City of York Multi-Agency
Preparing for Adulthood (PfA) Protocol

The Planning Process to support transition from Adolescence into Adulthood for Young People in Care, with Learning Difficulties, Disabilities, additional needs, or Mental Health needs

We know from speaking to children, young people and their parents that transition into adulthood is an important process. Embedding good practice between children and adult services is key to supporting this.
Partners across education, health and social care have a key role to play in helping all children and young people, this includes those with Learning Disability, Mental Health, Autism and or a Physical Disability, prepare well for the transition to adulthood. As such, Preparing for Adulthood Protocol has been co-produced to address the roles, responsibilities and accountability for partners whilst making sure the child, young person and their parent(s)/carer(s) are at the heart of the process.

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Signed off by: Jamaila Hussain (DASS)

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CITY OF YORK COUNCIL   LIVE WELL YORK   SHOW ME THAT I MATTER York's Children in Care Council   NHS Vale of York Clinical Commissioning Group

Introduction

This protocol aligns with the City of York Councils vision of One City for all. This sets a strong ambition to increase opportunities for everyone living in York to live healthy and fulfilling lives. It builds on our individual strengths, to help prepare for the future, and improve the quality of life for people living in York. This protocol supports this approach and embeds a strength-based approach to our work with individuals and communities.

A strength-based approach supports an individual's independence, resilience, and wellbeing. This is achieved by supporting people to have meaningful conversations about their lives, hopes, strengths, their networks and priorities.

Background

We know from speaking to children, young people and their parents that transition into adulthood is an important process. Embedding good practice between children and adult services is key to supporting this.

The Children and Families Act 2014 has brought about extensive changes to support children and young people including those who have special educational needs and disabilities.

The Care Act 2014 places a duty on local authorities to conduct an assessment for children, children's carers and young carers where there is a likely need for care and support after the child in question turns 18 and an assessment would be of significant benefit.

Both pieces of legislation deliver a clear message that agencies must work together to provide careful preparation, planning and communication to ensure that young people get the support they need so they can move from child to young person, to adult as seamlessly as possible.

Partners across education, health and social care have a key role to play in helping all children and young people, this includes those with Learning Disability, Mental Health, Autism and or a Physical Disability, prepare well for the transition to adulthood. This protocol sets out to address the roles, responsibilities and accountability for partners whilst making sure the child, young person and their parent(s)/carer(s) are at the heart of the process.

Purpose

The purpose of this protocol is to provide colleagues and partners with a guide to supporting young people in their journey to adulthood. The protocol supports the following principles:

- Transitional planning should commence as early as possible.
- A person centred, partnership approach to planning is key.

- There will be an outcome focussed approach to planning where the strengths of the individuals and their networks are central to the approach.
- All partners support the aim to enable a seamless and safe transition from adolescent to adulthood, ensuring focus on outcomes across employment, independent living, positive relationships, community inclusion and good health.
- Applies to all young people with Special Educational Needs and Disabilities (SEND), including mental health needs.
- Transition should be a time of opportunities, choices, and independence.
- This protocol highlights the central role of young people and their families in transition planning, commencing at Year 9 (age 14) with the "preparing for adulthood review." This review involves multi-disciplinary team of professionals and individuals discussing and planning the transition to adulthood, considering needs, goals, and support for education, employment, and independent living. By adopting a person-centred approach and active engagement of the child and their parents or carers, agencies can collaborate to improve outcomes.

From discussions with families, children, and young people it is evident that a good preparation for adulthood plan involves:

- Employment options like self-employment, apprenticeships, internships, and college courses.
- Independent living with choices and control over support and accommodations.
- Active participation in society and community.
- Ensuring good health in adult life.

Eligibility Criteria for Adult Services

Practitioners should be aware of the distinct eligibility criteria that apply to Children's Services and Adult Services. It's important to recognise that a young person receiving support from Children's Services may not automatically meet the eligibility requirements for similar support from Adult Services.

Work between Adults, Childrens social care and the individual should centre around the young person's aspirations for life after turning 18. What are their goals, and what kind of life do they envision? It's crucial to assess the young person's skills, leverage the strengths of their family, and tap into the resources available within their community. The guiding principle here is community-led support, aimed at tailoring assistance to each young person's unique needs and circumstances.

