Background

Sutton has piloted a multi-agency approach to developing care and support services for young people in line with the council’s personalisation policies and forthcoming legislation set out in both the Care Act (2014) and the Children and Families Act (2014).

This pilot was based on the objectives of the SEND (Special Educational Needs and Disabilities) Green Paper and Pathfinder programme that informed the Children and Families Bill. This programme established ‘single assessments’ across education, health and social care for those with long term support needs aged from 14 to 25 years old. This will lead to personal budgets that allow young people and their family/carers to exercise choice and control in how their support needs are met.

The pilot involved strengthening transition arrangements, which in this context meant the transfer of young people from children’s to adult services.\(^1\),\(^2\)

The Local Picture

The position prior to the pilot was that young people with long term social care and support needs were assessed and advised under the legal requirements for adult social services at or around 17 years of age, with legal transition (the move from children’s to adult services) at 18 years old. A member of Children’s Social Services, managed by the Assistant Team Manager - Children with Disabilities Team, carried out this function with Adults and Safeguarding staff, and historical funding aimed at those aged 14-18 years. This arrangement was based on plans put in place in 2006/07 aimed at those aged 14 years old and above. However, under this approach there was limited capacity to produce the timely assessments of need required.

The Adults with Learning Disabilities Clinical Health Team, commissioned by Sutton CCG from ASSHH, worked with people with learning disabilities aged 18 years old who are registered with a Sutton GP.

The transition pilot involved:

- The formation of a transition team consisting of three social workers and a senior practitioner
- The creation of an Education, Health and Care Plan (EHCP) for use with young people with Special Educational Needs and Disabilities
- Identification of a pilot group to trial the EHCP
- Change in eligibility of the Adults with Learning Disabilities Clinical Health Team to allow one nurse to work with people aged over 14 years but younger than 18 years

\(^1\) Implementing a new 0 to 25 special needs system: LAs and partners, new SEN Code of Practice. July 2014. 

http://preparingforadulthood.org.uk/media/355458/pfa_factsheet_-_care_act_-_royal_assent.pdf

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Governance
The Transitions Partnership Board was formed in 2012 with all key stakeholders and partners, chaired by a councillor. The Board provided quality assurance and oversight of the pilot. A multi-agency transition project steering group was formed to provide advice, direction and support to the project.

Sutton progress

Local data
50% of young people aged 17 to 19 years inclusive in the key transition age groups currently have a Social Worker.

Progress in Adult Services for young people turning 18 years old in the 2013/14 academic year:
• 43 young people have been referred or referrals pending
• 29 who will or are likely to receive services from the Adult Disability team: 14 to be signposted to other teams or referral pending
• 8 assessments completed: 6 assessments in progress; 15 allocations required
5 Support Plans authorised: 3 Support Plans in progress

The pilot
The transition team’s first task was to work with young people at the point of transition, a total of 74. There are also around 30 transition cases allocated to other workers in the Adult Disabilities social work team. This cleared the backlog of outstanding transition cases using existing resources. The transition team has continued to work with further young people with special educational needs and disabilities as they approach transition from children’s to adult services.

A key finding of the team was that there were between 30 and 40 young people in each academic year from the age of 14 upwards whom are likely to be eligible for adult disabilities services.

A pilot group was identified comprising 22 young people aged 14 – 17 years old. This represented a range of disabilities: learning disabilities, autistic spectrum and physical disabilities or complex health needs.

An Education, Health and Care Plan process was established for use with the pilot group. This was found to be effective at prompting consideration of employment, housing, health and relationships and for formulating plans to address how these areas would be met. Whilst the full version of the Care Plan was found to be useful for young people with special educational needs and disabilities, it was too detailed for others without disabilities but who would be in receipt of statements of educational needs (which Education, Health and Care Plans will start to replace in September 2014). In response, an abbreviated version of the Care Plan has been created to replace statements of educational needs.

It was recognised that the needs of young people with mental health problems should be included within the transition work. As a result, a mental health social worker is now working with the transition team to support the transition process for young people with mental health problems. Feedback from families involved in the pilot has been positive.

