OUR LEARNING -> OUR PRACTICE

Multi-Agency Transition Protocol:

Children with Disabilities and Complex Health and Educational Needs….

becoming adults with our care.

Contents (with hyperlinks)

Introduction: What is the Multi Agency Protocol?

This protocol sets out the roles and responsibilities for all teams and agencies providing transition services for young people from age 14 years, who have been identified as requiring support or possibly care management in their transition into adulthood, particularly when they have lived in residential care due to additional health and educational needs.

The protocol has been developed following the outcomes of the Doncaster Inquiry which was followed by phase one and phase two of the National Review into Safeguarding Children/Young People with Disabilities and Complex Health Needs in Residential Settings.

It aims to ensure that everyone involved in the transition understands their specific roles and responsibilities so that practitioners and families can effectively work together to support the young people in their transition to adulthood.

The protocol will provide clear guidance in terms of each agency's roles and responsibilities; outline expectations and ensure that there is a consistent approach across different areas and services; allow for professional curiosity and tenacity when it comes to safeguarding and achieving the best service possible.

It is a fundamental principle that children/young people with complex health needs have the same rights as non-disabled children to be protected from harm and abuse. Surrey Practice Standards and other policies and procedures must be followed in any instances prior to a young person's 18th birthday.

Often young people with complex health needs have additional needs related to physical, sensory, cognitive and/or communication requirements and some of the problems they face can be made worse by negative attitudes, prejudice, and unequal access to things necessary for a good quality of life.

For all practitioners and agencies, ensuring young people are safeguarded should therefore always be integral to everything we do. Practitioners should ensure that any young person is supported to remain safe as they move into new accommodation.

Underpinning Principles

Drawing on the key messages from the national review, all agencies involved in the young person's life should ensure our practice is in line with the following underpinning principles:

- ***Person-centred transitioning planning*** **-** The young person should be at the centre of the transition planning process, giving them choice and control over their own future. The focus should be on their safety, needs, hopes and aspirations.

- ***Young person, their carers and their families should be recognised as partners in the transitioning process*** and be actively involved in planning the future of the young person. The experience of the young person and their families should inform strategic planning and commissioning by ensuring the young person and their family are the centre of our planning.

- ***A shared vision*** that places the young person and their families at the centre and focuses on improving life chances, should be developed across all partners.

- **Partners must be committed to working together** and have a clear understanding of the specific roles and responsibilities of all the key agencies involved in the transition process.

- ***Information should be shared*** with the young person to raise aspirations by illustrating what has already worked for others.

- **Information should be developed with** the young person and their families to ensure it is relevant, accessible, and understandable.

- ***Agencies should share relevant information with each other*** **and with commissioners** to ensure the transition process is smooth and that services and opportunities are planned and developed to meet the needs of the young person.

- ***Diagnosis information*** **-** All children and young people have the right to receive the right care at the right time. Diagnosis information will be obtained from the GP summaries to confirm diagnosis and additional guidance will be sought from the GP and/or relevant ICB colleagues where young people have the appearance of need which warrants further exploration of their presentation.

- ***Information must be accurate and timely*** and provided in adherence to data sharing principles and safeguarding needs. It is also important that this information is used in a way to promote aspirational planning that motivates both the multi-agency network as well as the young person.

- ***Disagreement resolution***- even with the most productive and responsive planning situations will transpire where professional views differ or change regarding the care and support needs for a child or adult with complex needs. It is important that professionals utilise formal processes to escalate concerns in a timely way. For children, the Surrey Safeguarding Children Partnership (SSCP) have the Surrey FaST Resolution Process. For adults, the Surrey Safeguarding Adult's Board has an Inter-Agency Escalation Policy and Procedure.

- ***Starting assessments at age 14 and transition planning*** facilitates more responsive and flexible forward planning. This includes children who are subjected to Child in need plan as long as the required criteria is met.

- ***Transition planning covers every aspect of a young person's life,*** including education, employment, placement, health, and leisure activities. Transition planning is focused on life outcomes, promoting independence, and supporting the young person to lead meaningful and enjoyable adult lives.

- ***Quality and monitoring*** to be in place to ensure that all young people are tracked, and none fall through the net. Mechanisms need to be built in to ensure the quality of provision meets appropriate standards and that the transition process is as effective as possible.

- ***Young people with complex health needs should be protected from harm and abuse***. Surrey Practice Standards and policies and procedures must be followed in any instances prior to a young person's 18th birthday.

- ***Transition to be a continuous process*** that enables young person to be better prepared for adulthood. It happens over a period of time between the ages of 14 to 25. Transition planning offers a young person an overview of their needs and should ensure they fulfil their potential in adulthood.

- ***Advocacy*** for children and young adults is essential within the care planning and monitoring process. The needs and risks for a child will often remain within adulthood, advocates must understand the Care Act 2014 to support young people who require support to engage in their care planning as well as have the skills to challenge their child's needs assessmet(s). The commissioning arrangements must ensure non-instructed advocacy is available for both children and adults who require this type of advocacy.

Roles and Responsibilities

1. Looked After children/young people

A child / young person will become looked after when the child /young person's parents or the people who have parental responsibility for the child/young person are unable to look after them in a temporary or permanent capacity.

Timescales at a glance for Looked After children /young people	
Threshold	• Any child/young person who has become looked after meets the criteria to access services as a looked after child/young person.
Referral process	• Once a child/young person is looked after, social worker to notify the IRO service of the child/young person becoming CLA **within 2 working days** of their care episode. • An IRO to be allocated **within 5 working days.**
Policy and Statutory Guidance that underpin practices.	• S20, S31 and S38 of the Children Act 1989. Children Act 1989 • IRO Handbook 2010. iro_statutory_guidance_iros_and_las_march_2010_tagged.pdf (publishing.service.gov.uk)
Reports	• Care plan to be written **5 working days** before the review and should be shared with the young person, carers and parents by the social worker where appropriate but should in most circumstances. • Pathway plans will be completed within **3 months of the child's 16th birthday. This needs to be written with and to** the young person and a copy given to them**.** • Pre-meeting reports to be written **5 working days** before the review meetings.
Visits	• The IRO to see the young person during each review process or when needed outside the review process. • Social Worker to undertake the first CLA visit to the child/young person **within a week** of the child/young person's placement. • Subsequent visits to be completed at least **every 6 weeks.** • For a child/young person in a long-term placement, social work visit can be reduced to **every 12 weeks** if: ▪ the placement has been assessed to provide care that is of a good standard for the young person and, ▪ the young person has been with the same carer for over a year and the decision has been agreed at the child's looked after review meeting.

	• Social worker to ensure that visit to the child/young person is recorded **within 24 hours** of the child/young person being seen. Visits to be written to and with the young person.
Voice of the child/young person	• The views, wishes and feelings of the young person to be gathered and included within their reports. • The young person to be invited and encouraged to fully take part in their review meeting. • The young person to be consulted before the meeting. • Given their abilities to effectively contribute to meetings, young people with disabilities and complex health needs should have access to independently commissioned, non-instructed **advocacy** from advocates with specialist training to actively safeguard them and respond to their communication and other needs. • Children Act 1989 s1(3) (a) the ascertainable wishes and feelings of the child concerned (considered in the light of his age & understanding). • Munro report 2011; • Working together to safeguard children 2023 • Learning from Serious Case Reviews. Homepage - Surrey Safeguarding Children Partnership (surreyscp.org.uk) • Special educational needs and disability code of practice
Meeting	• Social worker to ensure that a placement planning meeting is held **within 5 working days** of a child / young person begun. • An initial looked after child review meeting to be held **within 20 working days** of the child becoming looked after. • Second CLA review meeting to be held **3 months from the initial meeting** thereafter the review to be taking place **every 6 months or more frequently** if and when needed taking into the account the child/young person's experiences and circumstances. • Within **4 weeks** of unplanned changes of placement. • Midway review to take place in between each review: 6 weeks after the initial review; **12 weeks** after the second review and thereafter.
Recording	• Recommendations/outcomes from the review to be recorded in LCS within **5 working days** of the review. • Minutes of the review to be recorded in a letter form/ dear diary way and completed within **15 working days** of the review and shared with the young person **within 20 working days.** • Midway review to be recorded on form on LCS within **5 days** of the midway taking place.
Supervision/Management	• IRO to have **monthly** reflective supervision which evidence some professional curiosity.

Oversight	• Social workers and other practitioners' reflective supervision will be a minimum of monthly. The frequency of supervision will also depend upon the complexity of the work. • Supervision Agreement to be agreed, signed, and reviewed annually
Safeguarding protocol	• In most cases where a child/young person is the subject of a child protection plan becomes looked after, it will no longer be necessary to maintain the child protection plan. If safeguarding issue remain, then the IRO needs to include the child protection plan/safety plan within the child/young person's care plan. **There need to be a single planning and reviewing process led by the IRO where possible.** • In the event of any safeguarding incident occurring while the child/young person is looked after, the IRO to ensure that: ➢ The child protection process is followed. ➢ The review is brought forward and a safety plan as well as a contingency plan is tailored when needed. ➢ Parents or carers who hold PR are informed. ➢ Referral is made to internal and external LADO where appropriate. **BE CURIOUS – QUESTION EVERYTHING – EVIDENCE – IMPACT – OUTCOMES**
Transfer process	• IRO to be involved at each transition point for the young person. • Review meeting to be held whenever there is a significant change of circumstances. • IRO to raise care planning alerts were leaving care PA's need to be allocated and/ or need to visit. • IRO to monitor when a child is appointed a leaving care worker and be involved in the transition service and planning for adulthood.
Transition planning	• Social work team and the IRO to identify and ensure that the referral to Adult Social Care is initiated when the young person turns up 14 and by the age of 16 the latest. If this does not happen the IRO should raise a care planning alert to the Service Manager. • IRO to convene a final LAC review meeting which should be held no later than one month before the young person's 18th birthday. • IRO to encourage and recommend work to be completed by the transition team and escalate where required. Key issues such as on-going family contact arrangements (including risk assessments), particularly where there are safeguarding concerns or health needs that need careful management, should be discussed with regular reviews and actions to carry over as adults.

	• The IRO role to end once a young person becomes an adult, although with consent of the young person an IRO can chair the first Pathway Plan review as an adult, in instances where this would greatly benefit the young person's transition into adulthood. Children in the looked after service who do not meet eligibility to be in the CWD team, but they may require a service from Transitions as adults. Please see CwD section for further clarity.

Practice expectations
IRO to ascertain that the social work team has obtained a voluntary accommodation document is signed by all persons holding Parental Responsibility for a child looked after under S20 and that this is stored within the young person's case file in the absence of a court order. Where this is not in place, to highlight to the social work team the requirement for them to obtain from all persons who hold parental responsibility for the child.
IRO to ascertain that a thorough placement plan is written setting out what should be done in the event of a significant incident taking place, who should be informed, that the placement plan provides information about medication, staff ratio, information about arrangements (including consent) for health, education and who the child/young person should spend time with outside of their placement.
IRO to ascertain that a thorough care plan or pathway plan is written, signed off by the team manager for the child /young person and that this is shared with the young person and their parents. The care plan or pathway plan should address all areas of child/young person's complexity of needs and identify how those needs will be met.
Care plan to include safety plan wherever needed which should outline how to promote the safety and protection of each young person by providing steps to be taken when a significant incident occurs as well as contingency planning in the event that the safety plan is unsuccessful.
IRO to speak to the allocated social worker at least 5 working days before the initial Looked After Review Meeting and at least 15 working days before subsequent reviews. An 'Independent Chair Oversight' case note should be recorded to reflect the discussion on the young person's case file.
IRO to hold midway review meeting between each looked after review for each child/young person to review their care plan to ensure its progress and effectiveness.
IRO to consult the child/young person before the meeting to establish their wishes and feelings and how they wish to contribute to the review of their care plan and to ensure that the child/young person is listened to and that their wishes and feelings is promoted.
Depending on the child/young person's capacity to participate/contribute at their review given the complexity of their health needs, consideration to be given to each child/young person having access to the independent advocacy services to ensure that the child/young person is involved at their meeting and through the development of their child friendly care plan.