However, we acknowledge that there will be instances where young people have complex needs that necessitate a referral to Adult Social Care. In those cases, it is considered best practice to establish a young person's eligibility for Adult Services as early as possible, preferably within their 16th year of age and no later than 17 and 6 months. The timing of the assessment may vary depending on the level and complexity of their needs and the planning required.

If a young person is found to be ineligible for Adult's Social Care, appropriate actions and signposting will be identified during transition planning meetings. These actions will ensure that any required services to support the young person's transition to adulthood are identified in a timely manner, promoting a smooth transition process.

Legislation and Guidance

It is widely accepted that good preparing for adulthood arrangements for children begin at 14 years old and therefore, this protocol is for children and young people aged 14 to 25 years old who are receiving a package of support from the City of York Council, their families/carer(s) and/or children looked after and leaving care and any professionals involved in preparing for adulthood.

This protocol is informed by the following legislation and national guidance. See for full information in Appendix.

Strategy is under review and will be linked here.

The Mental Capacity Act 2005

The Mental Capacity Act (2005) applies to all people aged 16 and over who are unable to make some, or all decisions themselves. If there are concerns in relation to a young person's capacity to make decisions from age 16 onwards, then a mental capacity assessment should be undertaken. All staff working with people over 16 have a legal duty to have regard to the MCA code of practice.

In accordance with the MCA, a person must be presumed to have capacity unless proved otherwise and should not be treated as incapable of making a decision unless all practicable steps have been taken to help them.

It is important to recognise that mental capacity can be affected by a number of factors, including previous trauma, the abusive situation the person is in, and by any threats or coercion.

A Mental Capacity Assessment must be carried out whenever:

A. There are doubts about the ability of any person from the age of 16 to make a particular decision at a particular time; and
B. There is a belief that the reason the person may be unable to make their own decision is because of, an impairment of, or a disturbance in the functioning of the mind or brain.

In accordance with the Act, mental capacity is both, decision and time specific. This means that the principles of the Act must be applied each time a decision needs to be made. Where there is a concern about mental capacity, this must be recorded.

If a young person is assessed as lacking capacity, then decisions can be made on their behalf using the principle that the decision made must be in the young person's Best Interests as set out in the Act.

Up until the young person's 18th birthday, the Children's allocated social worker is responsible for undertaking Mental Capacity Assessments in preparation for adulthood.

See Appendix 5 for further information around duties and responsibilities.

Deprivations of Liberty

Aged 16/17:

Should a young person aged 16 or 17 be living in a care setting or their own home and be potentially deprived of their liberty, an application should be made to the Court of Protection by the Local Authority.

A Court of Protection (COP) application should be submitted if a young person is deemed to lack mental capacity and meet the 'acid test':

- *Is the person subject to continuous supervision and control? and:*
- *Is the person free to leave?*

Further guidance about identifying and responding to Deprivations of Liberty (aged 16 and 17) can be found [here.]

If a deprivation of liberty may be occurring, the Local Authority is responsible for making an application to the Court of Protection, and the care plan should clearly set out these arrangements. This process remains the same if the young person is placed out of area.

Aged 18:

From age 18 the Deprivation of Liberty Safeguards is the legal framework for considering and authorising deprivations in a care home or hospital. Further information regarding these safeguards and duties can be found here.

When responding to deprivations of liberty in other settings please see guidance and forms in the Community Deprivation of Liberty Safeguards section of our Local Resources.

Section 117 Aftercare

If a child or young person has been detained on Section 3 of the Mental Health Act, they are eligible for section 117 aftercare. This is a statutory duty, from the Mental Health Act, that the local authority and the integrated care board (ICB) must ensure they provide the necessary support to ensure they reduce the likelihood of readmission to hospital. The aim of section 117 aftercare is also to support the young person to recover and reduce dependency on services. See link for more details of this legislation:
www.legislation.gov.uk/ukpga/1983/20/section/117

If a child or young person has Continuing Care for Children (CCC) shared funding prior to the detention in hospital. The CCC funding will stop at the point of admission and s117 aftercare funding will take over from discharge.

If a child or young person is fully CCC funded prior to detention, then some multi-disciplinary discussions will need to be had as soon as possible to support the discharge planning.

