

PROTOCOL AND PROCEDURE
FOR LINKING 'LEAVING CARE'
SERVICES WITH CHILDRENS AND
ADULT SERVICES FOR YOUNG
PEOPLE AND YOUNG ADULTS
WITH A PHYSICAL AND / OR
LEARNING DISABILITY

AGREED-MAY 2007

PROTOCOL AND PROCEDURE FOR LINKING 'LEAVING CARE' SERVICES WITH CHILDREN AND ADULT SERVICES FOR YOUNG PEOPLE AND YOUNG ADULTS WITH A PHYSICAL AND/OR LEARNING DISABILITY

1. Introduction

a) The Disabled Childrens Team (DCT) is one of 5 Teams that together make up the Childrens Health & Disability Service (CHAD). For reference only the other 4 Teams are a Nurses Team; Family Placement/Family Support Team; Multi Agency Partnership Team; and the Child Oncology Team.

The DCT is a Citywide Social Work Team dealing with children and young people aged 0-18 who have a significant learning or physical disability. This Team consists of a Team Manager, 7.5 Social Workers & 2 Transitions Social Workers. The Team is currently based at Chorlton Social Services Office, Tel No 0161 881 0911.

b) Barnardos Manchester Leaving Care Service (MLCS) are a City wide Service, contracted by Manchester Childrens Services to deal with all young people aged 16 → 21 (and occasionally beyond) who meet the legal criteria of the Children (Leaving Care) Act. Essentially these are all young people 'Looked After' on their 16th birthdays, but excluding those who receive respite care of 120 days per year and below.

MLCS consists of a Service Manager, 3 Team Managers (North, Central, South) and 21.5 'Personal Advisors, Leaving Care.' This Service is currently based at 36 Monton St, Moss Side, tel no 0161 226 6722.

c) The Adult Social Care Community Learning Disability Service (CLDTs) consists of 3 geographically based multi agency Teams – one in North (Beechmount, 0161 205 1364); one in Central (Chapman Street, 0161 223 9901); one in South (Oakwood, 0161 998 7424); and a Commissioning Team based at Fenham (0161 434 7316).

The 3 CLDTs each have a Team Manager, a Senior Care Manager, and someone within each Team who takes a lead on Transition. In North this is Diane Browczuk, Central Dean Rowe and South Elaine Marsland.

d) The Adult Social Care Physical Disability Service (PDS) again consists of 3 geographically based Teams – one in North (The Leaf Centre, 0161 202 4199); one in Central (Hillside, 0161 273 2016); and one in South (Minehead Centre, 0161 446 2551). Each has a Team Manager and, based in North District, a City wide Transitions Co-ordinator (Lesley Heffernan)

2. Principles

- To give the best and most appropriate service to children and young adults leaving care who have a disability.
- To commit all relevant agencies to work together in partnership and play whatever role is necessary to complement one another in delivering such a Service.
- To each try to meet the basic requirements of the various legislation to which we are all working, but avoid unnecessary duplication of one another's policies and procedures wherever possible.
- To try to be clear to the Young Person and their Carer(s) which, and why, various Workers are involved and what their roles are, thus avoiding duplication wherever possible.

3. To whom does this Protocol relate?

- Young people aged 16 plus, 'Looked After' on or after their 16th birthdays and who have been so 'looked after' for a continuous or aggregated period of 13 weeks or more since their 14th birthdays (i.e. 'eligible', 'relevant' or later 'formerly relevant' young people as defined by the 2000 Children Leaving Care Act). It then applies to such young people until they are aged 21, or up to 24 if in continuing / higher education.
- Young people Accommodated under S20 of the Children Act for periods of 'respite care' totalling 120 days or less per year are not covered by this Protocol.

4. Current Procedures within the Childrens Disability Team

- For most young people to whom this Protocol refers, the procedures currently in existence will be the primary procedures as they already work well and best serve the Principles in Section One. In summary these are
 - A 'LAC' disabled young person under 16 years of age has a Social Worker as lead professional from within the DCT
 - Such young people have Care Plans and are regularly 'LAC reviewed' by QA officers under the LAC Reviewing system
 - Within the DCT, cases are routinely transferred around 16 ¼ to DCT Transitions Workers.
 - Transitions Workers formulate a comprehensive 'Transition Plan' by the time a young person is 17 and ensure that this Plan and a referral is made at this age to the appropriate Adult District Learning Disability Team, so that joint planning can commence from this age

- Cases are then formally transferred to an Adult Services Care Manager (with accompanying input as required) when the young person is aged 18.
- This 'Transition Plan' and anticipation of future services begins at 14 if the young person has a Physical Disability.