IRO to ensure that reviews are timely and focussing on the child/young person's needs.
IRO to maintain close contact with the SW, parents or the people holding PR as well as key professionals to improve outcomes for the child/young people with complex health needs to ensure that they are receiving the best care.
IRO to raise practice concerns through the Care Planning Alert Process, when appropriate and necessary.
IRO to bring the review forward whenever there are safeguarding concerns for the child/young person with complex health needs. IRO to ensure that they have scrutinised incident logs, explore staffing ratios, and ensure that this is in line with the information within the placement plan and challenge or escalate concerns whenever needed.
IRO to scrutinise Regulation 44 and 45 reports and ensure that placement has effective approach to behavioural management, pursue recommendations; ensure that staff are caring for the child/young person appropriately and that the placement is well managed.
IRO to be informed of any significant changes to a child/young person's care plan to enable them to consider the impact of the change and monitor that what has been previously discussed within the review process or in consultation with the IRO outside the review process and such changes was agreed.
IRO, social worker and all involved professional to exercise professional curiosity in better understanding the child/young people's experiences in order to improve outcomes.
Social worker to respect the child/young person's heritage, culture, race, religion, and language and use appropriate methods of communication to engage them in any assessment.
SW and IRO to ensure that reports are written with and to the child/young person and that the child/young person's views, wishes and feelings are evidenced within the reports/minutes and any assessment.
Social worker to ensure work is carried out and recorded within the required timescales as outlined within the child/young person's recommendations / outcomes.
Social worker to respond to any allegation of abuse or neglect in accordance with Surrey's Safeguarding requirements.
Social worker to ensure that records and reports are accurate, complete, accessible, and up to date and demonstrate the decision–making process and evidence some curiosity.

2. Children with Disabilities

A child/young person will be allocated to work with the children with disability service when their needs are such that they meet the criteria of the service.

Timescales at a glance for children/young people with disabilities	
Threshold	A child will be allocated to work with the children with disability team if they have needs that relate to their child's disability and meet the eligibility for a specialist service. CWD work with children at Level 3 and Level 4. the service works with children across the whole pathway from referral /assessment/ Child in need /Child looked after /Child protection including care proceedings and PLO.
Referral process	Referrals are received from a range of sources including family members, friends, or professionals. All referrals to the CWD service are triaged in the CSPA to determine eligibility and to see if early help services could be used to meet need. There is a specialist CWD social worker based within the CSPA to ensure that only children who meet the eligibility for CWD are referred to the service and also to advise more generally on issues that relate to a child's disability and possible ways of supporting the child and family through early support.
Policy and Statutory Guidance that underpin practices.	Social Worker and Family Support Workers within the Children with Disability Team are expected to have a working knowledge of: • CA Act 1989- S17- All children defined as disabled are regarded as 'children in need'. • Children with Disabilities Services Eligibility Criteria for Assessment by the CWD Service- December 2020. • The Care Act 2014 has reinforced requirements to undertake transition assessments for disabled children who are likely to need care and support when they become adults. • Children Act 1989 updated 2004; • Children and Families Act 2014; • Care Act 2014; • The Chronically sick and Disabled Persons Act 1970 and 1978; • The Mental Capacity Act 2005; • Carers and Disabled Children's Act 2000; • SEND Code of Practice: 0 to 25 years (2015) • Article 5 of the European Court of Human Rights Act 1998; • DoH, Care Act and Support statutory guidance .

Visits	**Child in Need-** **Level 4** • Child to be seen **every 4 – 8 weeks, or 12 weeks** depending on complexity which will be agreed in supervision. • If there are concerns around parenting capacity the child should be seen **alone every 4 weeks.** **Level 3** • Where a child/family is settled and stable and does not need an ongoing social work intervention, children will be stepped down to the Review Team. **Child Protection-** • The social worker will have face to face contact with each child at least **every 10 working days**. This applies to each child irrespective of their age. • The child must be seen alone (normally with the parent's agreement) no less frequently than **every 6 weeks**. • The child's home and bedroom (or cot if sleeping in a cot) should **be seen no less than 8 weekly**. **Looked After Child-** • First visit **within 1 week** of the foster placement • Subsequent visits at least **every 6 weeks** • For a child in a long-term foster placement/residential setting visit can be reduced to **every 12 weeks** (agreed within a review meeting) **Level 3 (Review Team)** • Child to be seen every 6 months.
Voice of the child/young person	• Case worker to ensure that the lived experience of the child/young person, which include what a child sees, hears, thinks, and experiences on a daily basis that impacts on their personal development and welfare whether that be physically or emotionally is gathered and taken to consideration. • The young person will be consulted directly on the transfer, in whatever way best suits that young person's communication abilities and preferences. • The child/young person to be given the scope to raise concerns separately from parents and carers. • The child worker to promote early intervention and support for smooth transitions between children and adult services for children and young people with complex health needs. • The child worker to work with key partners to strengthen integration between Children and Adult provision in health, social care, and education services, and with services provided by wider partners.

	• The child worker to ensure that children are referred for independent advocacy and at 16 IMCA's (Independent Mental capacity Advocate) to be considered if there is a disagreement regarding care planning
Meeting	**<u>Level 3 (Review Team)</u>** • Child in Need reviews to take place **every 6 months**. **<u>Level 4</u>** • **Child in Need**- Child in Need reviews to take place within 10 **working days of a child stepping down from a CP plan. With 12 weekly /6 monthly – depending on needs identified reviews for care and support packages.** **<u>Child Protection-</u>** • **ICPC**- Held within **15 working days** of the strategy discussion or notification by another Local Authority that a child who is subject to a child protection plan has moved into the county. • **RCPC-** Held within **10 weeks of the initial conference**. Further reviews at intervals of no more than 6 months. • **CGM-** The first meeting within **10 working days of the initial** conference, every 6 weeks thereafter. **<u>Looked After child</u>**- • Social worker to notify the independent reviewing officer of child/young person coming into care **within 2 working** days. **Please refer to the CLA section.** **N.B.** CIN meetings will agree the visiting frequency which will be included in the plan, but this should be at **least 4 weekly**. The exception to this is children with disabilities, where CIN meetings are held but where the child remains open to social care packages and where there are no parenting capacity concerns- these children will be seen a minimum of **12 weekly. In the CWD service there will be children requiring more frequent visiting and this will be agreed by the team manager.**
Assessment & Report	**<u>Child in Need:</u>** • C&F assessment to be completed within **45 working days** of its initiation and needs to be updated in line with the needs of the child. **<u>Child Protection-</u>** • Social worker to ensure that the initial conference report is provided to the family and the child/young person at **least 2 working days** before the conference.

	• Social worker to ensure that the initial conference report is provided to the chair at least **1 working day** before the conference. • The review conference report to be provided to the family and the child/young person at **least 10 working** days before the conference. • The review conference report to be signed off by the team manager and provided to the chair, family and other professionals at least **5 working days** before the conference. **Looked After child**- **Looked after child review meeting:** • Please refer to the CLA section. **Report to looked after child meetings (initial and review):** • Within **5 working days** of the looked after child meeting **Health assessments** • Initial health assessment to be completed **before** the child/young person's first looked after child review within 15 working days of the child becoming looked after. • Review of the health assessment for the under 5 to be completed **once every 6 months**, and children/young people over 5 **once every 12 months.** **Personal education plan meeting (PEP):** • Social worker and virtual school key worker to ensure that this meeting is held within **20 working days** from a child becoming looked after, and once a term thereafter. **Placement Planning Meeting (PPM):** • PPM to be held **within 5 working days** of a child/young person once the placement beginning. **Mental Capacity Assessment** • In complex situations for children/young people practitioners from key partner agencies working with the individual should collaborate to formulate a shared analysis of how the individual's cognitive function is impacted in different circumstances. **N.B**. for CWD- The Care Act 2014 has reinforced requirements to undertake transition assessments for disabled children who are likely to need care and support when they become adults. Where transition assessments are undertaken these must include a carer's assessment on the appearance of need (whether of a parent, other adult carer or a young carer). The resulting care and support plan for when the young person reaches 18 should also identify where a need for support to the carer has been identified and say how this

	will be met. It is the responsibility of the Transition Team to complete and have oversight of these assessments. **<u>Family Contact</u>** • For children in care or residential settings with serious medical conditions, a risk assessment regarding contact with family must be completed by the children's social work team before they reach 18 and feature in both the EHCP and Pathway Plan. For example, this information would be written in section H2 of the EHCP with the addition of the risk assessment attached. **The Transition Assessment prior to transfer should involve both the child/young person's key worker and Adults Health and Social Care**.
Recording	• Visits to the child/young person to be recorded within **48 hours** of the child/young person being seen. • Child in need minutes to be distributed to parents and professional network **within 5 working days** of the meeting. **N.B. A good child/young person's record should show what is happening and has happened for a child at any given time. The records should tell the story of a family and include concise summaries along the way so that the analysis, recommendations, and plan is clear. A child/young person's record needs to be written to and with the young person.**
Safeguarding protocol	• Significant/safeguarding incident to be recorded **on the day** of the incident occurring or the next morning on the following day. • Visit to child/young person to be recorded **within 48 hours** of the child/young person being seen or attempted to be seen. • Strategy discussion to be held **within 3 hours** for serious incidents and needs to be documented within the case file. • The IRO to be informed of any significant events. • Consideration to be given whether consultation or referral to LADO should be made.
Supervision/Management Oversight	**<u>Supervision</u>** • For children with open to the CWD service but not CP/LAC they are supervised **every 3 months**. • ***The exception to this is for*** Looked After Children, supervision would be recorded at a ***minimum every 8 weeks with MO every 4 weeks between supervision; and children subject to*** Child Protection, within Care Proceedings and Looked After Children until their

	permanence plan is made, supervision will be held ***Minimum of every 4 weeks.*** **<u>Management Oversights</u>** • Management oversight to be documented at any point of a case allocation to a social worker or practitioner. • Management Oversight to be clearly recorded at all stages of work with a child and there is a clear audit trail of decision making. • Management oversight to be evidenced following completion of key interventions or significant event such as Child and Family Assessment, Section 47 Enquiries, or any safeguarding incident. • Management oversight to be evidenced prior to the cessation of the Children's Services involvement.
Transfer process	• **Initial referral to be made at 14 years** old to the appropriate Adult Social Care Team. Of all the various pre-18 meetings that can occur, Adult Social Care prioritise EHCP Reviews. Adult Social Care will attend other meetings if capacity allows, and circumstances require. • Follow up checklist to be completed, by the referring team with the Children's Continuing Care (CCC) once the child/young person turns up 16 years old. • Adult's Social Care will be financially responsible for meeting Care Act Needs, from the age of 18 (providing the referral was sent in a timely way and any provision commissioned by Children's Services. • Children or young people with a positive CHC Checklist and / or any element of NHS funding will require a full Adults DST prior to transfer. • Introductory meetings to be arranged where relevant, especially if moving into minimal supported services/ universal services, e.g., an introductory, informal meeting with a GP for those moving from consultant to GP led care. • Opportunity to be given to the young person about building familiarity with adults' service. For example, holding joint or overlapping appointments, visiting adults' services with the key worker.
Transition plan	• Case workers from Children Services, SEND and Adults Social Care to ensure that there are clear multi agency plans defining each one's roles and responsibilities within the transition process. • Transition protocols and agreements to be drawn up and this should include the involvement of all agencies involved namely children and adult social care, children's and adult health, education, housing, youth offending, information, advice, and guidance services, supported employment services and leisure services.