Transitional Safeguarding

Transitional safeguarding is about recognising that the needs of young people do not change or stop when they reach 18, although the legislation and services supporting them often do. It is about making sure they have the help they need to keep themselves safe and as independent as possible.

It is an approach to safeguarding that moves through developmental stages, rather than just focusing on chronological age, building on best practice and learning from both adult and children's services.

"Those working with adults should be curious about the childhood of the adult they are supporting. And those working with children should be ambitious about the adult they are helping to create" (Dez Holmes, 2021).

The Transitional Safeguarding Protocol *(link to be added at later date)* sets out the arrangements for young people aged 17 years and above, whose circumstances may mean that Safeguarding Adults procedures would apply

when they are 18. This would be young people who would meet the definition of an 'adult at risk' when they turn 18.

The aim of the protocol is to promote robust transitional arrangements and ensure effective and timely referrals between Children's and Adult Services in York. It recognises that harm is likely to continue post 18, and that abusers target vulnerability irrespective of age.

Continuing Care for Children (CCC)
A continuing care package will be required when a child or young person has needs arising from disability, accident or illness that cannot be met by existing universal or specialist services alone.

Diagnosis of a disease or condition is not in itself a determinant of a need for continuing care. A child or young person may have a rare condition which is difficult to diagnose but will still have support needs. There should be no differentiation based on whether the health need is physical, neurological, or psychological.

The continuing care process should be (and be seen to be) fair, consistent, transparent, culturally sensitive, and non-discriminatory. Some children and young people (up to their 18th birthday) may have very complex health needs. These may be the result of congenital conditions, long-term or life-limiting or life-threatening conditions, disability, or the after-effects of serious illness or injury.

These needs may be so complex, that they cannot be met by the services which are routinely available from GP practices, hospitals or in the community commissioned by clinical commissioning groups (ICBs) or NHS England. A package of additional health support may be needed. This additional package of care has come to be known as continuing care.

Children's Social care and CCC meeting should identify any health needs that the child may have and outcomes to maintain or improve health and wellbeing discussed and agreed including continuing health care checklist to be completed where appropriate.

Adult Social Care will receive information and intelligence about 14-year-old children and young people who may need support for their transition to adulthood. This will help in understanding the young person's needs in preparation for the transfer.

The following areas should be a feature during the Child in Need (CiN) Review or Section 17 Children Act 1989 Assessment and should be discussed at all future CiN Reviews leading up to their 18th birthday:

- **Moving to further/Higher education and/or employment or voluntary work** - this includes exploring different employment options such as supported internships, support to become self-employed and help from employment agencies. All schools should consider how to link employers with young people from year 9.
- **Independent living, independence at home or getting your own place** - this means young people having choice, control and freedom over their lives and the support they receive, their accommodation and living arrangements, including supported living.
- **Being part of a community and having independent friendships and relationships** - including having friends and supportive relationships and participating in and contributing to the local community.
- **Good health and emotional wellbeing** - this means having the opportunity to live a healthy lifestyle and have specific health needs met.

The preparing for adulthood process should help develop a clear direction of travel and assist the child 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 accessing paid work, learning & training opportunities, having their own personal budget, enjoying full and healthy lives and contributing to the local community. The need to engage positively with the young person, alongside family and carers is crucial in promoting strengths based social work principles, to create a safe navigation between children and the adult social care systems, and to maximise independence.

NHS Continuing Health Care (CHC)
There are significant differences between children and young people's continuing care and NHS Continuing Healthcare for adults. Although a child or young person may be in receipt of a package of continuing care, they may not be eligible for NHS Continuing Healthcare or NHS-funded Nursing Care once they turn 18.

The legislation and the respective responsibilities of the NHS, social care and other services are different in children's and adult services. The terms 'continuing care' (in relation to children's services) and 'NHS continuing healthcare' (in relation to adult and community wellbeing services) have different meanings. Section 1.1 of the National Framework for Children and Young People's continuing care explains the differences between the continuing care for children and NHS continuing healthcare for adults. In summary, Continuing care for children and NHS Continuing Healthcare for adults differ in terms of the age group they cater to, eligibility criteria, assessment focus, care settings, legal frameworks, decision-making processes, and the presence of a transition process as children grow into adulthood. While

both types of care provide ongoing support, they have distinct characteristics tailored to the specific needs and legal requirements of their respective populations.

