Written Evidence submitted by Hertfordshire City Council (TRN0017)

The Transition from Child to Adult Health and Social Care Services

Please provide a written submission answering, where possible, the questions set out in the planning grid below, relating to physical health, mental health and/or social care services. We are not expecting every stakeholder to be able to answer all the questions in the planning grid – please answer those that are relevant to your/your organisation's area of expertise. There are boxes below each question to be filled with your answer, should you wish to use this template.

<table>
<tr><th colspan="2">FOCUS AREA 1
TIMELINESS AND PACE OF THE TRANSITION TO ADULT SERVICES</th></tr>
<tr><td colspan="2">Statement of intent 1: "Young people who will move from children's to adults' services start planning their transition with health and social care practitioners by school year 9 (aged 13 to 14 years), or immediately if they enter children's services after school year 9". NICE QS140 (1, 2016)

Statement of intent 2: Duty for local authorities to assess a child's needs for care and support, where it appears to a local authority that the child is likely to have needs for care and support after turning 18. Care Act 2014 (Section 58) Where the child has previously been receiving services, the local authority must continue to provide those services until [adult care and support is in place]. This is to ensure no gap in provision during the transition to adult care and support. Care Act 2014 (Section 66)</td></tr>
<tr><td rowspan="2">Resourcing</td><td>1. What resources are required by health and social care services to enable identification and implementation of transition planning from year 9, or immediately after if the young person enters services later?</td></tr>
<tr><td>Hertfordshire County Council, Children Services host an integrated Children and Adult Social Care Team which seeks to facilitate safe and effective transitions from Childrens to Adults Social Care, the service was co-produced with our Parent/Carer Forum and is called 0-25 Together.

0-25 Together Service was introduced in 2016 in response to Local Area SEND Reforms. This social work and adult LD nursing team provides for statutory children and adult social care functions up to age 25.

Collaboration with NHS and Education colleagues is critical to effective planning and achieving inclusive outcomes. The benefit of this integrated approach is that transition points can be tailored to individual needs and circumstances and also allow for flexibility when there are pinch points in resourcing statutory functions either in Children or Adult social care services. Key roles that support effective outcomes are Social Workers (Child and Adult Disability), Learning Disability Nurses, Preparation for Adulthood practitioners (alternatively qualified from a range of backgrounds). The team in Hertfordshire also host Transforming Care Keyworkers which assists joint agency planning for those on the Dynamic Support Register with Autism and Learning Disability.

Health providers are less aligned locally, due to the complexity of commissioning and provider</td></tr>
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	arrangements. We have established a joint policy for NHS Continuing Care Transitions and this is being embedded. Whilst our design is proactive, resources are challenged and so families will describe that transitions at times feel insecure for them. We continually listen to feedback and target resources to support continuous improvement.
	2. To what extent are local authorities sufficiently resourced to assess children for continuing need and provide ongoing services, where needed, to ensure no gaps in provision?
	Social work demand is increasing due to pressure in SEND system and this is creating a resource pressure both in terms of staffing capacity and commissioned care and support. Since 2014, in line with trajectories for EHCP we have seen rising demand, this has led to increased budgetary pressures and continues to escalate. Child and Adult Social Care support does not perfectly align because eligibility criteria linked to legal mandate is less specific in children's social care, compared with adults. We have tried to overcome this through the application of a regionally developed, needs led eligibility threshold for Children and young people with disabilities. Similarly NHS continuing care assessment and provision do not neatly align. Policy reform in regard to Disabled Children Social Care and Children and Young People's Continuing Care would be helpful to clarify pathways and support seamless experiences for young people and their parent / carers and would also help expectation management.
Effectiveness and implementation	1. How do services identify those who will need to transition to adult services, and what proportion start transition planning in year 9? How is this monitored?
	0-25 Together Services are the primary service offer in Hertfordshire. From year 9 onwards, reviews of care needs are focussed on PFA outcomes. Data is used to forecast Adult Care demand and financial planning. Taking learning from Adult care practices we are focussed on 'connected lives' (three conversation model) and 'preventative transitions' focussed on inclusive outcomes and demonstrated best through our ASCOF performance outcomes with high levels of young people self directing their support and living in settled accommodation. Some children with less obvious 'disability needs' are supported by wider children's social care services. We have an internal pathway to transfer adults to the 0-25 Together Team at 16/17 where it is anticipated that their support needs will meet Care Act (2014) eligibility thresholds. This seeks to support planning for effective transitional safeguarding. From an EHCP perspective, transition starts in year 9 and young people across our system are supported by Services for Young People Careers Advisors. These Careers Guidance professionals also support identification of those who may require social care supports.
	2. To what extent are transfers from child to adult services managed without gaps in provision? How is this monitored?
	Very few (if any) children face gaps in their services being delivered as they move through transition. Children's services do not cease until Adult Care is in place and their needs provided for.

