

1) One-page briefing

Submission to: House of Commons Health and Social Care Committee Expert Panel, *The transition from child to adult health and social care services*.

Submitter: Hleb Buziuk, independent public policy and governance researcher. This submission is non-partisan and focuses on implementation, assurance and parliamentary checkability.

Key messages

- The evidence problem is not mainly absence of policy. It is whether early planning, no-gap transfer, named coordination and adult-service follow-up are delivered consistently across local systems [3][4][5][6][8].
- The most checkable risk group is young people leaving children's services who do not meet adult thresholds, have no equivalent adult service, or fall back to primary care without a clear plan [4][7][8].
- Parliament should ask for a small common transition return, not another high-level strategy.

Key findings

1. NICE sets a year 9 transition-planning benchmark and NHS England says most healthcare preparation should start at 11 to 12 and no later than 14, yet Ofsted/CQC found children's health services often waited too long, especially mental health [3][6][8].
2. NICE requires gap analysis for young people unable to access adult services; CQC and Ofsted/CQC then describe gaps when children's services stop before adult equivalents begin [4][7][8].
3. NICE allocates senior executive and senior manager ownership, and NHS England gives ICBs responsibility for models covering 16 to 17-year-olds and service gaps, but no common public assurance return is identified in the sources reviewed [4][6][8].
4. NIHR found only 3 of the 9 proposed beneficial transition features were associated with better outcomes in a longitudinal study with 274 participants at final visit [9].

Recommendations

- **DHSC and NHS England:** within 12 months, publish a common transition assurance return. Check by named owner, denominator and first national return.
- **ICBs and upper-tier local authorities:** within 6 months, publish a transition gap analysis for adult-threshold, no-equivalent-service and primary-care-only cohorts. Check by published cohort table.
- **Providers:** within 6 months, report named-worker coverage, pre-transfer adult-service contact and follow-up after missed first adult appointment. Check by board paper or quality account.
- **CQC and Ofsted/CQC:** within 12 months, align local assessment evidence with the same small field set. Check by inspection framework crosswalk.

What is new vs official sources

- Converts existing guidance into a governance-chain test: policy, owner, denominator, follow-up.
- Adds a specific "threshold and hand-off cohort" for scrutiny.
- Separates service offer from young-person receipt.

- Uses derived metrics only where inputs are published.

Methods and limits: origin-first desk review, with synthesis only where both anchors are visible. See section 3, Annex A, section 7 data requests and section 9 hearing questions.

2) About the submitter

Hleb Buziuk is an independent public policy and governance researcher. The submission does not represent a provider, commissioner, charity or political organisation. Its added value is in evidence synthesis, governance testing and practical assurance design.

3) Methods, sources and limitations

Sources were ranked origin-first: legislation, statutory or formal guidance, regulator and inspectorate reviews, official statistics and formal evaluation. Committee material is used for scope, not as origin evidence for empirical claims [1][2].

No headline claim is secondary-only. Where this submission infers an implementation gap, it states the inference and proposes a test in section 7. Synthesis insights use at least two visible anchors, with confidence and verification owners in Annex A. Local examples and case studies are illustrative, not national outcome evidence. Any impact claim without anchors is treated as a hypothesis requiring a data test.

4) Context and background

The Expert Panel is evaluating 15 statements of intent across six areas: timeliness, coordination, involvement, workforce, independence and equity [1]. The planning grid asks evaluative questions about resourcing, implementation, outcomes, appropriateness and equality [2]. This draft therefore concentrates on what can be checked nationally and locally: whether transition starts early enough, whether no-gap transfer is real, whether responsibilities are named, whether young people experience what services say they offer, and whether vulnerable cohorts are visible in data.

5) Evidence mapped to ToR/questions/themes

5.1 Timeliness and pace

- NICE expects planning by school year 9, with numerator and denominator definitions; the Care Act provides for assessment where a child is likely to have adult care and support needs and for continuity while decisions are reached [3][5]. NHS England reinforces early healthcare planning, but Ofsted/CQC found late initiation and waits for adult services [6][8].
- Observations: published standards already define measurable start points; no-gap duties exist in social care; current review evidence still shows late starts.
- Added value: the test is “dated start plus no-gap outcome”, not policy existence.
- Three points: early planning needs a denominator; no-gap transfer needs a transfer outcome; median months to transfer should be reported.
- Counterpoint: early planning must be proportionate.
- Options: A, local audit only. B, common return on year 9 or age 14 planning and gap days. Preferred: B.

5.2 Effectiveness and cross-service coordination

- a) NICE requires joint planning and a gap analysis covering young people who cannot access adult services, including where criteria are not met or no service exists [4]. CQC found some children's services stopped before equivalent adult services started; Ofsted/CQC found threshold cliff edges and weak health involvement [7][8].
- b) Observations: the planning grid itself asks for data on primary-care management where adult services are unavailable [2].
- c) Added value: name the "threshold and hand-off cohort".
- d) Three points: count those with no adult equivalent; count primary-care-only transfers; count proposed waits over 90 days.
- e) Counterpoint: adult eligibility rules may differ legitimately.
- f) Options: A, narrative gap analysis. B, cohort table and action log. Preferred: B.

