Scrutiny Committee: Pathway Experience

Independence Pathway

Young Person AB (year 11)

AB is a young person living at home and attending a mainstream school. He has an EHCP to support his specific literacy difficulties which impacts on his understanding of words and texts. Whilst this impacts on his self-esteem AB is friendly, sociable with a group of friends and aspirations to be a mobile mechanic. It is expected that he will complete school and go to college to become a mechanic.

AB is on the Independence Pathway as at his annual PfA review it is determined that he will not require support from adult services to maintain his home. He has no ongoing health needs so there are no health transitions and his health care continues to be delivered through his GP practice. He receives further education and employment advice from the school.

The young person or parents are able to access the Local Authority PfA Landmarks website which links them to useful information, took kits, websites and support groups from the Local Offer who can provide universal/ tier 2 supports.

Independence (Enhanced) Pathway:

Young person CD (year 9) and a child in care.

CD lives with her foster carer and attends mainstream school. Her home life with her foster carers is stable and they intend to remain together until CD is an adult. Due to early life experiences she has difficulty managing her emotions and can present with complex behaviours that unfortunately impacts on her friends and family and she has an EHCP to support her with these SEMH difficulties. Education services provide top up funding for targeted approaches and a teaching assistant. Health services are providing an ADHD assessment and social care provide a skills worker once a week who takes IB out to support her learning community skills.

Looking to the future IB would maintain her placement at school and home. Her EHCP will this year turn to a Preparing for Adulthood EHCP and in addition at 16 a Pathway Plan will describe support she will receive as an eligible adult.

There is no evidence at this time that she could not manage her own home, go to college or enter the workforce therefore will not need to transition to adult social services but the LA will discharge its obligations through the EHCP and Pathway

Plan until she reaches 25. There are no ongoing health needs which require a transition so all her health care needs will be met through GP services at 18. If, at a future PfA review, there were concerns she may need care and support from adult social care services then a notification of change is sent to the SEND PfA monitoring group who will move CD into the neighbourhood pathway thereby informing the relevant neighbourhood that there is a young person in their area they may need to assess.

The young person or parents are able to access the Local Authority PfA Landmarks website which links them to useful information, took kits, websites and support groups from the Local Offer who can provide universal/ tier 2 supports.

Neighbourhood Pathway

Yong person EF

EF is a young person 15 years old. He lives with his parents and attends a specialist school due to the impact of Foetal alcohol syndrome and ADHD. He struggles to concentrate for extended periods of time, is easily distracted, struggles to process information and finds it difficult not to act on impulses. Liam wants to attend a FE college but is not sure yet what he wants to study.

At the last EHCP PfA annual review it was felt that he would not be able to maintain a home by himself however at this time parents are saying that he will remain with them until he is in his 20's. Following the EHCP PfA review Liam was placed in the Neighbourhood Pathway as it was felt that he should receive an assessment for adult social care services when it would be of significant benefit to do so. At the Neighbourhood PfA monitoring group meetings EF's EHC is reviewed and consideration is given as to when it would be a good time to undertake the review. As he is currently living at home it was felt that such an assessment did not need to occur until he was closer to 18.

As EF approaches 18 the neighbourhood PfA monitoring group will see that an assessment is due and can contact the family to undertake a Let's Talk 1 level conversation about what support need they feel is needed. If they are satisfied that he is doing fine at college and is settled at home then there would be no need for a Let's Talk level 2 or 3 conversation at this time but this can be reviewed as part of the Neighbourhood PfA monitoring functions. St 18 there may not be any need for ongoing care and support as parents are managing the situation however they will have been provided with information on how to contact adult services when it is time for EF to move to independence.

Neighbourhood (Enhanced) pathway

Young person GH known to Complex Needs (children social care) and the Short Break team

GH is a 16 year old young person who attends a mainstream school but has an EHCP due to his complex autism. GH is an intelligent young person but there are strains on the family due to his complex behaviours. He is known to CAMHS due to his suicide ideation and is on the Dynamic Support Database (DSD) due to his risk of hospitalisation and/or entry into care. There have been periods when he has been a school refuser due to social and emotional needs and has open to the Complex Needs (children social care) due to him scoring red on the DSD. Currently he is stable and has returned to school and receives a direct payment to employ a PA who is supporting him access some of his old activities in the community.

At the EHCP PfA annual review it was felt that there would be periods in his life when he would be unable to maintain his own home, although it is not yet clear when and what level of support he will need. He does not have a learning disability so is not on the Complex Needs pathway and any future support will be delivered through the neighbourhood teams.

The neighbourhood PfA monitoring group is aware of GH as they have had his details since he was in year 9. The Neighbourhood PfA monitoring group have viewed the EHCP and feel they need more information. They have requested the Complex Needs social worker updates a Child and family assessment with a PfA Indicative Care Act (Transition) insert which asks specific question regarding the required support under the Care Act framework. When they receive this information they will be able to make a determination as to when it would be of significant benefit to undertake a Lets Talk assessment.

The monitoring Group also has representative by invite to the group and have asked the CAMHS transition coordinator update on GH the CAMHS transition. The CAMHS advice to the group is that GH does not at this stage meet the criteria for adult mental health services and he is being directed to his GP and wellbeing services. This information is sent back to the EHCP coordinator as advice of change to the EHCP. The Neighbourhood monitoring group, seeing the EHCP, the Child and Family (transition ) assessment and the short break support plan request a Lets Talk 2 assessment to be undertaken before JS is 18 to enable the necessary funding agreements to be made.

Complex Needs Pathway

IJ is a 16 year old young person known to Complex Needs (children social care) and short breaks team.

IJ has been known to the Complex Needs (children social care) since he was 7. She lives with his family and attends a specialist school due to his learning disabilities. The family receive a substantial package of support including oversight short breaks and PA hours delivered through a personal budget. The Complex Needs Monitoring group have tracked her progress since year 9 and whilst the EHCP is giving guidance on the key stage outcomes and provision the adult social care attendee believes there would be significant benefit to undertaking a Indicative Care Act (transition) to help detail the support planning. This assessment is undertaken by the Complex Needs social worker using a Child and Family assessment with a PfA Indicative Care insert. From the indicative care act assessment planning for adult services can begin. Parents have indicated that IJ will live with them for the foreseeable future but they are realistic about their ability to care for him as he and they get older, however these are not decisions that need to be made for a couple of years yet. The young person is allocated an adult social worker when they are 17 to ensure the current support will meet their needs in early adulthood and to make representations to All Age Panel if required.

Complex Needs (Enhanced) Pathway

KL is a 14 year old young person known to Complex Needs (CSC) and is a Child in Care.

KL is a young person with severe learning disabilities who recently began living in a specialist residential home as her care needs had become too difficult for her aging parents. She has been known to the Complex needs team (CSC) since she was 5. Since year 9 KL has been monitored through the Complex Needs PfA monitoring Panel. A PfA Indicative Care Act assessment will be requested by the monitoring group when she is 16 to enable joint planning with adults. The PfA Monitoring group makes the recommendation at 16 that a move to adult based residential services will need to take place on or around her 18th birthday. An adult worker is allocated at 17 to work with the children social worker to identify suitable provision and both social workers then attend All Age Pane to secure funding agreement for the move. The Complex Needs (adult health services (Cheshire Wirral Partnership)) are represented by their transition coordinator who queried whether TG should be in receipt of Continuing Health Care funding and has requested the social worker completed an CHC screening assessment. From this screening a multi-disciplinary meting (DMT) determines whether TG is eligible and if so then his adult support is delivered through the Cheshire Wirral partnership.