Disagreement Resolution	• Professionals' disagreement for the child/young person's transitioning plan to be clearly documented within the plan as well as views of each professional involved. • A multi-agency resolution meeting to be held when and if needs be and this needs to be documented within the child/young person's file as well as views of all others. • Decisions from the annual Disability Resource Panel, for children that are allocated to a worker within the children with disability team, to be recorded on the child's records and outcomes to be shared with the family. • Any changes to the transition plan and or support package, must be shared with the child/young person, their family and the multi-agency and the rationale for such changes need to be documented within the transitioning plan as well as within the child/young person's case file. • The child/young person needs to have scope where they are able to raise concerns separately from parents and carers. • Family and carers to be given the opportunity to express concerns; to be supported to understand the implications of the Mental Capacity Act and there need to be plans in place to address concerns identified. • The views of the young person to guide parents and carers' involvement. • All partners to recognise that views of young people, their parents and carers can different but must be respected.

Practice expectations

A child / young person with disability or complex health needs has rights and those rights must be respected. Their rights are highlighted in numerous policies and procedures therefore when working with a child/young person with complex health needs, the worker needs to ensure that they have familiarised themselves with policies and procedures that underpin practice expectations.
A child/young person with complex needs may have limited ability to share their lived experiences to inform assessment, decision making or planning, therefore effort needs to be made by the worker to establish how best to complete direct work with them considering their abilities, their wishes, and feelings to ensure that their views are heard. This might be done through formal direct work tools or through informal direct work such as observations of behaviours, vocalisations, and gestures.
Practitioners will be knowledgeable about how best to communicate with children and young people. Records will clearly explain how best to support children and young people with limited verbal communication, and this should be documented in the child/young person communication plan.
Voice of the child/young person to be represented at all times and be reliable and truly reflective of their wishes and views and needs to be further evidenced in their cases and plans.

Every child/young person with complex needs to have a care plan and this needs to be regularly reviewed and updated. The care plan to be distributed to all involved.
Every child/young person to have communication and positive behavioural plans that are regularly reviewed and consistently implemented.
Every safeguarding incident to be reported, recorded, and dealt with timely by ensuring that safeguarding protocol is followed up.
Practitioners to understand that behaviour is in itself a form of communication and that behaviours that challenge may indicate distress and the need for support. Therefore, practitioner needs to be more professionally curious in understanding and interpreting the children or young people's lived experiences and behaviours.
Statutory visits to be completed timely and there should be a rational completed within the case file when this is not completed.
Management oversight to be evidenced following a reported incident.
Prior to transfer of a child/young person, key involvements, chronology, genogram and the case summary should be updated as well as the work completed, and outcomes achieved.
Joint visit to be undertaken by both the new and previous worker to the young person prior to the transfer.
Ensure that young people who will be moving into universal services in adulthood, are provided with information that is accessible and up to date to help them understand the universal, voluntary and community offer that will be available to them.
Assessment to focus on the child/young person's needs, how they impact on their wellbeing, and the outcomes to be achieved.
The child/young person to be involved in the assessment, their carers, where appropriate, their parents or someone they have nominated or an independent advocate.
Care plans and support to recognise, understand and respond effectively to a child/young person's racial, ethnic, and cultural background and this very essential for the child/young person development and wellbeing.
Practitioner to ensure that a transitioning assessment of the young person, who is likely to have needs when they turn 18 and this needs to be completed in a multi-disciplinary setting involving all the key professionals and family.
Records to be non-judgemental regarding the child/young person's disabilities, behaviours, and demeanour. The focus to be on what the child is able to do, rather than what they cannot do. Creative explanations will reflect on the meaning of certain behaviours and consider past involvement to inform assessments and analysis.
There needs to be an effective leadership and system in place which to promote the voice of the child /young person which is essential for a robust safeguarding ethos with an effective child/young person's centred culture.

Autism Awareness training is strongly recommended for all staff working with children/young people with autism. This training is therefore mandatory for any practitioner who is to work with children/young people with autism as staff are expected to undertake direct work with them and their families. Managers wishing to allocate a practitioner to a child/young person with autism must ensure that the practitioner has undertaken this training, and if not, the practitioner must undertake the training without delay before they meet with the child.
Where an admission to a residential placement for 38 weeks or more is being considered, children, young people and their parents should have access to advice and support through their jointly commissioned and suitably resourced local Special Educational Needs and Disability Information Advice and Support Service

3. Health

When a child/young person becomes looked after health assessments are carried out by a health professional and reviewed accordingly to the statutory guidance.

Timescales at a glance to access services from the Designated Nurse for Looked after Children Surrey Heartlands ICB	
Threshold	• There is no requirement for threshold criteria, however, the health team **must** receive the right referral form/information in accordance with Statutory Guidance and Surrey County Council local processes (Refer to the SCC process maps). • The consent documentation **must** be completed prior to the Health Assessment. Health Assessments - RHAs Map 2022.pd Health Assessments - IHAs Map 2022.pdf
Referral process	**Notification to Integrated Care Board (ICB)** • Once a child/young person becomes Looked After, the local authority needs to notify the ICB Designated Team of the new episode of care, any changes of placement and when the child/young person leaves the care system. This to include when a child/young person is adopted or subject to a Special Guardianship Order. **Initial Health Assessment Process (IHA)**

	• Children Services to make a referral to the Surrey Health Team **within 2 days of the child becoming Looked After**. The health team will then arrange **an Initial Health Assessment** which should be completed **within 15 working days** of receiving the referral from CSC. • For children placed out of county, the health provider team to liaise with the health local team of the child/young person's placement. **Review Health Assessment (RHA)** • Children Services to make a referral to the Surrey Health Team **4 months ahead of the expected date** of the RHA for children placed out of county and 3 months ahead of the expected date of the RHA for children in county. • For children placed out of county the health provider team to liaise with the health local team of the child/young person's placement.
Policy and Statutory Guidance that underpin practices.	• Promoting the Health and Wellbeing of Looked After Children (2015). • Working Together to Safeguard Children (2018) • S11 Children Act (2004) • S27 Children's Act 1989 • Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework NHSE 2019 • Looked After Children Knowledge, Skills and competences for health care staff: Intercollegiate Role Framework (2020).
Visits	**Initial Health Assessment** • The Initial Health Assessment is usually completed by a Paediatrician. This is a one-off holistic appointment in accordance with the statutory guidance. **Review Health Assessment** • **Children aged 0-5 years** – the allocated health professional will see the child during the child's review of their health assessment (RHA) that takes place **every 6 monthly**. • **Children/young people aged 5-17 years** – the allocated health professional will see the child/young person during their review of their health assessment that takes place **annually**.
Voice of the child/young person	• In accordance with the statutory guidance, health professionals have the responsibility to ascertain and respond to views of a child/ young person and work with carers and family members who know the child/young person best.

	• The assessment is holistic to the child/young person's needs and wishes. • Views, feedback, wishes and feelings of the child/young person is captured within the assessment. • In order to ensure that children/young people's assessment is personalised to them, health professionals are currently moving towards writing the assessment to and with the child/young person.
Meeting	• The allocated health professional for the Looked After Child can attend the Looked After Initial or Review meeting if s/he is invited by the IRO or with the agreement of the child/young person.
Recording	• Information gathered is recorded within the child/young person's confidential health record in the Children's Community Health Services Provider Trust IT system. • The allocated health professional shares the child/young person's assessment with them, their social worker, and the GP.
Safeguarding protocol	• Safeguarding concerns that are identified during a health assessment/ contact are discussed with a senior colleague and a referral is made to the Surrey CSPA/MAP/LADO in accordance with SSCP Multi-agency Safeguarding Children Procedures. **BE CURIOUS – QUESTION EVERYTHING – EVIDENCE – IMPACT – OUTCOMES**
Supervision/Management Oversight	**Initial Health Assessment** • Medical doctors are offered quarterly supervision and peer review. **Review Health Assessment** • Named Nurse / Specialist Nurses for Looked After Children / Health Visitors, School Nurses are offered quarterly supervision.
Transfer process	• Health History is discussed sensitively and in detail with the young person at the final RHA prior to the young person turning 18 years of age. • Specialist Nurses for Looked After Children team to liaise with social workers and PA's when and as needed (as soon as a PA is identified)
Transition plan	• Health professionals identify the transition needs through the Review of the Health Assessment process and required actions form the health recommendations within part C of the RHA report, which the social work team need to incorporate into the Child/young person's Looked After Children Plan and Pathway plan for Care Leavers.

Practice expectations
The IHA/RHA sets out detailed health recommendations for the child and must be transposed into a child's Care Plan by the child's social worker and monitored for completion, and Pathway plan for Care Leavers.
The child's social worker in conjunction with the Independent Review Officer are expected to ensure that the health recommendations are incorporated into the child's care plan and monitor that they are carried out in accordance with the IHA and RHA report.
Each child's health needs will be unique to the individual child and the health recommendations will state who is the most appropriate carer/social worker/ health professional to complete each recommendation.

4. SEND (Inclusion and Additional Needs)

A child / young person has Special Education Need (SEN) if they have a learning difficulty or disability which calls for special educational provision to be made for him or her.