Eligibility for children's continuing healthcare should not be taken as indicating any likelihood of eligibility for adult continuing healthcare.

The National Framework for NHS CHC for adults notes that ICBs should clarify future entitlement for an episode of adult NHS CHC for young people in transition, as early as possible. The framework states that formal screening should take place at the age of 16, with eligibility determined by the age of 17. This should allow effective packages of care to be commissioned in time for the person's 18th birthday.

The National Framework for NHS CHC and NHS-Funded Nursing Care Revised 2018 sets out the principles and processes for the implementation of NHS CHC and NHS Funded Nursing Care (FNC). If it is felt that if a young person or young adult is eligible for CHC, the ICB will be informed as soon as possible following the young person entering year 9 (age 14). This information will also be shared with colleagues in preparing for adulthood team in adult social care, through a case-by-case intelligence-sharing process, when necessary. If appropriate the CHC checklist and subsequent assessment will be completed at 16 or above or whenever the young person or young adult becomes known to services.

The Mental Capacity Act principles will apply and the person's informed consent and views will be obtained before determining eligibility to NHS CHC. If the person lacks the mental capacity either to refuse or consent, a 'Best Interest' decision will be taken and recorded in line with the Mental Capacity Act 2005, as to whether to progress to an assessment.

The Decision Support Tool (DST) process will consider the person's health needs and whether they have a primary health need. Where a person has been assessed as having a primary health need, they will become eligible for NHS CHC.

Where a person is eligible for CHC the council will, where appropriate, continue to offer a role in assessment and review, support for carers, and social work services.

If a young person is not entitled to adult NHS CHC, their health needs will still be the responsibility of the NHS and they will be supported to access universal, targeted and specialist health services as appropriate. In such circumstances, the NHS will continue to play a full role in transition planning for the young

person and will ensure that appropriate arrangements are in place for services that meet these needs. The focus must always be on the young person's outcomes and support needed to achieve these.

All young people with SEND from the Age of 14 years and onwards have the opportunity to access an annual health check with their GP, with a specific health plan in place to support them should this be required.

Preparation for Adulthood Milestones

The transition pathway will begin at aged 14 or at the point of referral to children's social care if the child is older.

At the first review, which is the responsibility of Children's Social Care, the information collected needs to be 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
- Care and Support Plan
- Associated Health Plans, including Continuing Health Care

Year 9/10 (age 13 - 15)

- This is the start of the formal preparing for adulthood process. The first CiN review with focus around Preparing for Adulthood (PfA) will be held when the young person is 14. Young people will be 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.
- 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 and/or a meeting beforehand with an appropriate practitioner.
- Children's social care has the lead responsibility at the first review and will maintain case responsibility until the young person's 18th birthday.
- Where a child is looked after and requires a Personal Education Plan (PEP) this is reflected in the review. 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 young person 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 strengths 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 good support looks like and what is working and not working in their life. The transition plan should include specific, measurable, achievable, relevant and timed (S.M.A.R.T) actions, to identify how outcomes will be met.

Year 11 (age 15 to age 16)

- At this stage of the young person's life an annual CiN review with focus around PfA will be required. The support plan, outlining the care and support being provided should reflect the young person's wishes, feelings and aspirations, it should also reflect whether the child has capacity to make decision regarding their own care, support and accommodation requirements.
- The young person 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.
- For children who remain looked after in the care of the Local Authority, Pathway planning will take place from 15 ½ years old. A Pathway Needs assessment will be undertaken by the allocated Social Worker and developed into a Pathway Plan by 16 ½ years old. The Pathway
- Plan then becomes the active Care Plan for the young person. Any child who is likely to require ongoing support from adult social care aged 18, should also have a transition assessment to determine their eligibility to receive support under the Care Act 2014. If a transition assessment has been completed previously, the information in this assessment should inform the adult needs assessment. A Social Worker from Adult Social Care should be allocated to jointly review ongoing care and support arrangements (including EHCP where appropriate) prior to the young person reaching 18 years of age.
- For children who have an Education, Health and Care Plan, planning for preparing for adulthood must be integrated with the assessment and annual review process for EHCPs. Within the EHCP process, planning for adulthood begins when the child is 13/14 years old/ in year 9 in secondary school.
- If a child is looked after, they will require a Pathway Needs Assessment which is developed in a pathway plan by 16 ½ year old.
- The Pathway Needs Assessment should commence from the child reaches 15 years and 6 months. The assessment will then be developed into a Pathway Plan by 16 ½ years old and reviewed every 6 months or more frequently should their circumstances change.
- Where the child is planning to leave school in the next academic year, the review 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.