5. How the Leaving Care Service should fit with this Process

- The DCT Team Manager will send the names, together with the most recent LAC Review, of any disabled LAC who meet the criteria as outlined in Section 2. This will constitute a 'referral' to the Leaving Care Team. Such a referral will be made on or just before the young person's 16th birthday.
- In the majority of cases, where the young person has a profound or severe disability, that referral will be allocated by MLCS to one of their 3 District Team Managers, who will hold the case as that young person's named 'Worker.' In so doing however, within MLCS,
 - the case will not be allocated as per MLCS's 'usual' process to an Assessor/Planner, and an assessment followed by an Initial Pathway Plan undertaken.
 - Instead the existing Care Plan and accompanying LAC Reviews of that Plan will constitute that young person's 'Pathway Plan' until age 17.
 - By the age of 17, a comprehensive Transitions 'Plan / Summary' respect of that young person will have been written by a Transitions Worker within the DCT. That Document, once written, will be forwarded by the DCT Worker to the named Manager within MLCS and will become that young person's 'Pathway Plan'.
 - Within the 'Transitions Plan / Summary' however there will be a specific reference to Leaving Care, with an opportunity for the Transitions Worker / Manager to comment on such issues. Where it is considered that the young person may actually or potentially be moving towards independence in the coming period, MLCS will allocate this case to an Assessor \ Planner, do an assessment and write a Pathway Plan as per routine MLCS procedure.
 - Throughout the period from the point of referral through to 18 years of age, the named MLCS Team Manager will be available to Workers from the DCT in a consultative capacity as to what services, if any, the Leaving Care Team could add to the services already being provided by the DCT / other services that the DCT have brought into being. In particular the MLCS Manager will advise the DCT Transitions Workers as to any financial benefits (entitled or discretionary) the young person may qualify for under Manchester Children's Service's 16 / 21 Financial Policy. There may further be opportunities (so long as the Leaving Care Service is run by Barnardos) for young people to be able to access Barnardos In House Trust funds as with any other such young person qualifying for a service from MLCS.

5A. Cases held jointly by the DCT and District Teams within Children's Services.

- As regards links with Leaving Care such cases will follow exactly the same procedures as in Section 4 above, and be 'referred' to MLCS by the DCT as per this agreement.

5B. Cases held by the District Social Work Teams within Childrens Services

- Such cases will be referred within existing Childrens Services procedures to MLCS just before the young person's 16th birthday. If in discussing that referral with the referring Social Worker, the MLCS Manager feels that the young person has a significant level of disability the question will be asked whether and why this case has not been discussed / referred to the DCT. If even at this point such a referral is deemed appropriate, following consultation with the DCT, then such a referral will be made (by the District Social Worker) and the DCT will either take on, or jointly work, the case. If this happens, liaison with Leaving Care Services will be as in Section 4 or 4A above.
- If however the young person is not deemed to be referable to the DCT, MLCS will progress the referral on that young person by doing an Assessment and writing a Pathway Plan etc as per 'normal' procedure.

6. Current Procedures within Adult Services

6A. Learning Disability

- Cases known and open to the DCT will first be notified to the relevant District Adults Team by the DCT Transitions Worker at the age of 17, and a period of overlap and future planning will take place for that young person's transition to being Adult Services responsibility from the age of 18 onwards. The procedure already works well and is subject of an already clear and written Transitions Protocol.
- Cases known and open to the Childrens District Teams will be referred to Adult Services, again from 17 onwards, but in this instance direct to the Commissioning Team (at Fenham) to give one common referral point. The Commissioning Team will then liaise with the District Social Worker and determine what future role, and from which District CDLT, any future 'adult' service will be provided from 18 years onwards. This is a new procedure (to take effect from 8/4/07 onwards) with the purpose of ensuring one clear referral point and one clear 'clearing house' as to potential future service.
- Cases of young adults, 18 plus, coming first to any potential referrers attention, will be referred to Manchester's Contact Centre who will then pass the referral to the appropriate CDLT. A joint health / social care assessment – the 'Community Care Assessment' – will then be made under the 'Fair Access to

Care Services' criteria and if the young adult is found to have 'critical' or 'substantial' levels of need the CDLT Service will become involved; if however levels of need are found to be 'moderate' or 'low', signposting to other services will take place.