Timescales at a glance to access services from Special Educational Need or Disability (SEND Inclusion and Additional Needs)	
Threshold	• Should you have a concern about the development and/or learning needs of a child/ young person from 0 to 25 years old in Surrey, the first point of contact will be the **Learners' Single Point of Access (L-SPA)** who will be able to provide the required information on how to access services for children and young people (CYP) with Special Educational Needs and Disability (SEND) in Surrey. • A dedicated L-SPA call centre is available from 9am to 5pm, Monday to Friday (except Bank Holidays) on 0300 200 1015. Alternatively, you can complete the LSPA via rfs@surreycc.gov.uk where you will be able to gather advice. • All schools and educational provisions are expected to apply the Ordinarily Available Provision Ordinarily available provision (schools) | Surrey Local Offer. If this fails then you can apply for an EHCNAs which uses the following criteria Mainstream banding SEND framework (surreylocaloffer.org.uk)

	• If you wish to submit a Request for an EHC Needs Assessment, please use the Request for Assessment forms published on the Local Offer.  Amended-RTA-form-Professional-July-22 ( consent-for-statutory-assessment (1).pdf  learners_request_for_support_document.pd  OAP-checklist.pdf Transitions referral: Transition Referral Form blank.docx
Referral process	• The referral process is outlined in detail on the Surrey Local Offer Learners' Single Point of Access | Surrey Local Offer **Request for support pathway** • The Request for Support pathway allows professionals to access advice around complex problems likely to have an impact on the CYP's attainment, attendance, or progress. **Request for Support form** Practitioners in Surrey can access the Request for Support pathway by filling out: ▪ the **Learners' request for support document**; and ▪ the **Consent to share information form**. The above forms should then be submitted along with any other supporting documents, by using the **Request for support online form** portal. **What happens next?** • You should expect an initial response to your query within 72 hours. • Submitting a Learners' Request for Support provides access to a wide range of professionals, including Occupational Therapists, Specialist Teachers, Speech and Language Therapists, Educational Psychologists and a Qualified Social Worker. **Request for Statutory Education, Health and Care Needs Assessment** • Occasionally, children and young people's needs are so complex that a statutory assessment of their Education, Health and Care needs may be appropriate. • If you are a professional or practitioner working with CYP in Surrey, you can use the L-SPA to **submit a request for Statutory Education, Health and Care Needs Assessment**.

What happens next?

- Once the form is submitted, multi-agency professionals from LSPA will review the request and make a recommendation whether a statutory assessment is required, based on the child or young person's needs.
- The outcome will be provided within **six weeks** of the request being made.
- Should a decision be reached that a statutory assessment is not required, SEND will always provide specific and individual reasons for this, as well as signposting the user to services that may be more appropriate.

Way Forward meetings

- A Way Forward meeting will be called between families and LSPA professionals to discuss how best to support a child/young person with SEND going forward when an EHC Needs Assessment has not been agreed. The Way Forward meeting will offer a forum for everyone to work together to create **a Way Forward Plan** that supports the child /young person to make progress and thrive.

- The meeting is voluntary for parents and do not prevent them from accessing **mediation or their right of appeal**.

Timeline for the Education, Health and Care (EHC) needs assessment process.

The Education, Health and Care (EHC) needs assessment process starts the moment Surrey County Council receives the request to carry out an EHC needs assessment.

It ends when the local authority:

- decides not to carry out an EHC needs assessment; or
- carries out an EHC needs assessment, but decides not to issue an EHC plan; or
- issues a finalised EHC plan.

The process for the completion of an EHC needs process should take no more than 20 weeks.

Detailed timeline of what happens at each stage of the EHC needs assessment process:

	 Information regarding what is expected to take place can be find out in the links below: ▪ Week zero to six ▪ Week 7 to 12 ▪ Week 13 to 16 ▪ Week 17 to 20
Policy and Statutory Guidance that underpin practices.	• Special educational needs and disability code of practice: 0 to 25 years (2015) • Working Together to Safeguard Children (2018) • Keeping children safe in education 2023 • Care Act 2014 • Children and Families Act 2014 • Education Act 1996 • Equality Act 2010 • First-Tier Tribunal (Special Educational Needs and Disability) • Office for Standards in Education (Ofsted) • Pathfinder Information Packs • Special Educational Needs (Personal Budgets) Regulations 2014 • Special Educational Needs and Disability Regulations 2014 The Children Act 1989 guidance and regulations Volume 2: care planning, placement, and case review. • The Children Act 1989 guidance and regulations Volume 3: planning transition to adulthood for care leavers
Reports	• Advice and reports may be requested and obtained from the following professionals: Educational Psychologist Paediatrician/GP Social Worker (if applicable) Other professionals involved with the child, for example, a Speech and Language Therapist or a CAMHS professional. • SEND will provide an Education and Health Care Plan (EHCP)

Visits	If the LA agrees to undertake the EHC assessment: • A SEND Officer will seek written advice from parent/carer and the child/young person. • The educational setting will be asked for updated information since the initial request. Advice will also be requested from: • Educational Psychologist • Paediatrician/GP • Social Worker (if applicable) • Other professionals involved with the CYP to include a Speech and Language Therapist or a CAMHS professional. This may require in-person visits. These visits can be in the range of one visit to assess to a block of weekly visits.
Voice of the child/young person	• The EHCN assessment is holistic to the child/young person's needs and wishes. The voice of the CYP is always captured within the assessment precisely within the "One Page Profile". • Assessment will be written to the child/young person so that it is personalised. • CYP are encouraged to attend and participate in review meetings.
Meeting	During the Education Health & Care Needs Assessment (EHCNA) process, several meetings are held to gather information though assess the needs of the CYP. These may include: • Governance Panel meetings will decide if the EHCNA is agreed or not. • Way Forward meeting – if it is a no to assess. • If 'Yes to assess' there may be a variety of meeting with or between professionals. Once an EHCP has been finalised there will be an **Annual Review** meeting held. Interim Review meetings can be held, if required.
Recording	SEND records all data on the EHM/EYES system and all reports are uploaded onto Wisdom.
Supervision/Management Oversight	Case Officers (CO) have regular (monthly) reflective supervision.
Safeguarding protocol	• Staff are expected to adhere to the SCC Code of Conduct /Staff Behaviour Policy. • Any identified safeguarding concerns is recorded (with date, time and signed) following with a discussion with a senior colleague or designated Safeguarding Lead and, if required, a referral is made to the Surrey CSPA/MAP/LADO in accordance with SSCP Multi-agency Safeguarding Children Procedures.

Transfer process	**Transfer between Local Authorities** • Final EHCP and annual review is shared with the Surrey SEND team from the transferring out Local Authority. • The Case Officer (CO) puts the case to EGB panel seeking agreement to adopt the EHCP to a Surrey format. • CO transfers the other LA plan over to a Surrey template. • The CO holds a co-production meeting to discuss the context of the plan. • The CO consults with provisions. • The CO issues the final EHCP.  EHCP-Annual-Review -template-v9.6 (1).pdf **Transfer between the key stages of the CYP's education** When a CYP is moving between the key stages in their education such as between: ▪ early years education to school ▪ infant to junior school ▪ primary to middle school ▪ primary to secondary school ▪ middle to secondary school ▪ secondary school to a post-16 institution Discussions need to begin early, preferably in **the Autumn/Spring term the year before transfer** to allow plenty of time for the process to happen. For example, for a child transitioning to Secondary school, their transition review will take place in **the Autumn/Spring term of Year 5.** The SEND Case Officer will usually attend the meeting and paperwork should be submitted to the LA as soon as possible following the meeting, as detailed in the annual review process. For those transferring from secondary school to a post-16 institution, the **EHC plan must be reviewed and amended by 31 March in the year of transfer**. For all other phases of transfer, the deadline is **15 February in the year of transfer**. When a young person is already attending a post-16 institution and it is proposed that they move from one post-16 institution to another at any time, the LA must review and amend the EHC plan at least five months before that transfer takes place. **Transition to adulthood** Whilst preparation for Adulthood happens from the earliest years The Transition Review Meeting in Year 9 marks the start of planning for

	the young person's transition to adulthood. This means thinking about what they would want to do when they leave school at **age 16+**. Children and young people with an Education, Health and Care Plan (EHCP) will have **a review meeting every year** throughout their time at school or college to check that the support they receive is still appropriate and effective. The Transition Review Meeting in Year 9 marks the start of planning for the young person's transition to adulthood. This means thinking about what they would want to do when they leave school **at age 16+**, including: ▪ Their next steps in education, as all young people must remain in education, employment or training until age 18. ▪ Training and employment opportunities. ▪ Becoming more independent, including where they will want to live. ▪ Being part of their community (friendships, sport and leisure). ▪ Qualifications and skills they will need to achieve their goals. ▪ Health pathway, including a review of factors relating to their health. Review meetings will continue to be held as the young person moves through their school and college years. EHC plan reviews must be person-centred, which means the young person's aspirations for the future will be key considerations for every decision made. The young person should be helped by their SENCO or teacher to prepare for how they would like to share their hopes and goals for the future at their review meeting. **Preparing for Adulthood: What to think about and when? Year 9 (age 13/14)** https://youtu.be/xqedqf1mg0g Transitions referral: Transition Referral Form blank.docx
Transition planning	The transition needs are identified through the Annual Review process and actions will form the education recommendations within the report. It is the allocated Case Officer's responsibility to ensure recommendations are incorporated into the Child/young person's plan. EHCP-Annual-Review-template-v9.6 (1).pdf For CYP moving from school to college/Post 16 provision they are responsible for applying directly and securing a placement. This may include completing an application form and having an interview. The

	LA will also approach the setting to establish whether they can meet the CYP's needs. **Preparing For Adulthood** **https://www.surreylocaloffer.org.uk/young-people/education-and-training/next-steps** **Accessing post-16 education support** Schools work with post-16 education providers to ensure the young person experiences a smooth transition to college, training or employment focused education. This should first be planned in the young person's Year 9 Transition Review Meeting and at subsequent reviews until the move. The ways that the school may help the young person to prepare for moving to a post 16 education provider can include the following: ▪ Taster sessions. ▪ Discussions between the SENCOs at each provider to ensure the young person's needs are understood. ▪ Link Courses at post 16 education providers before leaving school. These are to assist in transition planning, vocational tasting, and shared understanding of need. If the young person has an Education, Health, and Care (EHC) plan, this will be with them until they achieve their identified learning objectives, leave education or training permanently or turn 25 years old. The support outlined in their plan must be fulfilled by their Post 16 education provider, such as a further education college. Post 16 education providers have similar responsibilities to schools to provide reasonable support to young people with special educational needs, including when they do not have an EHC plan. This could include access to a teaching assistant, specialist teachers, one to one support, therapy input, independence skills and adaptations to resources or technology to make them more accessible. If a young person arrives at a post 16 education provider and is assessed to need more support than they could usually provide, the post 16 education provider can request an EHC needs assessment, up until the young person achieves their learning objectives, leaves education or training or turns 25 years old (whichever happens first). **Surrey County Council your transition guide to local post 16 education, options, and support:** **https://www.surreycc.gov.uk/children/support-and-advice/families/send-support/send-support-document/your-transition-guide-to-local-post-16-education-options-and-support-services#section-1** **Surrey County Council Preparing for adulthood booklet: https://www.surreylocaloffer.org.uk/young-people/preparing-for-adulthood/booklet**

	Refer to the Preparing for Adulthood year 9 review document: https://councilfordisabledchildren.org.uk/sites/default/files/uploads/attachments/Year%209%20Annual%20Review%20Guide.pdf

Practice expectations
Practitioners to ensure that the Code of Practice is followed. The SEND code of practice state that annual reviews must happen once a year for all students with an EHCP. For children open to Social Care, the Social Worker must be included in the annual review of the EHCP. Children's Social Workers should attend or provide a report to the meeting if they cannot attend. (Where risk assessments are required i.e. residential students where safeguarding concerns are present for family contact, this must be updated within the review and shared with any placement arranged by the leaving care service, SEND or adult social care to ensure that the assessment is kept up-to-date and used to devise safely plans for contact.
Practitioner to ensure that SCC CP & Safeguarding Policies are followed.
'Lived Experiences' and 'Pupil Voice' will be acknowledged, reported on, and used.
Collaboration between agencies

5. Care Leavers Service

Care leavers are young people aged 16-25 years old who have been in care at some point since they were 14-years old and were in care on or after their sixteenth birthday. These young people are statutorily entitled to some ongoing help and support from the local authority after they leave care.

