legal responsibility to ensure that the needs of children and young people in their care are prioritised in the same way as any concerned parent would want for their own children. The term covers all the members of the local council and any services provided by the local council.
Commissioning Intentions Database (CID)	A database that holds information about housing and support requirements for young people and adults. This includes information about what services and support may need to be commissioned by the local authority in the future.
Education, Health and Care Plan (EHCP)	EHC plans set out how services will work together to meet the child or young person's needs. EHC plans are based on a co-ordinated assessment and planning process which puts the child and young person and their parents at the centre of decision making. An EHC plan replaces a Statement of special educational need and could replace some other plans.
Health Assessment and Health Plan	An assessment to identify a child's needs in relation to their physical and mental health. A health assessment should be carried out with all children who are looked after so that a health plan can be developed to reflect the child's health needs and be

	included as part of the child's overall Care Plan.
Independent reviewing officer (IRO)	The person who makes sure that the health and welfare of looked-after children and young people are prioritised, that they have completed and accurate care plans in place (which are regularly reviewed and updated), that any physical, emotional health or wellbeing needs or assessments identified by their care plans are met or completed, and that their views and wishes, and those of their families, are heard.
Leaving care services	Services to prepare and support children/young people when they are planning to leave care and live independently.
Multi-agency	A description for services that involve more than one agency (for example NHS and social work). Children's Services carry responsibility for the care plan of a looked-after child or young person, but different agencies and professionals contribute to it, for example, the school, the GP, the looked-after children's nurse, and adult services for the parent or for the young person as they approach adulthood. A range of professionals also have a role in assessing a child's general wellbeing and development.
Out-of-area placements	A term used to describe when a child or young person moves to a new home outside the geographical boundaries of the local authority legally responsible for them and they use the services – for example, for education, health, leisure or housing – of the local authority responsible for area they have moved into.
Personal Education Plan (PEP)	A personal education plan (PEP) is a school based meeting to plan for the education of a child who is looked after. The government has made PEPs a statutory requirement for children in care to help track and promote their achievements.
Pathway Plan	The plan that sets out the activities and support for any looked-after young person planning to move to independent living. The pathway plan builds on and replaces the care plan and young people who are leaving care are eligible for one from the age of 16.
Personal Budget	An amount of money allocated to someone who has eligible needs following an assessment. A personal budget can be used in a variety of ways to meet a person's needs providing some choice and control over how those needs are met.
Placement	The foster or residential home where the child or young person is living. A child or young person may also be 'placed' with their family at home if they are in care under a court order.
Resources Commissioning Panel	This panel receives the final draft of the EHCP once it has been completed. The panel reviews the plan and makes a decision on whether the plan can be authorised.
Review meeting	A meeting or meetings where the relevant plan is considered reconfirmed or changed and such decisions agreed and recorded in consultation with all those who have an interest in the child's life, including the child.
Specialist services or support	Specialist support can include services for disabled children, specialist child and adolescent mental health services, child protection services and support for those with the most severe

	and complex needs.
Targeted services or support	Services or support that aim to support certain people or groups who have needs that can't be met by a universal service; such as school counselling, parenting programmes, supported youth groups and clubs, some short break services.
Transitions	A phase or period of time when a person experiences significant change, some of which may be challenging. Some changes are experienced only by looked-after children or young people, for example, becoming looked after, changing placement, changing social worker or leaving care.
Universal services or support	Services or support that is available to anyone i.e. schools, health visiting, GP's, leisure centres etc.

Appendix 4 – PFA Checklist

	Tick when completed
At year 9/ age 14 - discuss best plan forward re the following areas with young person and their support network. Employment/Further education, Independent Living, Community and Relationships and Good Health.	
Check which assessments and plans the child or young person has including but not exclusively EHCP, Pathway Plan, CIN plan.	
Date of year 9 Preparing for Adulthood (PFA) review _____	
If unable to attend the review, information has been provided to school/college for PFA review including C/YP outcomes set?	
Transition Assessment completed on _____	
Consider if Mental Capacity Assessment has to be undertaken. If so, what for?	
Information provided to Transition Management Group on _____	
Ordinary residence considered (reports/medical information referenced)	
Was the case discussed at the Complex Needs Panel and Placement Panel? If so, date: _____	
Family/social ties to Sunderland have been discussed (how strong are the ties?)	
'Staying Put' evidence gathered (agreed or not agreed)	
Shared Lives assessment discussed on _____	
Risks/contact issues discussed	
Leaving Care responsibilities named	
The plan how we support the YP for transition has been discussed	
Considered if the YP needs an advocate?	
Discussion with a parent(s) for LAC about the decision after the Legal Planning Meeting	
Agree who is taking responsibility for YP health (consider CHC, if relevant)	
Discuss the plan for further education/training	
Education leaving date agreed and funding implication discussed	
Emotional/behavioural development discussed (consider MH, if relevant)	

Finances, welfare benefits has been discussed	
Personal Adviser named	
Young person's views taken into consideration/reflected in paperwork	
Best Interest decision undertaken, if relevant	
DoLS Assessment undertaken, if relevant	
Trust funds, investments, NHS pay-outs, CICA discussed, if relevant	
Housing needs post 18 discussed	
Referral to adult accommodation forum if required – Register person on commissioning intentions database.	

Appendix 5 – Useful Resources

Area	Resource	Link
General	Preparing for Adulthood website	http://councilfordisabledchildren.org.uk/preparing-adulthood/our-work
	Disability Matters E-Learning	https://www.disabilitymatters.org.uk/mod/page/view.php?id=3
	Sunderland Local Offer	https://sunderland.fsd.org.uk/kb5/sunderland/directory/home.page
Health	Wellbeing Information	http://www.wellbeinginfo.org/#
	Sunderland Action for Health	http://www.sunderlandactionforhealth.co.uk/
	Youth Wellbeing	http://www.youthwellbeing.co.uk/
Employment	Access to work	https://www.gov.uk/access-to-work/overview
	How to support young people with SEND into work	http://www.ndti.org.uk/uploads/files/How_to_Support_Young_People_With_Special_Educational_Needs_into_Work_FINAL.pdf
Community, friendships and relationships	Euan's Guide	https://www.euansguide.com/
	Community Circles	http://community-circles.co.uk/
Home and independence	My Own Place	http://www.ndti.org.uk/publications/ndti-publications/my-own-housing
	Your Place to Live	http://www.housingandsupport.org.uk/your-place-to-live
	Housing and Support	http://www.housingandsupport.org.uk/home

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