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Transport provision:

The decommissioning of in-house transport provision impacted on the provision of college transport for young people. This approach was not only not personalised and was expensive, unreliable, did not encourage young people to develop independent living skills and resulted in the department receiving numerous complaints.

In the last nine months, a Community Care Assessor from the Disabilities Team has carried out a review of the purchasing of college transport for young people in transition to adult services. This included assessing the needs of young people who are unable to travel independently and assessing their eligibility for council funded transport as part of their personal budget. It involved exploring various options for the provision of this support. The preferred option has been the offer of direct payments for the recruitment of personal assistants from young persons’ existing networks to support them to use public transport.

Clear outcomes for the personalised transport provision included the following:

- To give the young person the opportunity to participate in new, enjoyable and meaningful activities
- For the young person to gain confidence and learn new skills
- To build on skills the young person already has and/or hopes to develop which will promote independent living in future such as travel training, dealing with money, and support with making choices
- To work with the young person to set clear targets to gain a sense of achievement and progress
- To support access to opportunity for progression route from college into employment

Overall, this new approach to college transport has been more creative, has offered young people the ability to take responsibility for their own arrangements and has been cost effective. The project delivered significant financial savings to LBS.

Workstreams

National Transition guidance consistently indicates that young people with SEN and disabilities have difficulty accessing opportunities in the following four areas:

- Good Health
- Employment
- Housing
- Social opportunities

Multi-agency practice development groups (work streams) have been set up and meet every 6-8 weeks to identify, discuss and plan service development work in these four areas.
Other Liaison work

- Cedar Lodge and Sutton Parent Forum meetings, LD Action Group
- LD Health team
- LDD team (formerly Connexions) – annual reviews
- Sherwood Park School parents meeting
- Other local schools/colleges - increased Social work representation at key annual reviews
- Contact A Family – Transition Fair initially planned for March 2014; to be delayed to incorporate Care Bill work and potentially make use of LBS funding available
- Promotional documentation/multi-media work in progress
- Team members representing borough at regional events

Highlights

- Positive feedback/engagement from families in the pilot group
- On-going crisis-intervention work has provided significant outcomes for families in immediate need
- Various liaison work has been successful in sharing information about the work of the team and addressing reputational issues
- Most infrastructure is now in place to advance out of ‘project’ phase into being a fully-fledged team

What works

Evaluation of the SEND pathfinder programme found the following to be effective:

- The assignment of a key worker so that families have a single point of contact
- The development of personal profiles through which families and young people can express themselves
- Adopting person centred planning approaches
- Involving families in planning meetings so that they can contribute to and be aware of support actions that are being put forward
- Moving to a single EHCP document
- Training for key workers and other professional to help promote culture change and the new ethos to put families and young people at the centre of the system, and in parallel capacity building support for families
- Better sharing of information between agencies, and between agencies and families

Source: Evaluation of the SEND pathfinder programme

Links to further information

- Pathfinder website http://www.sendpathfinder.co.uk/
- Preparing for Adulthood National Development Team for Inclusion: http://www.ndti.org.uk/
- Contact a Family www.cafamily.org.uk/parentcarerparticipation
- National Network of Parent Carer Forums www.nnpcf.org.uk
- SEN Gateway for schools www.nasen.org.uk

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Other relevant departmental advice and statutory guidance

- [http://www.preparingforadulthood.org.uk/](http://www.preparingforadulthood.org.uk/)

Priorities for Sutton

- To note the review of the pilot of new ways of working between education, NHS and social services with SEND young people and their families.
- To approve the continued involvement of the Learning Disability Clinical Health Service in the transition, work within existing resources.

Areas for Development

- Balance of work for team members – more crisis-intervention means less time for long-term Transition planning
- Urgent improvement on timing of allocation of Transition Social Worker required
- Need to continue to develop additional support systems to the team
- Work streams need to develop from being information-sharing groups to more outcome-focused