Timescales at a glance for Care Leavers services	
Threshold	• The young person must have been looked after to be entitled to access services from care leaver services. S/He/they must have been looked after by children's services for a period of 13 weeks since the age of 14. • The young person is currently looked after. • Relevant child/young person aged 16 or 17 but they must have been looked after for a period of time after their 16th birthday. • Former Relevant Child aged 18 and 25 previously an eligible child and or a relevant child. • Qualifying care leaver aged between 16 and 25, *Looked after by children's services on, or after, their 16th birthday and no longer looked after, spent less than 13 weeks in care since 14th birthday, i.e. do not fulfil criteria for eligible or relevant child.*
Referral process	• The allocated case worker, PA makes the referral
Policy and Statutory Guidance that underpin practices.	• Surrey Practice standards • Working Together to Safeguard Children. • Care Standards Act 2000 • Care Leavers Regulations • The Children Act 1989 Guidance and Regulations • Care Planning guidance Doc
Visits	• *Visit to care leavers takes places **every 8 weeks**.* • *Workers to refer to Guidance Template for Recording 2-way Contact / Visits with Young People on LCS: cls-visit-template-updated-july-2021-final.pdf (proceduresonline.com)* • **At least every 8 weeks** and should be face to face. • **At least 4 visits a year** when the young person is 16, and to be increased during their 17th year. • **Visits agenda to be considered:** ❖ Reason for involvement ❖ Purpose of visit? ❖ Who was present? ❖ Was the young person seen alone? If not, why not? ❖ Observations

	❖ YP's views/ what does the YP understand of why we are involved and what life is like for them? ❖ Significant events since last visit. • **SW to provide an analysis** of the information gathered during the visit (**identify strengths, needs and risks, what has been achieved and what needs to be achieved and by when**)
Voice of the child/Young Person.	• PA to ensure that young person's wishes and feelings fully shape and inform their care plans. • PA to ensure that recording is written with and to the young person in the first person. • PA to ensure that the young person's voice is evident in their plans. • Young person to be clear about the support they can receive from their Personal Adviser. • Young people to feel well supported in their transition to independence and are aware of their eligibility. • PA to ensure that direct work with the young people considering their communication ability and level of understanding, using appropriate tools. This to include creative methods of ensuring age appropriate and purposeful interaction. • Young person is seen regularly and in accordance with statutory guidelines. • Advocacy services is actively encouraged when appropriate. • Life story/journey work completed with the young person prior to the young person's majority.
Meeting	**<u>Pathway plans</u>** • To be completed **every 6 months** or updated if significant changes occur. • **Reviewing risk management meeting** (RMM) to be arranged for care leavers placed in and outside of Surrey who are at risk of exploitation. An Adult social care and Police safeguarding lead need to attend this meeting. Practitioners to ensure that information from relevant professionals and treating clinicians is gathered and informs the meeting. • **All relevant professionals and treating clinicians are invited to reviews of pathway plans.**
Recording	• Every young person's pathway plan to be shared with the young person and should be recorded in their preferred method and in a language that they understand. • There needs to be evidence in all records of the beginnings of a 'my diary' approach to recording.
Safeguarding protocol	• If a safeguarding incident happened or suspected, this needs to be reported to PA who in turn needs to discuss with the TM immediately.

	• A multi-agency discussion will need to take place without any delay, to increase the quality and volume of information in order to inform Intervention Meetings. • Reviewing risk management meeting (RMM) to be held in order to tailor a safety plan and ensure that the young person is immediately safeguarded. • RMM lead to request an Adult social care and Police safeguarding lead to join RMM for discussions on care leavers, single point of contact. • Risk assessments should be completed by the PA according to need, but at minimum updated every six months alongside the Pathway Plan. If there is a significant change in circumstances the Pathway Plan and risk assessment will both be updated. Risk assessments will include information from partner agencies to ensure that all risks and needs are fully understood and analysed. • For individuals within the Leaving Care Service, who live in a residential setting, must have a risk assessment completed by the setting when there are overnight stays or planned trips away. This must be jointly understood (setting professionals and Leaving Care service) and monitored within the pathway plan. • The information related to the risk assessment would need to be updated within the H2 section of the EHCP and risk assessment attached. The PA to work with SEND officers to ensure this information is clear and updated at the annual review. • For young people with complex health needs, Personal Advisors must update their own knowledge of the health concern to ensure they are able to respond appropriately. It is also the responsibility of the Personal Advisor to call a meeting if emerging health needs develop to address planning and the response of the multi-agency network and wider family, where applicable.
Supervision/Management Oversight	• All young people open to care leaving services to have an initial allocation management oversight case note recorded. • Following this, the practitioners are to be provided regular supervisions for every young person that they are assigned to work with.
Transfer process	• *From CLA to Care Leavers, Young people will be allocated and introduced to their Personal Advisor (PA) at 16. This will enable care leavers to get to know their PA earlier and develop trusting relationships.* • *SW and PA will work together till the young person reaches 18 where the PA will take over as the key worker.*
Transition plan	• Any transfer of support of young people should take place in a planned and managed way and this should include:

	• A shared commitment from Children's Services and Housing Services to adopt a 'corporate parenting' approach for looked after children and care leavers making the transition to adulthood. • There needs to be clear roles and responsibilities for supporting the transition from care, including the role of the PA. • Full range of potentially suitable supported accommodation options in the area. • Pathway planning systems that anticipate accommodation needs. They should engage each young person, their PA and housing services staff regarding suitable housing options and any additional support needed, so that the necessary arrangements are in place at the point where the young person is ready to move on from their care placement. Subsequent moves should also be carefully planned. • Arrangements to offer care leavers in need of social housing reasonable preference on welfare grounds through local housing authority allocations schemes. • Contingency planning arrangements for when placements are at risk or break down, led by PAs working with accommodation providers, housing options teams and other support services. • Planned access to accommodation and support for care leavers who will need accommodation on release from custodial institutions. • Ensuring supported transitions to adult services where needed, such as adult social care, adult mental health services, substance misuse services and the Probation Service.

Practice expectations
Ensure that all relevant or former relevant young people have an appointed PA who will then plan and coordinate their plan. The PA will need to establish a rapport and act as the focal point to ensure that care leavers are provided with the right kind of personal support. All care leavers should be aware of who their PA is and 24 how to contact them, so that throughout their transition to adulthood they are able to rely on consistent support from their own key professional.
The aim of the service is to support care leavers so that they can live successful independent lives. Each care leaver will reach that point at a different age. It would be expected that support for care leavers will taper away over time, in recognition of their growing maturity and independence.
When a young person becomes eligible, they will be allocated to the care leavers service. A personal advisor will be allocated to a young person when they are 16 years old. The personal adviser will work alongside the young person's social worker in preparation for when the young person turns 18 years old.

The personal adviser will attend looked after child reviews and personal education planning meetings to build a relationship and get to know the young person. They will find out how the young person would like to be contacted. There will be a flexible approach to supporting the young person.
PA 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 into adulthood.
The pathway plan will be developed with the young person, using their language so that it is a supportive document that speaks to the young person. It will be written with the young person in mind, including the support that has been offered. It is a legal document, and it is important it is completed within timescales. The risk assessment will be updated alongside the pathway plan.
A team around the person approach to review a young person's pathway plan is taken. This approach includes all professionals working with the young person and ensure that they are invited to statutory reviews and consulted with when necessary to inform risk assessments or mental capacity assessments.
The team manager should approve and sign the pathway plan timely and this should be shared with the young person and a copy given to them.
Every young person will be supported to be in some form of education, employment, or training. Children who are not, will be supported additionally by a referral to the education and employment specialist within the care leavers service.
Young people will be supported and encouraged to be independent and move forward with their lives by the care leavers service. The service will keep in touch with young people until they are 21, or 25 if they should wish.
Preparedness for independence to start earlier when young people are living with their foster carers or residential keyworkers, incrementally developing the skills required for independence.
Pathway plans to include contributions from partner agencies working with care leavers, providing a more holistic understanding of needs.
Any new issues arising after a significant incident will be understood and as required relevant support can be implemented. There will be a current understanding of a young person's circumstances which informs the PA and other professional's interventions.
PA to understand the needs of the young person, be committed to the development of good relationships and undertake skilled work which instils a sense of belief in our care leavers and hope for their futures.
Care leavers to continue to benefit from a dedicated mental health practitioner and services which promote emotional wellbeing.

6. Continuing Care

According to The National Framework for Children and Young People's Continuing Care 2016 stipulates that 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.

Timescales at a glance	
Threshold	• All the children /young people who have accessed support from Children Services, SEND and Early Help and who may need support from the National Health Services in their transitioning to adult services.
Referral process	• Referrals are made into the ICB for review and consideration of Childrens Continuing Care. • If CCC referral forms are required these will be sent out by the ICB. The CCC Team assists Children's Services, SEND and Early Help with the referral process to the National Health Services (NHS).
Policy and Statutory Guidance that underpin practices.	• National Framework for Children and Young People's Continuing Care (publishing.service.gov.uk)2016 • National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care - July 2022 (Revised) (publishing.service.gov.uk)
Visits	• The Children's Continuing Care Team do not undertake regular visit to children/young people. • Once a referral is received, the Clinical Case Managers will visit the young person as part of the assessment even though this could also be done virtually. • If the young person meets CCC's eligibility criteria this will be reviewed on a yearly basis, so another visit maybe made. • A visit can also be made if there is a change or deterioration of a young person's health condition.
Voice of the child/young person	• The views/wishes and feelings of the child/young person is considered as part of the initial assessment. Child Young Person would be seen, and their views incorporated into the assessment where appropriate.
Meeting	The Children's Continuing Care Team attends: • Commissioning Panel. • NHS CYP CC Eligibility Panel which takes place twice monthly. • Team meetings in social care when needed.

	• Education when needed. • Weekly referral meeting attended by Clinical Case Managers.
Report	• The CCC team uses data to report on the number of referrals received and their progress, compare data between different services and departments over a chosen period, analyse changes in contributions from Health and unmet need and share this information with senior managers.
Safeguarding	• The ICB CCC team would work with ICB and LA children's safeguarding designates to support any investigation. Such as attending meetings, sharing intelligence etc. • If any of the team became aware of or had suspicion of any concern, they would raise a safeguarding alert via local processes and alert the ICB children's safeguarding team if there are specific health concerns.
Recording	• The CCC team to records any involvements on LCS, on own Children's Continuing Care headings. • The CCC team uses Health Reclaims Master Sheet to keep track of the children with health conditions and provide reports to colleagues when needed. • The CCC team uploads referrals and assessment outcomes on Wisdom.
Supervision/Management Oversight	• Supervision is given by the Head of Continuing Care **once a month.** • Group supervision is **held quarterly** with the social worker. • **Weekly** meetings are held for both Children and Adult Leads.
Transfer process	• The transfer **process begins from the age of 16** by the adults Continuing Health Care process and by the Team's Specialist Lead who advises on Transition to adulthood services. **The process should be completed by the age of 18th**. • Referrals to adults to be overseen by colleagues in Adults' Continuing Care Team.
Transition plan	• This will be developed within the all-age continuing care team
Disagreement Resolution	• There is no disagreement resolution in place. • The CYP CC Policy and joint funding protocol are currently in draft.