5.3 Meaningful involvement of young people and carers

- a) NICE requires help to involve young people, including peer support, advocacy and communication tools, and requires adult services to respect individual wishes about parent or carer involvement [4]. NIHR shows why receipt must be checked: service-reported offer and young-person experience did not always agree [9].
- b) Observations: involvement should be measured both by record and by young-person feedback; co-production should show what changed.
- c) Added value: move from "we offered" to "they received".
- d) Three points: verify receipt; audit accessible communication; feed back changes made.
- e) Counterpoint: surveys need accessible design.
- f) Options: A, annual survey. B, record-experience concordance audit. Preferred: B.

5.4 Workforce and training

- a) NICE says every relevant organisation should nominate a senior executive and senior manager for transition, and young people should have a named worker before, during and after transfer [3][4]. NHS England says ICBs should define responsibility for 16 to 17-year-olds and identify service gaps [6].
- b) Observations: roles are specified, but comparable coverage data are not identified nationally in these sources.
- c) Added value: distinguish named role from named coverage.
- d) Three points: publish named-worker denominator; publish executive owner; publish 16 to 17 SOP.
- e) Counterpoint: excessive returns can burden services.
- f) Options: A, board sign-off. B, named-owner and coverage return. Preferred: B.

5.5 Developmentally appropriate independence

- a) NICE says transition should be developmentally appropriate, not based on a rigid age threshold, and should support education, employment, community inclusion, health, wellbeing, independent living and housing [4]. DfE statistics show 40% of care leavers aged 19 to 21 were NEET, compared with an estimated 15% of all young people aged 19 to 21 in England from Labour Force Survey data cited in the DfE release; the cited release text does not state n for this comparison [10].
- b) Observations: care leaver data provide a measurable independence warning, not proof for all transition groups.
- c) Added value: use care-leaver outcomes as a comparator for wider transition assurance.
- d) Three points: measure EET; measure housing stability; measure self-management support.
- e) Counterpoint: vulnerable groups differ.

f) Options: A, service-process measures. B, link process to EET, accommodation and engagement outcomes. Preferred: B.

5.6 Promoting equity across transition

a) NICE requires transition support to reflect maturity, cognitive ability, communication needs and social circumstances, and recommends communication passports or other tools where needed [3][4]. Ofsted/CQC found stronger transition planning for some with EHC plans than for young people receiving SEN support without one [8].

b) Observations: public evidence is thinner on protected-characteristic splits than on general process.

c) Added value: make equity visible through denominator splits and threshold outcomes.

d) Three points: split by disability, SEN status and protected characteristic where numbers are large enough for safe aggregate reporting; report accessible-information use; report adult-threshold outcomes.

e) Counterpoint: small numbers can be volatile.

f) Options: A, narrative equality statement. B, small protected-characteristic and support-status dashboard. Preferred: B.

Public case note: NHS England's Burdett Transition Nursing Network example reported an adult clinic DNA rate falling from 45% to 5% after youth-friendly redesign, with no additional resource; n is not published in the guidance. Treat this as a service-design signal, not national outcome evidence [6].

6) Recommendations

Quick wins

1. **DHSC and NHS England:** issue a common transition assurance return within 12 months. Check: published template, denominator rules and first return.
2. **Providers:** report named worker, adult-team meeting and missed-first-appointment follow-up coverage within 6 months. Check: quality account or board paper.
3. **ICBs and local authorities:** produce a gap analysis within 6 months. Check: cohort table for no adult equivalent, adult-threshold failure, primary-care-only transfer and wait over 90 days.

Structural actions

4. **CQC, Ofsted/CQC and NHS England:** align inspection and guidance language around the same field set within 12 months. Check: inspection framework crosswalk.
5. **DHSC, DfE and NHS England:** review, within 18 months, whether transition duties across health, SEND and social care produce inconsistent cliff edges. Check: joint written update to the Committee.

Committee levers: request the field set, take evidence from DHSC, NHS England, CQC, DfE, ICBs and young people, and require a 9-month progress letter.

Delivery actions: implement named ownership, SOPs, gap analysis and receipt audits.

7) Quant-lite results and Minimum Data Request Pack

Derived metric 1: care leaver NEET risk ratio. Inputs: 40% of care leavers aged 19 to 21 NEET and an estimated 15% of all young people aged 19 to 21 NEET [10]. Calculation: 40 minus 15 equals 25 percentage points; 40 divided by 15 equals 2.7 times. Denominator note: the cited release text does not state n for this comparison; extract national numerators

and denominators from DfE underlying tables before local comparison. Volatility: vulnerable subgroup proxy, not all transitions.

Derived metric 2: youth-friendly redesign engagement. Inputs: DNA rate fell from 45% to 5% in NHS England case study [6]. Calculation: 40 percentage point fall; 40 divided by 45 equals 88.9% relative reduction. Denominator note: n is not published in the guidance. Volatility: single-site illustrative case.