	The most seamless transitions are often for those using Direct Payments as commonly, adult provision is assessed for and transferred, charging policies are applied and provision continues. Challenges and delay occur where there is a need to transfer between child and adult regulated services (Ofsted / CQC), such as short break settings or residential care to supported living, pathways to housing can also create challenges which make care planning more complicated. At times sufficiency issues arise that we plan for but can be disrupted especially where a young person displays behaviours that are a risk to themselves or others. Demand for this type of bespoke provision has increased as we seek to respond to MHA reform and Transforming Care agenda, observing higher prevalence of Autism within the Disabled peoples community who have high risk support needs
Impact and outcomes	1. How is the transition support strengths-based, focusing on what is positive and possible for the young person NICE NG43 (1.1.3, 2016)?
	Person Centred planning is central to our operating model. Our connected lives model supports conversations with young people that seek to build on their strengths and connect them with their communities based on what is important to and for them. Goal Based plans are being introduced to support enablement and skill building. These take time and resource pressures limit our consistency of effectiveness in this activity, nonetheless we have made positive progress in implementing over the past year.
	2. How is the recommendation that the point of transfer to adult services should be based on individual need, rather than rigid age criteria, managed in practice NICE NG43 (1.2.3, 2016)?
	Our social care approach is typically flexible between ages of 18 and 19.5 and dependent upon circumstances. We will always secure stability prior to transfer and our integrated service model supports this as budgets are held by one overarching Head of Service who can support safe, effective and person-centred decisions.
Appropriateness	1. To what extent are service providers able to meet these statements of intent?
	Service providers aspire to achieve effective transitions but clearly registration issues serve as a barrier to delivering continuity of services and there are few 16-25 services that both Ofsted and CQC would jointly register. A challenge for example is a young disabled person coming into care at 16 who needs a highly bespoke arrangement. The regulatory system can feel inflexible in this regard and makes creative and personalised service design a challenge. Inevitably young people need to move home more than once which might not serve their long term interest.
	2. How appropriate are the current expectations on the timeliness and pace of the transition at both the individual and service level?
	Early planning is helpful, but it is not possible to plan with specificity for social care provision years in advance. At 14 we tend to focus on outcomes aspired to, and provision of information, advice and guidance. It is only in the 17 and 18th year that we design and execute an adult care plan where we know we can provide a particular service offer. There is a gap between policy design and practicable delivery and again this can confuse expectation of families and lead to feelings of dissatisfaction and uncertainty.
Equality and diversity	1. How is the progress of underserved or vulnerable service-user groups, including those with protected characteristics, monitored in the delivery of services under this guidance?
	Practitioners are trained and supported to operate in an anti discriminatory, anti racist and anti oppressive way. We evaluate the diversity across our communities and use this to broaden

	awareness and support effective service delivery.