Practice expectations
The CCC team to work with all departments to ensure that all children who have additional health needs that cannot be met by universal and specialist services are brought to the attention of the ICB. This can be via the CYP CC referral or conversations with the ICB facilitated by the CCC Team.
The CC team to support colleagues to be clear about the legal limitations placed on the local authority and that each agency is meeting their duties in the transition process.
The CCC team to ensure that therapies and any registered nursing intervention are included and overseeing the care workers and the care delivery.
The CCC team to collect data about children with health contributions and monitor the progress of the referral.
The CCC team to participate in discussions about the strategic overview of children with complex health needs and share their expertise and experience to promote better outcomes for children and young people with complex health needs.
The CCC team to identifies potential referrals through a range of sources such as from the individual case discussions, panels, team, service, and management meetings or directly from the ICB.
The CCC team to be involved in complex meetings about children who have high health needs and advise on the correct pathway for receiving support from the NHS.
Should the CCC team becomes aware of any safeguarding issues this will need to be shared promptly with the relevant partner agency.
The CCC team to ensure that the referee is advised in a timely manner to prevent any delay in the transition process.
The CCC team to ensure that information is recorded promptly and accurately on the young person's file.

7. Commissioning

The purpose of the Additional Needs & Disabilities Commissioning team is secure appropriate decisions for children and young people with education, health and care plans (EHCPS), secure decisions about placement requirements and maximise the use of resources for children and young people with an EHCP living away from home who may require internal or external provision to meet educational, care or health needs, or a combination thereof. This includes securing Non-Maintained Independent Provision (NMI) for 38-, 42- or 52-week placements.

The commissioning team works closely with Gateway to Resources (Children's social care), Adults transition team and health as part of a multi-agency response.

Timescales at a glance	
Threshold	Children who are looked after, with an Education, Health and Care Plan (EHCP) and placed in a day, 38-, 42- or 52-week residential placement often Non- Maintained Independent (NMI) settings. The Arrangements Surrey Children Care has in place to monitor the quality and safety of placements made cover the following external (non-Surrey CC managed) settings: • Non-maintained Independent (NMI) Schools (education only and residential) • Residential Children's Homes • Independent Foster Agencies (IFA) • Supported Accommodation Provision
Referral process	Placements in these settings are made through Gateway to Resource (GtR), Resource Allocation Team and SEND Admissions / SEND Placements. Unless a placement in a different geographical location is requested then the principle applies that a child/young person's current educational placement will continue where a placement type different to a residential school is being requested – i.e., Fostering, Children's Home, Supported Accommodation. Where it is not possible to identify a social care placement that enables a child/young person to continue in their current educational provision then it would be the responsibility of the child/young person's social worker to ensure that the process for identifying an appropriate education placement is identified. When a suitable educational provision is identified, the social worker will be made aware so that this resource is known to SEND colleagues. This would involve liaison with the CYP's SEND Case Manager, SEND Admissions Team or SEND Placement team and the Joint Commissioning Panel (JCP) process.

	A list of all children who have been referred to the Gateway to Allocations Team is sent on a weekly basis to the Virtual School so that they are informed of likely changes of placement that may impact upon a child/young person's school placement. Where a residential school has been identified by the SEND Placements/Admissions Team it is the responsibility of the allocated worker to ensure that the Gateway to Resources Allocation Team is aware of this provision. This is in order that 'due diligence' can be undertaken on the residential aspect of the provision. This would always involve reviewing of the latest full Ofsted inspection report and any subsequent monitoring visit reports along with the Statement of Purpose and the last 3 Regulation 44 reports. In the circumstance where the provision does not currently have any Surrey children/young people living within it or the last child/young person living there was more than 6 months ago then safeguarding policies including the safer recruitment policy are requested along with details of staff training. References would be sought from 2 local authorities of children / young people living in the home or recently left. An in-person visit to the home would be undertaken prior to a child/young person moving in to review the accommodation; to ensure that the required framework of policies, procedures and processes is in place and to ensure that the home is able to meet the needs of the child /young person.
Policy and Statutory Guidance that underpin practices.	• Section 22(3) of the Children Act 1989 sets out the general duty of the local authority looking after a child/young person to safeguard and promote the welfare of the child/young people. Children Act 1989, Section 22 • Applying corporate parenting principles to looked-after children and care leavers; Department for Education February 2018). • Applying corporate parenting principles to looked-after ... • Regulation 44 of The Children's Homes (England) Regulations 2015 The Children's Homes (England) Regulations 2015
Reports	• Children's Cross Regional Arrangements Group (CCRAG) Quality Audit reports • Regulation 44 visit reports • Required QA documentation (Link)
Visits	Commissioning are part of the wider Children's Cross Regional Arrangements (CCRAG) Group; a collective of 30+ local authorities working together The CCRAG monitoring procedures allow 1 local authority to visit a provider to undertake monitoring and share their findings. This

	allows providers to focus on the young people in their care rather than having numerous monitoring visits from commissioners in addition to visits from Ofsted and regulation 44 visitors. The CCRAG monitoring procedures (referred to as Quality Assurance Monitoring) involve the allocation of all NMISS and Children's Residential Homes used by 2 or more of the local authority across the participating regions, to a link local authority. • Each link local authority undertakes monitoring tasks (Quality Assurance Monitoring visits) with its allocated providers on behalf of the other local authorities using a standard form. • Where 2 or more partner local authorities have placements, visits will be allocated to the local authority whose Head Office is closest to the placement address. • Where 1 local authority in the CCRAG partnership has a sole placement with a provider, that provider will automatically be the link local authority but be under no obligation from CCRAG to carry out a monitoring visit. • However, local authorities often undertake monitoring visits to their sole placements, and where this is the case that local authority is encouraged to use the partnership's forms (Quality Assurance Monitoring Form) for the monitoring and submit this for inclusion on to the CCRAG Providers Database. • Sharing of this information is facilitated through a web based regional database known as the CCRAG providers database. Local authorities are requested that where a provider has not registered on the providers database, they take all necessary steps to encourage the provider to register their establishment.
Voice of the child/young person	All CCRAG QA reports allow for the capture of the experiences of children and young people at the setting. CCRAG visits are expected to – where appropriate – ensure they capture the views of the child/young people placed.
Meeting	• Provision(s) are reviewed via the CCRAG Allocation and QA Monitoring process.
Recording	• Risk Assessment Tool (RAV)

	• Quality Assurance reports (CCRAG) are uploaded to the CCRAG portal following signed return from the provider. • Non- Maintained Independent QA Steering Group – "Settings causing concern". • Commissioning provider risk & issue log.
Supervision/Management Oversight	• Non- Maintained Independent QA Steering Group – settings causing concern monitoring list. The NMI QA steering group is comprised of multi-agency partners across health, education and social care (including LADO representation). • The Resource Review Team and Additional Needs & Disabilities commissioning team hold a database detailing provider concern. Any concern raised against a provider is recorded within the database. These concerns may come from a variety of sources including directly from social workers/ team Manager; from LADO; from quality assurance visits; from Ofsted inspection reports and from the contract/ accreditation visits undertaken through the frameworks that Surrey Children Care are part of. If wider concerns are identified, a meeting with the provider is arranged. As part of the meeting with the provider the Team Manager or commissioning team member will always consider whether they concern could be systemic in nature and consider the impact for all children placed with the provider. Dependent upon the seriousness of the concern an unannounced or announced visit may also take place. • The Team Manager or Commissioning lead reviews this database monthly and ensures that all concerns have been addressed and that these are accurately recorded on the spread sheet. Patterns and themes are also reviewed as part of this monthly review. • All concerns are added to the CCRAG RAV Tool. This would have an impact of the rating of a provider and may trigger a visit needing to take place. • All authorised CCRAG reports are reviewed by the service manager and provider for approval.
Safeguarding protocol	• Where an immediate concern is raised (and the setting is located within Surrey), the first point of notification is often the Local Area Designated Officer (LADO). Where notifications are made outside of surrey, the relevant out of area LADO will contact SCCs dedicated safeguarding lead and/or LADO service. • If the incident raised occurred within Surrey, the Health and Social Care allocated worker(s) in Surrey are notified OR the concern is raised via the Children's single point of access (C-SPA) who notify relevant involved individuals / teams.

	• In some circumstances, concerns may be raised directly by parents to the Local Authority. Where this is the case, identify commissioning and/or QA leads may meet with the parents to establish the nature of the concern. • A lead individual is identified in Surrey to co-ordinate activity relating to the response, including notifying other local authorities if children are placed within the setting. • Dependant on the nature of the concern, OFSTED are notified and/or other relevant parties (such as the police if such a response is warranted) • A Quality Assurance (CCRAG) visit is arranged (which may be announced or un-announced) • SEND, Social Care and Health work jointly to share information (often at the multi-agency Quality Assurance (QA) NMI Steering Group) to co-ordinate response. Options may include placing an immediate pause of current or upcoming placements or providing options for parents to request an alternative setting.
Transfer process	• In-Year SEND placement – where a child or young person with an EHCP requires a change in placement (for example, as a result of placement breakdown or change of need), In-Year SEND placements team source appropriate provision that meets the need of the individual. Where a provision has existing concerns raised (for example, via a previous CCRAG report or identified within the risks and issues log), alternative placements are identified. Provisions consulted must be DfE registered.
Transition planning	• Key Stage transfer -where a child or young person with an EHCP approaches a change in key stage (for example, primary to secondary, secondary to post-16), the SEND Admissions team co-ordinate placements. These are sourced similarly to those in the In-Year SEND Placement team.

Practice expectations
Where it is not possible to do the visit in person then a virtual visit will be undertaken. Where it is not possible to undertake a visit prior to a child moving in then this will be undertaken within one month of the child moving in
No individual with looked after status should be placed in an educational setting inspected as “Inadequate” or “Requires Improvement”.
On-going monitoring of residential schools is undertaken jointly between SEND and Gateway to Resources (GtR) with GtR focusing upon the residential aspect of the placement.

Commissioning work in partnership to improve overall quality standards and outcomes for young people in care.
Working with the market to provide quality up to date information on individual service providers/provisions and improve sufficiency.
CCRAG allocated services must be risk assessed (colour co-ordinated). SCC utilises Best Practice - risk assessing all placements to ensure young people are safeguarded.
Details of all providers where Surrey CC have a child/ young person placed are inputted into the Risk Assessment Vehicle (RAV) tool. The tool will then provider a score for providers dependent upon certain factors such as Ofsted rating, concerns, date of last visit. Where the score is 8 or higher than a planned visit will be undertaken to the provider.
Unannounced visits will be undertaken to providers where concerns are raised that would indicate that an unannounced visit would be appropriate to fully understand the scale of these concerns.

8. The Transitions Team

The transition team support young people who have been identified as requiring continuing support and or care management into adulthood. The transition process starts at the earliest possible opportunity, ideally from the age of 14. Involvement in the transition planning process is not a guarantee of service in adulthood as the eligibility criteria of each adult agency will need to be met, but all partners will work together to ensure that the young person and their family and carers will receive the most appropriate service to meet identified needs.