Year 12 (age 16 to age 17)

- At the Review (CiN/LAC) the CHC Checklist should be completed for those young people with identified needs, gathering views and information from all relevant parties involved in the young person's care.
- If the checklist determines the young person is eligible for a CHC assessment a copy should be sent to the relevant ICB. As soon as practically possible after the young person's 17th birthday the ICB should arrange an MDT to determine eligibility in principle. If the young person triggers a full Decision Support Tool (DST) and assessment and is likely to or is in receipt of full CHC funding, the young person at 18 years old will transfer to CHC Nurses for continued care and support at aged 18. They do not require transition into adult social care.
- A referral to the preparing for adulthood panel should be submitted for discussion without prejudice.

Link ToR for PfA will follow later.

The local offer https://www.york.gov.uk/looked-children/local-offer-care-leavers

- 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. This should be done with the young person.
- 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.

Year 13 (age 17 to age 18)

- The referral, if needed, should be made to adult social care by the young person's 17th birthday. Adult social care will collaborate with children's colleagues to prepare for the transition to adult social care.
- If there is an existing package of care and support in place this will be continued to be funded through children's social care until the adult social care teams are able to assess, review and agree future care and support for the young person. This will be undertaken in accordance with the Care Act 2014.
- The annual transition review for children will take place three months before the child's 18th birthday; all key stakeholders (including adult social

care) are requested to provide information regarding their involvement and are invited to attend the review.
- This review is where children's services and adult services agree the point of transfer.
- It is important to be aware that the financial position of the child may have changed depending on their circumstances and they may be eligible to claim Personal Independence Payment (PIP) and access Employment Support Allowance (ESA).
- In cases where a young person has substantial health needs, an application for Continuing Healthcare (CHC) should have been evaluated at the age of 16. If, for any reason, this evaluation has not been done, the checklist must be completed as part of the review process.
- As part of the review the young person should be supported to access the appropriate information and advice to ensure they are in receipt of all benefits. If a young person lacks capacity to manage their finances, an appointee may need to be appointed to do this on their behalf.
- On the young person's 18th birthday, the responsibility for their care and support will transfer to adult social care. Children in care are allocated a Pathway Worker at 17 ½ to work in partnership with the allocated adult social worker to assist with Pathway Planning and next steps. The allocated Pathway Worker will take responsibility for Pathway Planning when the young person becomes 18 and offer support in line with the Local Offer up until 21 years old when their support needs are reviewed. The Children and Social Work Act requires Local Authorities to provide support to all care leavers up to the age of 25, if they want this support.
- The Local Offer in York is a comprehensive resource and information platform that provides details about support services, activities, and resources available to children and young people with special educational needs and disabilities (SEND) in the city of York, UK. It is designed to help parents, carers, and young people access the necessary information and support to meet their specific needs and requirements.

Further Education (age 18 to age 25)

- If the young person is deemed as lacking capacity and COP review completed at age of 17, at 18, the adult social worker will submit the adults care and support plan with a COP24 witness statement to the Court of Protection. Adult Services will become responsible.
- An EHCP will be reviewed every year whilst a person remains in education or training until or until the outcomes have been achieved. Where an EHCP remains in place beyond the age of 19 years, consider whether special educational provision provided through an EHC plan will be necessary to enable the young person to progress towards agreed outcomes.