FOCUS AREA 2 **EFFECTIVENESS OF THE TRANSITION PROCESS AND CROSS-SERVICE COORDINATION**	
Statement of intent 1: Jointly plan services for all young people making a transition from children's to adults' services. For young people with education, health and care plans, local authorities and health commissioners must jointly commission services, as per the Children and Families Act 2014. NICE NG43 (1.5.9, 2016) **Statement of intent 2:** Carry out a gap analysis to identify and respond to the needs of young people who have been receiving support from children's services, including child and adolescent mental health services, but who are not able to get support from adult services. The gap analysis should inform local planning and commissioning of services. When carrying out the gap analysis: take into account resources already available in primary care practices; include young people who don't meet eligibility criteria for support from adults' services and those for whom services are not available for another reason; pay particular attention to young people: with neurodevelopmental disorders, with cerebral palsy, with challenging behaviour, or who are being supported with palliative care. NICE NG43 (1.5.7-8, 2016)	
Resourcing	1. What resourcing is needed for health and social care services to effectively enable joint working and commissioning?
	Relationships are key to system innovation and sharing of responsibility. Recent NHS reform has led to a current phase of uncertainty in terms of relations across ICB and LA. This feels cyclical with each system restructure leading to insecurity and restrictions to shared vision and delivery. Financial pressures at times lead to service reductions which can cause distress for families and drive unintended consequences that are realised later – essentially increasing demand and cost overall.
	2. Are gap analyses taking place across services, when do these take place, how are they acted on and how is this monitored?
	Sufficient capacity of both NHS and LA commissioners is needed to effectively jointly analyse gaps and plan and invest collaboratively. In a Hertfordshire context this is a challenge as local councils become smaller (LGR) and ICB become larger. Most recently the ICB reforms mean that NHS Leaders previously focused on the 1.2m Hertfordshire population are now having to reconcile a 3m plus population for the Central East ICB which spans 9 local authorities. Clarity about sustainable partnership delivery models are needed in order to analyse and share responsibility for closing gaps at Place. Budget pressures typically restrict proactive investment or stepping beyond the statutory minimum.
Effectiveness and implementation	1. How effective is joint commissioning and coordinated delivery of the care received by children and young people at the point of transition?
	Planning for sufficiency across Hertfordshire is strengthening. Use of SEND, Social Care as well as DSR data is supporting an effective response. The scale of our local area commissioning capacity is an enabler. We will need to give careful thought to how the new local authorities sustain this position as we move to new local government arrangements.
	2. Are there ways in which better and more effective joint working could improve the provision and quality of services? What does good practice look like in cross-service commissioning and delivery?
	A range of financial streams and commissioning activity are needed to support effective

	transitions. Governance in Hertfordshire is provided by our PFA Board which provides system governance that is accountable to our SEND Board. This collaborative approach enables a birds eye view of the system and importantly connects lived experience with operational and commissioning leadership so that our ambition is continually focussed on improving outcomes with a shared understanding of opportunities and pressures.
Impact and outcomes	1. Where health and social care organisations have not been able to fulfil these statements of intent, what has the impact been?
	In 2022, we had a shortage of Adult Overnight Short Breaks which created huge concern for families. The local authority sought to overcome this position and it is now resolved, whilst we would always seek to offer an alternative but at times support at home might not be as appreciated as breaks within an alternative setting.
	2. What is the impact of joint working on an individual's experience of the transition between child and adult services?
	Where services are planned for at both a personalised and strategic level then families feel better supported and will often be enabled to care for their young person at home for longer.
	3. Is there available data demonstrating the proportion of young people who are transitioned to primary care management, for example where there is no specific adult service, or they do not meet the requirements for adult services?
	This data is not currently visible to the local authority. I would suspect variability according to NHS Trust capacity to collate data.
Appropriateness	1. Are current guidelines and guidance in this area appropriate for children and young people, and for the health and social care professionals involved?
	Updated guidance would be timely and support more specific expectations and in turn consistency of self-evaluation for both health and social care commissioners / providers.
Equality and diversity	1. How are underserved or vulnerable service-user groups, including those with additional needs, considered in the delivery of services under this guidance?
	By listening to all groups and collating lived experience of unmet need we are able to respond in design of both personalised and new support services. We have not devised an effective means of data capture to reliably assess our performance.