Timescales at a glance	
Threshold	• Only referral from professionals is accepted and this needs to be done when the young person is **aged 14 and must be made by the age of 16 at the latest**. Nintex Workflow Cloud • The Transition Teams are one of the Adult Social Care Teams in Surrey. The Transition Team are a specialist Adult Social Care Team and, as such, they can only accept new referrals: ➢ Where the young person has an active EHCP and is actively involved in education. ➢ Where the young person has an evidenced diagnosed primary need of either learning disability, physical and/or sensory disability and/or Autism. ➢ Any young person that may have Care Act needs but does not meet the criteria for the Transition Team. Referral pathway should be directed, by the referrer, to the Locality Team where the young person resides, or the Mental Health Locality Team where the young person resides or the PLD and Autism Team if this is more appropriate.
Referral process	• Referrals is done only via the SharePoint Referral site. • Referrals **must be** accompanied by a copy of the EHCP, evidence of diagnosis and, where the case is being referred by Children's Social Care Services, a Continuing Healthcare Checklist. • The referring team to be able to demonstrate how the work completed with the young person by any agency prior to the young person's 16th birthday was compliant with the Mental Capacity Act 2005. • Any assessment completed by the Occupational Therapist in the event that they were involved **should be included** in the referrals. This should include Occupational Therapy Assessment / Risk Assessments and other relevant documentation that underpin the intervention(s) and demonstration of Mental Capacity assessments / Best Interests decisions.

Policy and Statutory Guidance that underpin practices.	• Practitioners working within the Transition Team are expected to have a working knowledge of: ➢ The Care Act 2014 (including s58; child's needs assessment) ➢ The Mental Capacity Act 2005 ➢ The National Framework for Continuing Healthcare 2002. • Principles of transitional safeguarding in according with the 'Bridging the Gap' guidance will be followed.
Visits	• Young people and Carers are **reviewed annually**. • Additional visits *may* be made outside of this, depending on circumstance of the young person or family (such as safeguarding concern or unplanned change in circumstance / need).
Recording	• Adult Social Care record in LAS. Relevant Children's Teams and SEND Teams should have read-only access. • Children's Services and SEND must continue to record their work in their own Systems (eg LCS, EYES). • Adult Social Care will upload any other documents produced outside of LAS or sent by third parties to LAS/WISDOM. • Case updates are recorded within case notes on LAS on the same day.
Voice of the young person	• The young person to be at the heart of the assessment process in order to understand their needs, outcomes and wellbeing and deliver better care and support. • In the event that an adult has a care and support needs, his/her carer needs to be involved. • An independent advocate to be provided by the local authority to facilitate the young person's involvement in the care and support assessment, planning and review processes where an individual would experience substantial difficulty in understanding, retaining, or using information given, or in communicating their views, wishes or feelings and where there is nobody else appropriate. • Where there is concern about a young person's capacity to make a specific decision due to a mental impairment or learning disabilities, a mental capacity assessment should be carried out under the Mental Capacity Act (MCA). • Those who may lack capacity will need extra support to identify and communicate their needs and make subsequent decisions and may need an Independent Mental Capacity Advocate. The more serious the needs, the more support people may need to identify their impact and the consequences.
Meeting	***Practitioners from the Transition Team are expected to attend:*** • EHCP Review meeting (from year 9, by invite, for young person who do meet the Transition Pathway and may require care and support as adults).

	• Adult Social Care Assessments meeting. This starts from the age of 17 and is reviewed annually as part of the Adult Social Care Review to establish the young person's Care Act eligibility, and their needs and outcomes. • Carers Assessments meetings to establish the Carers eligibility, needs and outcomes. • Support Planning Meetings which usually occur after Adult Social Care Assessment if a separate meeting is required, to identify advice, guidance, signposting, and support required to meet Care Act needs. • Adult Social Care Reviews meeting which takes place annually, to review the Adult Social Care Assessment and Support Plan). • Carers Reviews meeting which takes place annually, to review the Carers Assessment and Support Plan. • Any required safeguarding meeting. Frequency of the safeguarding meeting is not statutorily defined; this is dependent on circumstances. • Mental Capacity Assessments meeting. Frequency is time and decision specific, and dependent upon the young person's needs; the purpose is to carry out an assessment required by the Mental Capacity Act 2005 when the young person ability to decide is in question. • Continuing Healthcare Decision Support Tool Meetings (usually, one-off meetings, jointly attended by the ICB, to determine Continuing Healthcare Eligibility.
Reports	LAS, the Adult's Social Care case recording system, directs the following documents to be produced: • School Review Forms (when attending EHCP Review). • Adults Social Care Assessments. • Occupational Therapy Assessments. • Carers Assessments. • Adults Support Plans. • Carers Support Plans • Adults Social Care Review • Carers Review • Occupational Therapy Review • Mental Capacity Assessments • Case Transfer Summary Document (to be used between Adults Services) • Consistent Practice Checklists (to support applications for funded Care Packages. • Safeguarding Concerns and Enquiry Documents. • Safeguarding Plans Additionally, Transition Team case workers may generate: • Adult Continuing Healthcare Checklists • Joint Funding Applications • Best Interest Decision Forms

Safeguarding protocol	• Adult Social Care will attend all the required safeguarding meeting when and as required. • Everyone has the right to refuse an Adult Social Care assessment, however Surrey Council must undertake an Adult Social Care assessment if it suspects that an Adult meets the criteria for a Care Act Section 42 safeguarding Enquiry. Staff in Adult Social Care carrying out tasks in line with this protocol must remain mindful of their responsibilities to adhere to the Surrey Safeguarding policies and procedures, which can be found at: Care Act 2014 - Safeguarding adults at risk...
Supervision/Management Oversight	• One-to-one Supervision should occur **every 4 weeks**. The Supervisor will have completed Surrey County Council Supervision training and possess appropriate experience. • Group Supervisions, in addition to one-to-one, occur throughout the team on **a 6-weekly** basis.
Transfer process	• Referrals are accepted from the age of 14 and should be received by the age of 16 at the latest. • Once the **young person turns 18,** the transfer is triggered by a Transition Assessment, carried out at the relevant time depending on services and circumstances. • Partners will be alert to opportunities for earlier transfer when that is in the interest of the young person concerned and will bring those opportunities to the Transition Strategy Group. • The Transition Team only accept referrals if the young person is evidenced to meet the Transition Referral Pathway, and they are accompanied by a properly completed Adults CHC checklist. • The case transfer to either Adult Social Care or Adults Continuing Healthcare on their 18th birthday, and if transferring from Transition as part of a rising 25 cohort, will transfer on 1st April of the financial year they will turn 25. • Cases may transfer out of the Transition Team either by way of age (the Rising 25 process) or if they become eligible for Continuing Healthcare. • In the Rising 25 Process, a case will transfer to either a Locality Team, a Mental Health Locality Team, or the PLD&A Service, as appropriate, on 1st April of the financial year that the young person turns 25. • If the young person becomes eligible for Continuing Healthcare before this point, the case should transfer to the relevant ICB on day 29 after CHC Eligibility was determined. Hanover occurs via an exchange of paperwork between the LA (Adult Social Care Assessments, Support Plans and any other documents that may be relevant.
Transition plan	• Adult team undertake assessment of needs in order to tailor the young person's **support plan** in accordance with the Care Act.

Disagreement resolution	• If there is disagreement between service regarding a transfer, this will be escalated through line management levels. As an illustration, if differences regarding a young person's eligibility for an Adult Service cannot be resolved, then the Team Manager who is responsible for the case should bring the matter to the attention of the Service Manager. The Head of CLA Services will consider escalation to the Assistant Director of Specialist Children's Services and Safeguarding and to the Director of Health and Social Care Provider Services for a decision.

Practice expectations
Transition to adulthood for looked after children should not just start on their 16th birthday; preparation for a time when they will no longer be looked after should be integral to the care planning process throughout their time in care. Starting assessments at age 14 and transition planning facilitates more responsive and flexible forward planning. Timely assessments and transition plans are essential for commissioners to plan services.
Person centred planning to ensure that planning for young people/ and young people with eligible Care Act Needs to make the transition to adulthood focused on what is important to the young person for the future and what needs to be in place to ensure that they receive the support to achieve their goals.
Each young person has their own individual aspirations, hopes, needs, and wants, therefore whilst different services have their own eligibility and access criteria, they must work together to adopt a holistic approach based on assessment of individual needs informed by each young person's wishes and feelings.
Adult Social Care transition planning to cover aspect of a young person's life that are covered by the Care Act 2014, including education, employment, placement/accommodation, and leisure activities. Transition planning should be focused on life outcomes, promoting independence, and supporting young people to lead meaningful and enjoyable adult lives.
The core purpose of adult care and support is to help young people to achieve the outcomes that matter to them in their life.
It is critical to the vision in the Care Act that the care and support system works to actively promote wellbeing and independence and does not just wait to respond when people reach a crisis point.
Adult Social Care Practitioners are expected to take a strengths-based approach to assessment, eligibility decisions and support planning. This means that the focus is on what is most important to the young person, recognising their strengths and networks, helping them to stay connected to their communities and support them to feel safe.
The work of the Adult Social Care to be completed jointly in partnership with Children's Services, SEND and Health and it is incumbent on all partners to have an awareness of the legislative and policy context of one another.

All professionals working with young people with complex needs should be given training to ensure that they are equipped to communicate effectively with them, including those with high communication needs. Practitioners who assess children and younger adults should have experience of this work, or training to support their assessments to ensure they have a full understanding of the impact of trauma on care experienced young people.
All young people to have an assessment or review of the assessment prior to any transfer. Their supported participation in this Review or Reassessment is mandated by the Care Act. Practitioners are expected to consider and plan how this is best achieved, thinking about time, place, duration and frequency of meetings, appropriate attendees, the need for advocacy and any communication methods.
The transfer stage should consider any relationships that the young person has built up in children's services. This includes relationships with professionals and other children and young people using services. Where appropriate, plans for the future for the young person will include maintaining relationships and will reflect the young person's aspirations and personal group and will be in line with the principles of the Mental Health Capacity Act where that applies.
Trained advocates should also be available to ensure that young people's views are heard and considered.
Practitioner must carry out an assessment of anyone who appears to require care and support, regardless of their likely eligibility for state-funded care.
Where the needs are complex practitioners from key partner agencies working with the individual should collaborate to formulate a shared analysis of how the individual's cognition function is impacted in different circumstances to support frontline practitioners in undertaking mental capacity assessments that are decision and time specific.

9. Local Authority Designated Officer (LADO)

All organisations which provide services for children or provide staff or volunteers to work with or care for children are required to operate a procedure for handling allegations which is consistent with the guidance in of Working Together. The management of allegations is undertaken by the LADO service here in Surrey County.