- Young people with EHC plans may take longer to achieve their outcomes, however, this does not mean there is automatic entitlement to continued support at age 19 or an expectation that those with an EHC plan should all remain in education until age 25.
- The local authority can decide to cease an EHC plan if it decides that it is no longer necessary for the EHC plan to be maintained. The young person and parent/carers would be informed. Consider whether remaining in education would enable the young person to progress and achieve and whether the young person **wants** to remain in learning. Young people who no longer need to remain in formal learning or training will not require special educational provision to be made for them through an EHC plan.
- Develop exit plan for when EHC plan ceases. Termly meetings with school health and the community Team for People with a Learning Disability takes place to ensure a smooth transition into adult health. If a person's post 19 education is out of the city, then school health with liaise with the new provider around their health input
- A review of a social care support plan will take place at least annually to identify actions/support to enable preparation for adulthood. Consider whether all appropriate professionals/organisations are involved. Identify other key Transition points in the Young Person's journey – consider actions required to make these transitions as smooth as possible.

Appendices Appendix 1 - Legal Framework

1. **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.
2. **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).
3. **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.
4. **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.
5. **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.
6. **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 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.
7. **The Care Act 2014 and Health and Care Act 2022**
    a. sets out the framework for the provision of services to ‘vulnerable adults’ and sets out a framework that defines each adults ‘Ordinary Resident’.
8. **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.

9. **Special Educational Needs and Disability Code of Practice 0-25 years**
    a. Statutory guidance for organisations which work with and support children and young people who have special educational needs or disabilities.

There has also been **significant case law** that the Local Authority has to be mindful of in undertaking their statutory duties and obligations to Children in Care 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)
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.

Mental Capacity (Amendment) Act 2019
Mental Capacity (Amendment) **Act 2019** The **Mental Capacity** (**Amendment**) Bill entered parliament in July **2018** and gained royal assent on 16 May **2019**. The act follows recommendations made by the **Law Commission** around **mental capacity** and deprivation of liberty and creates a new regime, Liberty Protection Safeguards (LPS).

Appendix 2: Roles and Responsibilities

Children's Social Care –The Disabled Children and Young People Team, York

1. The Disabled Children and Young People Teamwork with children from birth up to the age of 18 where the child has one or more of the following:
    a. a substantial physical disability
    b. a severe communication disability (including autistic spectrum disorder)
    c. a severe learning disability
    d. Sensory Impairment
    e. People with Autistic Spectrum Conditions (ASCs);
    f. People with Emotional and Behavioural difficulties; this includes recognising the impact of ACE's which may lead young people to have needs for care and support as adults
2. The Disabled Children and Young People Team provides a range of opportunities and provisions for disabled children and their families.
3. The Disabled Children and Young People Team provides the care management and assessment function for disabled children in the transition years up to the age of 18.
4. **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, they will attend the annual transition planning meetings (from age 14) in school (usually as part of EHCP) and organise provision to meet the care needs of the child and their family. The social workers based within The Disabled Children and Young People Team are responsible for providing information from the child's Care Plan, Leaving Care Assessment and Pathway Plan (if they have one) to the social workers in adult services so that a smooth transfer takes place at age 18.
5. **Advocate** - Young People in Care and care leavers are entitled to Statutory advocacy from the Speak Up service. This is arranged by the social worker within services for disabled children or adult social care if the young person is over 18. A list of who is entitled to this can be found here: https://www.showmethatimatter.com/advocacy-for-children-and-young-people-in-york-copy-3.htm

Referrals for this service can be made by the young person, a family member, social worker, or another adult working with the young person.

Leaving Care Personal Adviser – Pathway Worker

6. All eligible, relevant, and former relevant young people eligible for leaving care services will be appointed a Pathway Worker who will fulfil a key role in providing the right support to them as they make the transition to adulthood.
7. The young person's allocated social worker (from 16 - 18) can undertake the role of the child's Pathway Worker up until the young person attains 18

years of Age. At 17½ years of age a Pathways Worker will be allocated to the young person. The transfer of support from the social worker to the Pathway Worker will take place in a planned and managed way.