FOCUS AREA 3 **MEANINGFUL INVOLVEMENT OF CHILDREN, YOUNG PEOPLE AND THEIR CARERS**
Statement of intent 1: Adults' services should take into account the individual needs and wishes of the young person when involving parents or carers in assessment, planning and support. For young people with an education, health and care plan or a care and support plan this must happen, as set out in the Children and Families Act 2014 and the Care Act 2014. NICE NG43 (1.2.22, 2016) **Statement of intent 2:** Offer young people help to become involved in their transition planning. This may be through:

peer support, coaching and mentoring, advocacy, the use of mobile technology. NICE NG43 (1.2.11, 2016) **Statement of intent 3:** Involve young people and their carers in service design, delivery and evaluation related to transition by: coproducing transition policies and strategies with them; planning, coproducing and piloting materials and tools; asking them if the services helped them achieve agreed outcomes; feeding back to them about the effect their involvement has had. NICE NG43 (1.1.1, 2016)	
Resourcing	1. How are services resourced to take into account the needs, wishes and aspirations of the young person, including during the planning process and after transition?
	Assessments are personalised and an opportunity to amplify voice and personalise care planning. Similarly follow up reviews need to focus on needs and outcomes and be focussed on principles of person-centred planning. Our application of 'Goal Based planning' is supporting outcome based planning and increased independence for young people who have potential to gain autonomy and control in their lives whilst staying safe.
	2. What resourcing is required to enable co-production of transition strategies/policies and provide feedback on the outcomes of the co-produced initiatives?
	Parent/ Carer Forums and their extended partnership networks are critical. We have also recruited a number of young disabled adults who are experts by experience. This capacity supports effective partnership commissioning and is an important yardstick in determining and delivering against priority actions within our local context. Of course commissioning and leadership capacity to support PFA Partnership Board.
Effectiveness and implementation	1. How are young people, and their carers, involved in their transition planning and what methods are effective in supporting involvement?
	Health Passports / Purple Folders are supporting self directed access to NHS care into adulthood, enabling reasonable adjustments. One-page profiles bring self-identity into care and support planning. SC assessment processes are designed to capture and amplify voice and our QA activity amongst other factors seeks to focus on this and continuously improve practice
	2. What does effective inclusion of young people in the planning and delivery of their transition look like?
	Young people and their families are empowered and informed early so that they can make choices about their next steps and have access to professional, advice guidance and resources to support them to navigate support systems.
Impact and outcomes	1. What are the impacts of co-producing transition policies and strategies with children and young people?
	Co-producing transition policies and strategies with children and young people has a significant positive impact on the quality, effectiveness, accessibility, and outcomes of transition services. It ensures that services are designed around real needs, preferences, and lived experience, rather than assumptions, and directly supports the principles set out.
	2. What does a good transition service look like, and how is an effective transition defined, measured and monitored at both individual and service levels?

	A good transition service is planned, person-centred, coordinated, and outcome-focused, supporting young people to move from children's to adult services in a way that maintains continuity, promotes independence, and achieves outcomes that matter to them. 0-25 Together in Hertfordshire is built with the ambition to support Disabled Young people to lead safe, independent and fulfilled lives – a vision that was coproduced.
Appropriateness	1. Are the current guidelines for the involvement of individuals and their carers in the transition to adult services appropriate for the needs of young people and services?
	Overall, current guidelines are appropriate and well-evidenced in principle, setting out a strong, person-centred framework for involving young people and their carers in transition to adult services. They clearly reflect young people's rights, developmental needs, and legal entitlements. However, the main challenge lies not in the guidance itself, but in its consistent implementation, given service capacity, workforce variation, and system complexity.
Equality and diversity	1. How are underserved or vulnerable patient groups, including those with special educational needs and disabilities involved in their own transition planning? SEND Code of Practice 0-25 years (8.54, 2015)
	Personalised approaches to assessment, review and planning facilitate application of the SEND code of practice.
	2. To what extent are underserved or vulnerable service-user groups involved in co-production of transition policies and strategies?
	Co production with experts by experience and parent care forums are supporting inclusivity and voice in system and service design.