6B. Physical Disability

- In essence the process is very similar to that described in Section 6A above regarding learning disability. Cases of children are largely known to the DCT, but could also be known to the District Childrens Teams. Liaison as to future potential adult service however takes place from the age of 14 onwards via the City wide Transitions Co-ordinator (who is based in provision at the Leaf Centre). Cases are then transferred at the age of 17 to a Care Manager within one of the District PD Teams. This process applies to cases that meet the 'critical' or 'substantial' criteria under the 'fair access to care' criteria. However PD has a further Citywide short term intervention team (based at Carisbrooke, 0161 205 1406) for cases that meet the 'low' or 'moderate' criteria. This Team is able to provide a short term intervention service of its own and / or signpost the young adult to other appropriate services.

7. How the Leaving Care Service should fit with this Process.

a) Learning Disability

- As part of the 'Transitions' process that exists between the DCT and the CDLT's, the relevant Team Manager's (or Leaving Care Workers) contact name within MLCS will be notified to the Care Manager within the CDLT taking over responsibility for the case. At minimum, a copy of the annual review of that young adults case will be sent by the Care Manager to the link MLCS Manager and this will in turn form part of the review of those young adults Pathway Plan as required by the Children (Leaving Care) Act.
- Just however as with a young person under 18, the MLCS Team Manager will act as a link / consultation point to the Adult Services Care Manager with regard to any services / input/ financial entitlements (entitled or discretionary) the young adult may be able to access up to the age of 21 (or occasionally beyond) in their capacity as a care leaver. Throughout this process, if appropriate, it may well be that the young adults identified needs become such that the allocation of a Leaving Care Worker from within MLCS can add something specific to the 'care package' the young adult is receiving, in which case this will happen and future liaison between the CLDT and MLCS will take place between that Worker and the Care Manager.
- There could be further occasions where a Worker from within MLCS, already allocated to a disabled ' young person, and now being the only / lead Worker involved with that young person, finds that a referral needs to be made to the

Adults Disability Service. If that young person is under 18, this should be done direct to the Commissioning Team at Fenham; if over 18 to the Social Services Contact Centre who will direct it to the appropriate CDLT to make a Community Care assessment.

b) Physical Disability

- Again as part of the 'transitions' process between the DCT / District Teams & Adult Services, the Transitions Worker (?) (or DCT Manager?) will notify MLCS of any LAC who meets the legal 'leaving care criteria' as defined in Section 3 of this Protocol, and send MLCS a copy at that point of the young persons care plan / transitions plan. The receiving MLCS Manager will then either allocate the case to themselves and act as a consultation / referral point as regards leaving care issues to the Social Worker / Transition Worker, or allocate the case as per 'usual' to a MLCS Assessor / Planner for a leaving care assessment, leading to a Pathway Plan, to be written
- As the case 'progresses' from Childrens to Adult Services, again the MLCS Manager will act as this leaving care focal point and liaise as appropriate with the Adult Services Care Manager, or the case will have been 'fully' allocated within MLCS in which case such liaison will be between the MLCS allocated Worker and the Care Manager.
- Should a case ever first become known to MLCS where the DCT or Adults PDS is not involved, then in the case of the former discussion will take place with the City wide Transition Worker as to how to refer the young person to such a Service, or (in the case of an adult) a referral will be made to the Social Services Contact Centre for such a referral to be passed to the appropriate District PD Team for a 'Community Care' assessment.

APPENDIX A USEFUL CONTACT NUMBERS

1. Disabled Childrens Team

Social Work Team Manager	Russell Kirby	881 0911
Transitions Worker	Richard Smaling	881 0911
Transitions Worker	Susan Grimes	881 0911
Transitions Worker	Sue Tellett	881 0911

2. Adult Learning Disability

North Team Manager	Andy Todd	205 1364
Lead Transitions Manager	Diane Browczuk	205 1364
Central Team Manager	Mags Doherty	223 9901
Lead Transitions Manager	Dean Rowe	223 9901
South Team Manager	Sheila Dawber	998 7424
Lead Transitions Manager	Elaine Marsland	998 7424
Commissioning Principal Manager	Denise Price	434 7316
Commissioning Team Manager	Pam McCormick	434 7316

3. Adult Physical Disability

North Team Manager	Carmel Breen	202 4199
Central Team Manager	Janet Hayes	273 2016
South Team Manager	Carol Abrams	446 2551
City Wide Transitions Co-ordinator	Lesley Heffernan	205 4325

4. Manchester Leaving Care Service

Service Manager	John Strongman	226 6722
North Team Manager	Jeanette Smith	226 6722
Central Team Manager	Yasmin Tryon	226 6722
South Team Manager	Kim Harwood	226 6722