Managing Allegations Timescales and LADO process at a glance	
Threshold	According to the Working Together to Safeguard Children, the LADO becomes involved when any person who works with children, in connection with their employment or voluntary activity has: • Behaved in a way that has harmed or may have harmed a child. • Possibly committed a criminal offence against or related to a child. • Behaved in a way that raises concern about the adult's suitability to work with children. • Behaved or may have behaved in a way that indicates they may not be suitable to work with children (Transferable Risk)
Referral process	• Allegations are referred to the Local Authority where the adults work and are made within **1 working day** of when the incident occurs or when it was disclosed. • Referral forms should be sent to LADO in box or email LADO@surreycc.gov.uk • All referrals are triaged by a duty LADO within 24 hours of receipt and where threshold is met, a named LADO is allocated to work with the referring organisation. • Non threshold allegations which are known as consultations are dealt with on the day of contact by the duty LADO. • Advice and guidance can also be provided by the duty LADO via telephone - Contact phone number for duty LADO, **0300 123 1650 (option 3).**
Policy and Statutory Guidance that underpin practices.	• Children Act 1989 and the Children Act 2004 • Working Together To Safeguard Children- Appendix • Chapter 7 of the London Safeguarding Children Procedures
Reports	• Not applicable
Visits	• Not applicable

Voice of the child/young person	• The voice of the child is reflected in the allegation referred to the LADO service and is also obtained as part of the investigation. • The Young Person's wishes and feelings should be reflected in the outcome of the investigation which is undertaken by the employer, the police and or children Social Care.
Meeting	• Where required and where there is enough information to suggest a child may have been harmed or a criminal offence may have been committed, the LADO will hold a Multi - agency Child Protection meeting known as an **Allegation Against Volunteer Meeting (ASV)** with the employers, the police, and other relevant parties such as regulatory bodies. • The allocated LADO will endeavour to arrange the ASV within 3 to 5 working days of the referral. • Where appropriate, a review ASV will be held within 2 weeks of the initial ASV.
Recording	• LADO's are required to record and update all contact on LCS following each contact. • All cases open to the LADO service should be reviewed sand updated every **4 – 6 weeks.**
Supervision/Management Oversight	• LADO's have **monthly** supervision and reflective practice which evidence some self-assessment re anti discriminatory practice and power re decision making.
Safeguarding protocol	• Not applicable
Transfer process	• Not applicable
Transition planning	• The LADO process is applicable to adults who work in regulated activities with children 0- 18. • Allegations relating to adults who work with adults should be sent directly to Adult Social Care.

Practice expectations

The LADO will:

- Assess and review the referrals and decides if an allegation Against staff and Volunteers Meeting (ASV)is required.
- Organise, investigate, and chair the ASV.
- Manage and have oversight of individual cases.
- Provide advice and guidance to employers and voluntary organisations.
- Liaise with the police and other agencies like Ofsted.
- Monitor the progress of cases to ensure they are dealt with fairly, consistently, and quickly.

Appendices

Appendix 1. TRANSITION PLANNING PROCESS

AGE 14

Key Action required	Responsible officer	Considerations
Start to consider transition planning	Allocated Social Worker.	Need to involve all other professionals in the team around the young person. Consider if there is a need for advocacy at this point.
Ensure that young person's record has a clear detailed diagnosis of their disability	Allocated Social Worker	This will be required in the future so full details need to be obtained and recorded. This may take some time, so work needs to start at this point.
Transition Plan to be created	Allocated Social Worker	This Transition Plan will need to be reviewed annually at young person's statutory review meetings. Details of diagnosis will be required.
Referral to be made to Transition Team – PfA Function	Allocated Social Worker	Referral will enable Transition Team PfA workers to attend the young person's EHCP annual review on a regular basis.
Complete CHC checklist	Allocated Social Worker	Need to consider health funding needs for current placement and post 18 funding.
To attend SEND Annual Review	Allocated Social Worker Transition worker	12 monthly
Planning for Preparation for Adulthood work to commence and this is be reflected in young person's support plans and activities going forward.	Allocated Social Worker	Ensuring YP is prepared for adulthood in terms of health and wellbeing, relationships, education/employment/training , and accommodation.

AGE 16

Key Action required	Responsible officer	Considerations

Full referral to be made to Transition Team if not already completed.	Allocated Social Worker	At this stage the referral will be a flag only and the lead officer remains the Allocated Social Worker.
Complete CHC checklist	Allocated Social Worker	Need to consider health funding needs for current placement and post 18 funding.
To attend SEND reviews	Allocated Social Worker Transition Team PfA Worker	12 monthly or as required
Mental Capacity assessment may need to be considered	Allocated Social Worker.	Does the YP have capacity?
Parents to be given advice re; Deputyship and Appointeeship	Allocated Social Worker	Are the parent/s best placed to be the Deputy or Appointee? Consider if there is a need for advocacy at this point.
Decision re; Deputyship is required	Allocated Social Worker	If Deputyship is required, then Childrens legal services to sign off Court of Protection forms.
Preparation for Adulthood reflected in young person's support plans and activities	Allocated Social Worker	Ensuring YP is prepared for adulthood in terms of health and wellbeing, relationships, education/employment and accommodation.

AGE 17

Key action required	Responsible Officer	Considerations
Follow up contact to be made with the Transition Team at 17 to confirm case allocation.	Allocated Social Worker	This starts the joint partnership work between Transition Team and social worker.
Transition Plan is reviewed updated and finalised. Clear and timely plan with key milestones to achieve plan in place.	Allocated Social Worker/ Transition Worker	Options for future placements to be explored i.e. supported living/ return home/Shared Lives
Regular tracking meetings for all young people of transition age.	Transition Team Manager Head of CWD Transition Development Manager	Are all young people being captured and appropriate and timely planning in place?
Preparation for Adulthood reflected in young person's support plans and activities	Allocated Social Worker	Ensuring YP is prepared for adulthood in terms of health and wellbeing, relationships, education/employment and accommodation.

MCA considered (if not done at 16) or reviewed.	Allocated Social Worker	Is deputyship required?
Bank account to be set up Benefits to be applied for	Allocated Social Worker	Benefits will be required as part of the move on plan.
If Deputyship needed – then papers to be prepared at least 3 months before the YPs 18th Birthday.	Allocated Social Worker supported by Transition Team.	Legal oversight required. Contact may need to be established with the Adult Deputyship Team for post 18 support.
Formal review of EHCP and completion of Section D	Led by SEND colleagues. All involved professionals to have input. Section D to be completed by Allocated Social Worker.	
If YP meets Continuing Care Criteria threshold, then referral to CCG (if not completed at 16)	Allocated Social Worker / Transition Worker	If case is adult CHC the case will move to Health and will not have the involvement of the Transition Team

Transition Duty Team contact number - 01276 800 270.

Link for referrals to The Transition Team.

Welcome to the Adult Social Care Transition Team (sharepoint.com)

Required information to make a referral.

- Copy of the latest EHCP
- Completed CHC checklist
- Up to date GP Summary and formal evidence of diagnosis
- Family contact details
- Details of education background, achievements to date
- Contact details of all involved professionals

Appendix 2. Template for a Transition Plan

Detailed below is a copy of the young person's transition plan. This records how the young person's eligible needs will be met and the outcomes achieved. Throughout this planning process, professionals can also give the young person information and advice about other services or organisations that may be able to offer them support.

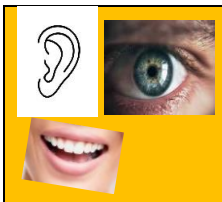
My key outcomes:

Which needs will be met by family and friends
Which needs will be met by Education
Which needs will be met by Health
Which needs will be met by my community (voluntary, faith, community organisations)
Which needs will be met by Surrey Adult Social Care Services

Appendix 3- Surrey Transition Plan

All About Me

Name:	
Address:	
Telephone Number:	
DOB:	
Ethnicity:	
Gender:	
First Language/appropriate mean of communication:	
Behavioural Plan or Behavioural de-escalation strategy:	
Parents/Primary Carers name Address & contact number	
Other key family members/friends	
Children's Social Worker:	
Adult Social Worker:	
Virtual Key worker:	
SEND key worker/SEN Personal Advisor:	
Commissioning Key worker:	
Placement Key worker:	
Like:	
Dislike:	

	**Where I live and who I live with**:
	**People who are important to me (my family, friends, at school, other people):**
	**To be successful in supporting me and communicating with me, you need to:**
	**To be successful in managing my behaviours, you need to:**
	**Things people like about me:**
	My religious and cultural needs:

	What I am good at and what I enjoy doing (at home, at school and out and about):

	To stay healthy and safe I need to:

What can I do? What the help and support that I need?

	Washing, dressing, cleaning my teeth, brushing my hair, choosing my clothes, bathing, showering, going to the toilet, eating, drinking, shaving, help with transferring, getting in and out of bed, looking after my personal hygiene, preparing off etc

	**Getting out and about and using transport etc:**

Reading, writing, counting, and managing my money etc:

Making friends and getting along with people:

My hopes and dreams for the future

<u>My Learning</u>

<u>Work & Employment</u> (What would I like to do)

<u>Where I would like to live in the future:</u>

	**Who I would like to live with:**

	**Other Hopes and Dreams that I have for the Future**

My Post Care Leaving Action Plan
Date:

Key Hopes and Dreams about the future	What I want to do	How can we make it happen?	Who will take responsibility & who will be involved?	By when?
 **My Learning (school, college, Adult Education)**				
 **How I will support myself in the future (work, employment)**				
 **Where I want to live**				

 **Other hopes and dreams**				

Health & Well-Being

Transition Health Profile: This section of the Post care Leaving Plan, should be completed with the help of the school nurse, GP, specialist health professional (i.e., paediatrician, hospital consultant, nurse specialist, occupational therapist psychiatrists etc) parents/carers &/or significant other.

Nature of the Young Person's Disability

Medical services, therapies & interventions used (include names and contact details of known individuals).

Medical issues (i.e., pain, continence, sleeping, mobility, weight, allergies, etc)

Medication (what it is prescribed for, how often, if the young person is self-medicating, known side effects)

Mental Health (are there any concerns related to depression, anxiety, self-harm etc)

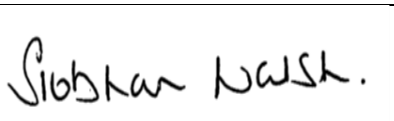
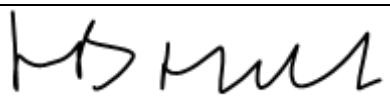
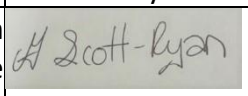
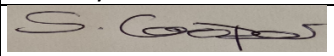
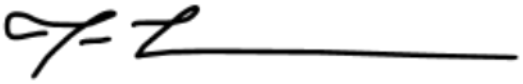
Behaviour (are there any behaviours which cause concern or prevent the person from participating in activities)

Does the young person use any specialist equipment, who provides this equipment and how often is it reviewed?

How will this young person access this equipment once they leave school move to adult health care?

What are the plans for this young person's transition to adult health services?

Signatures

Department/Team	Responsible officer	Date & Signature
Looked After Children/Young People and Care Leavers	Siobhan Walsh Assistant Director	 26.02.24
Children with disabilities	Jenny Brickell Assistant Director	 23 February 2024
Health	Audrey Scott-Ryan Surrey ICB Associate Director Safeguarding	 13th February 2024
SEND	Jim Nunns Assistant Director	 26th February 2024
Continuing Care Services	Sara Barrington Sharon Cooper	 01/03/2024
Commissioning	Eamon Gilbert Assistant Director	 20/3/2024
Transition Team	Fadzai Tande Director Disabilities Learning Disabilities & Autism & Transition	 19/03/2024
LADO	Linde Webber Service Manager	Linde Webber 22/02/2024
Quality Assurance	Tom Stevenson Assistant Director	
Quality Performance	Patricia Denney Director, Quality Practice, Relationships & Support	 20th September 2024