FOCUS AREA 4 **WORKFORCE AND TRAINING**	
Statement of intent 1: Staff receive training in adolescent development, managing long-term conditions and transitional care, such as the Adolescent Health Programme e-learning, as a context for understanding the impact of complex and long-term health needs. OHID You're Welcome (4, 2023) **Statement of intent 2**: Young people who are moving from children's to adults' services have a named worker to coordinate care and support before, during and after transfer. NICE QS140 (4, 2016) **Statement of intent 3:** Each health and social care organisation, in both children's and adults' services supporting young people in transition, should nominate: 1 senior executive to be accountable for developing and publishing transition strategies and policies, 1 senior manager to be accountable for implementing transition strategies and policies. The senior executive should be responsible for championing transitions at a strategic level. The senior manager should be responsible for: liaising with the senior executive; championing, implementing, monitoring and reviewing the effectiveness of transition strategies and policies. NICE NG43 (1.5.1-3, 2016)	
Resourcing	1. Which healthcare professionals form the transition team for young people, and are their roles- including that of the lead healthcare professional- clearly defined? Do staff have sufficient time allocated for their specified roles?

	The Designated Clinical Officer supports active planning and thinking around Health Transitions. Adult LD Nurses provide a critical role and link with Children's Transition nurses and who support children with most complex needs approaching adulthood.
	2. What is the role of health and social care organisation executives in overseeing the implementation and evaluation of the transfer to adult services?
	Hertfordshire have a long standing, PFA Board which is accountable to SEND Partnership. The Board evaluates outcomes data and tracks progress of collective improvement activity.
	3. Is there any workforce data to demonstrate the required capacity to deliver an effective transition for young people at service level? To what extent is this currently being met?
	No
Effectiveness and implementation	1. Are existing training and education in place for staff effective in improving experiences for young people at the point of transition/transfer between services?
	No
	2. How are staff trained to effectively support young people through the transition from child to adult health and social care? What is the standard training offer- is this available to all, and how is this different for staff regularly involved in transitions?
	We have a matrix of minimum training requirements focused on Communication, Safeguarding, Equalities, Restrictive Practices and Oliver McGowan and we reinforce skills in person centred planning. Support from experienced practice mangers.
	3. To what extent are executives of health and social care organisations exercising their duty to champion transitions at a strategic level?
	Regional DCS / DASS are focussed on Transitions and sponsored most recently some collective developments around Transitional Safeguarding.
Impact and outcomes	1. What is the impact of training and education for staff on their experience, and young people's experiences, of transitioning between child to adult services? How is this monitored?
	Our parent carer forum issue an annual survey and 0-25 Together have a live pulse survey which is continuously available to families after every interaction. We also monitor complaints and compliments. Our SEND Partnership operates a dashboard that captures and amplifies voice. Activity of access to our online SEND local offer is also used to understand need for information and guidance.
	2. Where staff are not equipped with the right skills, what is the impact on the service, and the young people it serves?
	This would lead to poorer outcomes.
	3. What is the impact of having named staff members responsible for transitions – for example, a named worker for each individual, a clinical lead and a named executive and senior manager at the organisational level?

	This would support increased effectiveness
Appropriateness	1. Is the level of training and education provided to staff appropriate for the needs of young people at the point of transition?
	We believe so and believe that colleagues should continue to learn. We value tie role of regional improvement partnerships and would encourage greater investment to support further learning and development opportunities, importantly these networks should straddle health and social care to continue to encourage joined up leadership and collective focus where this is underdeveloped.
	2. Is there any staff feedback on the utility and suitability of the training provided, or data on the uptake?
	Not specific to Transitions but given daily work pressures we know it is important to focus on attendance of colleagues at learning events to ensure engagement.
Equality and diversity	1. To what extent are staff trained to deliver person-centred care for young people with additional needs, and to support their carers?
	Whilst it is an aspiration of all systems and services, it is important to acknowledge that skills in person centred thinking, strategies and tools must be consistently promoted in order to serve the population well, particularly where young people have learning disability or total communication need. We would suggest that standards are variable. There are gaps in policy guidance with regard to assessment of Mental Capacity / BIA and guidance has not supported consistent practice across health and social care in this regard. It would be helpful to reignite the ambition of Liberty Protection Safeguards.