Derived metric 3: receipt gap. Inputs: NIHR, 3 of 9 proposed beneficial features associated with better outcomes; agreement 30% for written plans and 49% for key workers [9]. Calculation: 33.3% feature yield; disagreement 70% and 51%. Denominator note: the 3-of-9 figure uses nine proposed beneficial features; NIHR reports 274 participants at final visit. The 30% and 49% agreement figures are reported at visit 2; this submission does not reproduce the relevant n. Volatility: selected long-term-condition cohorts.

Field	Definition	Owner	Cadence	Test
Transition cohort	Young people due to transfer	Provider or LA	Quarterly	Denominator
Plan by year 9 or age 14	Numerator and denominator	Provider or LA	Quarterly	Timeliness
Named worker	Before, during and after transfer	Provider	Quarterly	Coordination
Adult threshold outcome	Eligible, not eligible, no equivalent	ICB and LA	Quarterly	Cliff edge
First adult contact	Date and attendance	Provider	Quarterly	Engagement
Protected splits	Disability, SEN/EHCP, care leaver, ethnicity	ICB and LA	Annual	Equity

8) Impact, performance and VFM artefact

Based on the measures above, the Committee could ask for a one-page **transition value and assurance template**:

- **Inputs:** transition staff time, named-worker coverage, training completion.
- **Outputs:** plans by age 14, adult-team meetings, gap analyses completed.
- **Outcomes:** first adult appointment attended, engagement at 12 months, no discharge without contact, care leaver EET and accommodation stability.
- **Equity:** protected splits, SEN/EHCP status, care leaver status, communication-support need.

- **Value test:** whether low-cost redesign reduces did-not-attend or was-not-brought rates as a signal for further testing, not proof of national effect, before larger service reconfiguration is proposed.

Candidate metrics: plan coverage, named-worker coverage, adult-team contact, gap days, first adult appointment missed, follow-up after missed appointment, engagement at 12 months, receipt-record concordance.

9) Committee may wish to ask

DHSC and NHS England

1. What national transition metrics do you currently receive?
2. Will you publish a common assurance return by ICB?
3. How will the 2026 NHS England guidance be checked in practice?

ICBs and local authorities

4. How many young people left children's services last year with no adult equivalent?
5. How many were transferred to primary care only?
6. Who owns the 16 to 17 pathway where children's and adult criteria differ?

Providers and regulators

7. What percentage had a named worker before, during and after transfer?
8. How do you verify young-person-reported receipt?
9. How many missed first adult appointments were followed up rather than discharged?

10) Risks, references and annexes

Risks and further work

- Guidance may be mistaken for delivery evidence.
- SEND, care leaver and complex-health evidence may not generalise to every group.
- Some fields may be locally held but not nationally comparable.
- Small equality splits can be volatile.
- Single-site examples should not be treated as national effect sizes.
- New 2026 NHS England guidance may need time to embed.

References

- [1] UK Parliament, [Call for evidence: The transition from child to adult health and social care services](#), Health and Social Care Committee Expert Panel, 2026.
- [2] UK Parliament, [Panel evaluation planning grid: child to adult health and social care transitions](#), Health and Social Care Committee Expert Panel, 2026.
- [3] NICE, [QS140 Transition from children's to adults' services: quality statements](#), updated 2023.
- [4] NICE, [NG43 Transition from children's to adults' services](#), 2016.
- [5] Care Act 2014, [section 58](#) and [section 66](#).
- [6] NHS England, [Supporting young people to transition into adolescent and adult services](#), 2026.
- [7] CQC, [Transition arrangements for young people with complex health needs](#), 2022.
- [8] Ofsted and CQC, [Preparation for adulthood arrangements in local areas](#), 2024.
- [9] NIHR, [Facilitating the transition of young people with long-term conditions through health](#)

[services from childhood to adulthood: the Transition research programme](#), 2019.

[10] Department for Education, [Children looked after in England including adoptions](#), 2025.

Annex list: Annex A evidence ledger only.

Annex A: Evidence Ledger

Claim	Type	Source A	Source B and role	Status and confidence	What would change my mind	Verification owner
Early-planning standards exist but late starts persist.	SYNTHESIS	[3]	[8], independent corroboration	INPUTS-ANCHORED, High: standard plus review finding	High dated-plan compliance	DHSC, NHS England, ICBs
Threshold and hand-off cohort is a key risk.	SYNTHESIS	[4]	[7][8], independent corroboration	INPUTS-ANCHORED, High: guidance and regulator evidence align	Gap-cohort data showing minimal waits	DHSC, ICBs, LAs
Roles exist but common public assurance is not identified in the sources reviewed.	INFERENCE	[4]	[8], independent corroboration; [6], context only	INPUTS-ANCHORED, Medium: absence from reviewed sources	Published ICB return already exists	DHSC, NHS England
Service offer and young-person receipt diverge.	SYNTHESIS	[9]	[6], context only	ORIGIN-ANCHORED for metric, High	National concordance audit contradicts	Providers, ICBs