8. The allocated Pathway Worker will take responsibility for Pathway Planning when the young person becomes 18 and offer support in line with the Local Offer up until 21 years old when their support needs are reviewed. This support can then be extended up until 25 years old dependent on the views of young people and their identified needs.
9. The Pathway (Leaving Care) Team offer information, advice and support for young people to access:
    a. Accommodation
    b. Education
    c. Training
    d. Work Experience
    e. Health Services
    f. Financial Advice
    g. Relationship Advice
    h. Social Opportunities

The team works with other agencies to help young people achieve their goals and ambitions. The team is made up of 6 pathway workers, an accommodation officer and an education, training and employment officer (ETE) and a manager

10. The pathway worker will keep in contact with young people at a minimum of every 8 weeks, they will visit young people at home and also arrange to meet them in the community. The pathway worker will provide advice, information and guidance to help young people make informed choices and decisions in all areas of their life. The Pathway worker will support young people in co-producing their Pathway Plan and reviewing on a regular basis.

Adult Social Care

13. The team who has responsibility for transitions will support young adults into adult social care, they will continue to support adults who have a learning disability, autism or are vulnerable, those, who are based in the other area team or who have a physical disability will be transferred into those teams once the transition period is over. All adult social care teams include social workers and social care assistant practitioners.
14. 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 at least 2 eligible needs within the age range of 18 onwards, with full participation of their carers as appropriate.

15. 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.
16. Following an adult needs assessment, if the person is eligible to receive support, a worker from the specialist 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
17. 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 adult social care
18. Colleagues 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 look at the persons skills, the family's skill and what the community has to offer before facilitating 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.
19. In situations where eligibility has not been established staff will offer advice and guidance to the referrer to access independent support, where appropriate.

Appendix 3 - Glossary of Terms

Advocacy/IMCA

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. If the young person has reached 16 years of age, and lacks mental capacity, then they are entitled to an Independent Mental Capacity Advocate (IMCA) under Mental Capacity Act 2005, should they have no family or friends to support them.

Adult Needs Assessment

An assessment to determine eligible social care needs for adults under Care Act 2014 legislation. The ANA will determine an indicative personal budget.

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.

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.

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.

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
Specialist support can include services for disabled children, or specialist support for the 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, GPs, leisure centres etc.

Appendix 4

This protocol is informed by the following legislation and national guidance:

- Children Act 1989
- The Children and Families Act 2014 (Part 3)
- The Mental Health Act (1983)
- The Care Act 2014
- The Mental Capacity Act (MCA) 2005.
- Children looked after and leaving care policies and procedures
- Staying put Policies and Procedures
- Adult Services Policies and Procedures
- Health and Care Act 2022
- Special Educational Needs and Disability Code of Practice 2014.
- SEND Priorities
- Transitional Safeguarding
- National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care - July 2022 (Revised) (publishing.service.gov.uk).
- NICE - Overview | Transition from children's to adults' services | Quality standards | NICE.

Appendix 5

In addition to the above key legislation and code of practice, this document also recognises duties and responsibilities under the following acts and guidance:

- The Children's Act 1989/2004
- Think Autism – 2014
- National Framework for Children and Young People's Continuing Care
- National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care
- Mental Health Act 1983 / 2005
- NICE Guidance - Transition from Children's to Adult's Services for Young People using Health or Social Care Services 2016
- Care Standards Act 2000
- The Education Act 1996
- Learning and Skills Act 2000
- Equality Act 2010
- United Nations Convention on the Rights of the Child 1989

Useful Links and Attachments

- Advocacy: https://www.showmethatimatter.com/advocacy-for-children-and-young-people-in-york-copy-3.htm
- Live Well York Homepage https://www.livewellyork.co.uk/
- YorOk Preparing for Adulthood https://www.yorksend.org/homepage/8/preparation-for-adulthood
- City of York Council Benefits Advice
    - Phone: 01904 552044
    - Email: incomeservices@york.gov.uk
- York Carers Centre - Unpaid carers
    - Phone:01904 715490
    - Email: enquiries@yorkcarerscentre.co.uk
- Booklet on Post 16 options for young people: https://www.yor-ok.org.uk/families/Local%20Offer/preparing-for-adulthood-2.htm
- Financial Support information: https://www.yor-ok.org.uk/families/Local%20Offer/financial-support-3.htm
- Supported Adulthood and Opportunities https://www.yor-ok.org.uk/families/Local%20Offer/supported-adulthood.htm
- Financial assessments and social care costs from 18 https://www.york.gov.uk/personalisation-care/financial-assessments-social-care-costs-from-18