FOCUS AREA 5 **ENABLING DEVELOPMENTALLY APPROPRIATE INDEPENDENCE**	
Statement of intent 1: Service managers should ensure there are developmentally appropriate services for children, young people and adults to support transition, for example, age banded clinics. NICE NG43 (1.5.11, 2016) **Statement of intent 2:** Use person-centred approaches to ensure that transition support addresses all relevant outcomes, including those related to education and employment, community inclusion, health and wellbeing, including emotional health, independent living and housing options. NICE NG43 (1.1.4) **Statement of intent 3**: Local authorities are required to maintain a Pathway Plan for every eligible care leaver, setting out how the young person's health needs- including mental health- will be met. Children Act 1989 as amended by the Children (Leaving Care) Act 2000.	
Resourcing	1. Are services sufficiently resourced to offer developmentally appropriate provisions, such as age-banded services, and how is this monitored?
	Im not aware of this in social care context
	2. Are services sufficiently resourced to assess need and provide support for the cross-sector outcomes listed in NICE NG43 (1.1.4)?
	Services are **partially resourced** to meet the ambitions of NICE NG43 (1.1.4), but not at a level that ensures consistent, equitable delivery of cross-sector outcomes. The main constraints are: • Insufficient workforce capacity

	• Fragmented commissioning and funding • Limited integration between health, social care, education, and housing systems
Effectiveness and implementation	1. What methods of delivering person-centred transition support have been effective in improving outcomes across the areas listed in statement of intent 2? Are there any methods that have been ineffective and have been discontinued as a result?
	1) Named Keyworker 2) Proactive information and advice 3) Integrated Team 4) Multi Agency strategic partnership
	2. What methods of service design and delivery have been effective in ensuring that transition provision is developmentally appropriate, including being responsive to young people's developmental stage, maturity and readiness for independence? Are there any particular methods of service design which have been ineffective and discontinued?
	0-25 Together has been an effective model of practice. Parents identify with the service model and understand the offer. There have been benefits to bringing together children's and adult social work professionals and bringing adult care knowledge into children's disability services.
	3. To what extent are local authorities fulfilling their duty to provide 'Pathway Plans' for children in care as they approach adulthood, in accordance with the Care Leavers (England) Regulations 2010? How is this monitored?
	In Hertfordshire we fulfil our statutory duty to provide Pathway Plans by ensuring that all children in care approaching adulthood, and all eligible, relevant and former relevant care leavers, have a Pathway Plan in place that is timely, reviewed at least six-monthly and responsive to changes in need and risk. Pathway Plans are initiated early, developed with the young person, and used as a live planning tool to support successful transitions into adulthood, including clear plans for accommodation, education, employment, health, relationships and emotional wellbeing. We monitor this robustly through a multi-layered governance framework that includes live performance dashboards tracking Pathway Plan timeliness and review compliance, routine management oversight through supervision and senior management meetings, and targeted quality assurance activity, including audits and thematic reviews. Learning from internal audits and Ofsted expectations is embedded into practice guidance, training and supervision, ensuring continuous improvement and providing assurance to leaders that statutory duties are being met and that Pathway Plans are making a meaningful difference to the lives of children in care and care leavers.
Impact and outcomes	1. What evidence is there that developmentally appropriate transition support improves safety and independence-related outcomes after entry to adult services?
	Connected Lives | Hertfordshire County Council Adult Care Service delivery is underpinned by our Connected Lives approach- outcome-focused, meaning the support we provide is determined by the outcomes a person wants to achieve. Many people's outcomes can be achieved by engaging with resources available in their local community whilst others may require more formal services. Where possible, we will support a person to explore preventative

	and enabling support options to achieve their outcomes before considering formal services. We want to connect people to real lives so they can live independent lives in their local community. It's not just about connecting people to other people – it could be services, work, technology or activities in their local community. Often a service will help people be independent. The principles of Connected Lives are embedded in everything we do: - the way our social care practitioners work with people to support independence, choice and citizenship - the way our commissioners and care providers think beyond just 'good care' and focus on what people want to get out of life - the way we talk to family carers about their aspirations and support them to achieve their goals as individuals. - This focus is supported by an outcomes focussed model in children services that prioritises inclusion and participation that enables young people to achieve.
	2. Across education and employment, community inclusion, health and wellbeing, independent living and housing options, are there areas which require more or better guidance to enable effective transition?
	Guidance to support access to Adult Short Break services with greater links between preventive models of support in adult social care and housing that align with early help models of support in children social care. This is possible but delivery is inconsistent.
	3. What evidence is there that the use of 'Pathway Plans' improves care leavers' access to appropriate health and mental health support and contributes to better outcomes in adult life?
	In Hertfordshire, evidence from our local audits, quality assurance activity and direct feedback from young people via our regular Bright Spots Survey's demonstrates that high-quality Pathway Plans play a central role in improving care leavers' access to health and mental health support. Where Pathway Plans are timely, co-produced and actively reviewed, they provide a clear framework for identifying emotional and mental health needs early, planning transitions from children to adult health services, and coordinating support across social care, health, housing and justice partners. Our audits show that care leavers are more likely to engage with mental health services when their needs, referrals and advocacy actions are clearly set out within a Pathway Plan and revisited during supervision and key transition points such as entering or leaving custody. While we recognise that Pathway Plans alone cannot eliminate the structural inequalities faced by care leavers, Hertfordshire's evidence indicates that strong Pathway Planning contributes to improved adult outcomes. To support this area of work we have 2 Mental Health Workers embedded within the Care Leaver Service and a senior leader role specific to the strategic oversight of our children in care and care leavers mental health. These roles strengthen our ability to provide effective, outcome-focused Pathway Plans which are more likely to ensure young people to experience stability in housing, sustained participation in education, training or employment, and continued relationships with trusted professionals—factors that are strongly

	associated with better mental health, resilience and wellbeing in adulthood.
	4. What are the consequences when transition support is absent or inconsistent?
	When transition support is absent or inconsistent, young people are not simply *unsupported*—they are actively placed at risk of poorer lifelong outcomes. Greater focus and preventative investment is important, prior to 2010 Supporting People Housing options and Youth Connexions were an important support to social care systems that are missed.
Appropriateness	1. How far are current approaches to promoting independence tailored to developmental stage and individual circumstances, compared to standard age-based assumptions?
	Current approaches have moved away from rigid age-based assumptions towards developmental and individualised models. Tailoring is improving in principle and in pockets of good practice. We continue to challenge ourselves to be outcome focussed and enabling within the social care support that we commission and provide.
	2. How is the model of independence appropriately adapted for young people who will continue to require substantial support in adult life?
	Connected lives More about the Connected Lives principles
Equality and diversity	1. How far do services adapt support for independence to the differing needs and circumstances of distinct groups of young people?
	Services do adapt support for independence, but selectively and unevenly. Adaptation is strongest where needs are: • Legally recognised • Diagnostically defined • Aligned with existing service structures It is weakest where needs are: • Developmental • Relational • Cumulative or trauma-related As a result, the young people most in need of nuanced, flexible support are often the hardest to serve, especially where they pose a risk to themselves our others through their first few years of adulthood.
	2. What evidence is there that some groups are less likely to receive appropriate or sufficiently ambitious support for independence, and why?
	Some groups—particularly care leavers, those with mental health needs, and young people with complex but non-categorised difficulties—are less likely both to receive appropriate support and to be supported ambitiously toward independence. Hertfordshire has recognised this by introducing Mental Health Workers and additional senior leadership specifically to address this.

FOCUS AREA 6 **PROMOTING EQUITY ACROSS THE TRANSITION**	
Statement of intent 1: The service provides publicity material specifically on transition to adult services that is accessible for everyone such as in different languages or for young people with or without disabilities. This is youth-friendly, and uses age-appropriate language and images for the age and ability of the young person. OHID You're Welcome (8, 2023) **Statement of intent 2:** Service managers should ensure a range of tools is available, and used, to help young people communicate effectively with practitioners. These may include, for example: ways to produce a written record of how a young person communicates, for example, communication passports or 1-page profiles; ways to help the young person communicate, for example, communication boards and digital communication tools. NICE NG43 (1.2.12, 2016)	
Resourcing	1. Do services have the capacity and funding to deliver on these statements of intent for young people with additional needs?
	Hertfordshire has a SEND Local Offer that is published in English and includes required information for health and care pathways within a preparation for adulthood section. We do not print information in other languages but our systems do support links into google translate.
	2. Do all staff involved in transition services receive training that is culturally competent based on local population needs?
	Local Authority staff are trained in culturally competent ways of working for the populations that they support. Each Team has a EDI champion and these issues are discussed weekly to continually boost priority and focus on improved practice and outcomes.
Effectiveness and implementation	1. How effective are services in addressing the specific needs of young people as individuals?
	We believe that our plans and planning are strength based and highly personalised. Personal budgets are allocated according to needs and resources available to each young person and the service they use are many and varied.
	2. To what extent are services providing the right tools to ensure that all young people can communicate their needs?
	Young people use a range of communication tools, often initially accessed in education settings and then moving with them when they leave school.
	3. To what extent is data recorded and monitored for effectiveness and quality of the transition for individuals from underserved patient groups, or with protected characteristics?
	Underdeveloped – whilst we could capture a range of protected characteristics within our user base, we do not have a qualitative measure of effectiveness for all young people.
Impact and outcomes	1. What is the impact of the provision, or lack of provision, of person-centred care for individuals with additional needs?
	The provision of person-centred care has a significant and measurable impact on the health, wellbeing, safety, and life outcomes of individuals with additional needs. Where person-centred care is embedded, individuals experience improved engagement and outcomes; where it is absent or inconsistent, the impact can be negative and long-lasting.

	2. What is the impact of comprehensive data collection and usage for young people with additional needs and/or protected characteristics?
	Comprehensive and appropriate data collection, when used ethically and effectively, has a significant positive impact on young people with additional needs and/or protected characteristics in Hertfordshire, particularly during transition to adult services.
Appropriateness	1. How appropriately are health and social care services providing tailored care to individuals with additional needs?
	Health and social care services are providing tailored care to individuals with additional needs with mixed but improving effectiveness. Appropriateness varies depending on the consistency of assessment, quality of data use, workforce capability, and system integration.
	2. To what extent are services able to accommodate different communication needs for individuals with communication difficulties?
	Health and social care services are able to accommodate different communication needs to a moderate and improving extent, but this capability is likely to be variable. We ensure staff are trained in communicating with Disabled Children and are supported to actively amplify voice in the records they maintain of their practice activities.
Equality and diversity	1. How are underserved or vulnerable patient groups considered in the planning, strategy and delivery of transition services?
	Underserved or vulnerable patient groups are increasingly considered in the planning, strategy, and delivery of transition services, though the extent and consistency of this consideration varies across systems and organisations. We need to do more to capture data that supports strategic analysis and longer term planning.
	2. What extra data is captured for young people with additional needs, specifically those at the intersection of different protected characteristics?
	Data capture is in line with DFE guidance which is limited in regards to specificity of impairment, complexity of need and circumstances compounded by intersecting need. It does not align with DHSC data capture. Efforts to define demographic understanding across public organisations would be helpful to improve collective collation and evaluation.