Shadow Health and Wellbeing Scrutiny Committee
Policy Review 2015 – 2016

Moving On: the transition from child to adult care services

Draft Report

Contents

1 Foreword

"Becoming an adult means leaving the world of your parents and starting to make your way toward the future that you will share with your peers."

Alison Gopnik

Growing up and moving from being a child to an adult is never an easy thing, but it is something everyone must face. For the vast majority of young people they make this transition with the support and guidance of parents, who help them along the path to adulthood and the wider world outside of the family environment. However for young people with more complex health and social care needs, this time of transition can be especially stressful.

It is just as important that young people with long-term conditions, mental health problems or those leaving the care system have the same ability to make that step into adulthood. The transition arrangement is the process that supports this move from a children's orientated care system into the very different adult health services. The committee decided to look at this transition process and how it supports young people, parents and families through this difficult phase of life.

Through the Committee's investigations Members received evidence from a wide range of people and organisations relating to the transition process. It is apparent from these discussions that there is a lot of excellent work being conducted to ensure that the transition process is not only person-centred but also as seamless as possible. The introduction in late 2014 of Education and Health Care Plans are a clear driver in supporting a young person's development and aspirations as well as bringing together providers from education and health service spheres.

Finally the Shadow Health and Wellbeing Scrutiny Committee would like to thank the officers, individuals and partner organisations who provided their time so willingly to help the panel gather the evidence for this review, this contribution and cooperation is, as always, greatly appreciated.

Cllr Jill Fletcher
Shadow Health and Wellbeing Scrutiny Committee
March 2016

2 Introduction

2.1 The Scrutiny Debate provided the usual variety of scrutiny topics for potential review during the coming year. The Health, Housing and Adult Services Scrutiny Panel, commissioned by the Scrutiny Committee, agreed to undertake a spotlight review around the issue of transition from child to adult care services.

3 Aim of the Review

3.1 To understand the transition process from child to adult care services and how to promote and develop sustainable and seamless transitions to adulthood.

4 Terms of Reference

4.1 The title of the review was agreed as 'Moving on: the transition from child to adult care services' and its terms of reference were agreed as:

(a) To define and understand the transition arrangements that exist from child to adult care services;

(b) To ensure that transitional awareness, understanding and expectations are developed, managed and in place from an appropriate early stage;

(c) To understand the differences that exist between child and adult services and what this means in terms of transition;

(d) To consider how a seamless transition into adulthood can be developed, sustained and promoted.

5 Membership of the Shadow Committee

5.1 The membership of the Shadow Health and Wellbeing Scrutiny Committee during the Municipal Year is outlined below:

Cllrs Jill Fletcher (Scrutiny Lead Member for Health, Housing and Adult Services), George Howe (Lead Member for Public Health, Wellness and Culture), Rebecca Atkinson, Richard Bell, Rosalind Copeland, John Cummings, Michael Dixon, Alan Emerson, Louise Farthing, Juliana Heron, Julia Jackson, Shirley Leadbitter, Barbara McClennan, Paul Middleton, Dorothy Trueman, Doris Turner and Geoff Walker.

6 Methods of Investigation

6.1 The approach to this work included a range of research methods namely:

(a) Desktop Research;
(b) Use of secondary research e.g. surveys, questionnaires;
(c) Evidence presented by key stakeholders;
(d) Evidence from members of the public at meetings or focus groups; and,
(e) Site Visits.

6.2 Throughout the course of the review process the panel gathered evidence from a number of key witnesses including:

(a) Martin Birch (Interim Head of Looked After Children)
(b) Lynden Langman (Service Manager)
(c) Ben Rosamond (Person Centred Planning Development Officer)
(d) Paul James
(e) Peter Nicol (Team Leader – Connexions)
(f) Annette Parr (Lead Support and Intervention Officer)
(g) Denise Geary (Health Transition Nurse)
(h) Nigel Harrett (Deputy Principal – Sunderland College)
(i) Rachel Wiles (Student Services Manager – Sunderland College)
(j) Lennie Sahota (Head of Service Adult Social Care)
(k) Melanie Carson (Headteacher – Portland Academy)
(l) Steve Murphy (Deputy Headteacher – Portland Academy)
(m) Martin Hope (Portland Academy)

6.3 All statements in this report are made based on information received from more than one source, unless it is clarified in the text that it is an individual view. Opinions held by a small number of people may or may not be representative of others' views but are worthy of consideration nevertheless.

7 Findings of the Review

Findings relate to the main themes raised during the panel's investigations and evidence gathering.

7.1 Transition: Facts and Figures

What do we mean by transition?

7.1.1 Transition is defined as the process or a period of changing from one state or condition to another. The Department for Health's 2006 publication 'Transition: getting it right for young people' defines transition as '*a purposeful, planned process that addresses the medical, psychosocial and educational/vocational needs of adolescents and young adults with chronic physical and medical conditions as they move from child-centred to adult-orientated health care systems'.*[1] Transition is a period of increased risk where young people move from their 'safe' environments of paediatric teams coordinating health service requirements to an adult environment where consultation with several different health teams and adult social care services is not uncommon.

7.1.2 The journey from adolescence into adulthood is particularly challenging for all young people from biological, social and psychological perspectives. For those young people with any form of disability, long-term conditions or significant mental health problems, this is made even more difficult. As they move between different health care services, they will find significant differences in the expectations, style and culture of these services, at the same time as their own care needs will be changing.

7.1.3 Young people who have a lot of contact with agencies, services or support, it can prove very difficult to navigate that move between children's and adults' service provision. When young people leave one service and enter into another, they may be faced with a swathe of new assessment criteria. Assessed needs may be met in alternative ways, and they may receive a different level or type of support to what they have been used to. Young people, their parents, carers and families have reported that this can be a very difficult and daunting experience.

National Context

7.1.4 In England, there are more than 40,000 children and young people under 18 who are living with a life-threatening illness or life-limiting condition. There are also 55,000 young adults (aged 18-40) living with a life-threatening illness or life-limiting condition. In terms of life-limiting or life threatening conditions there are more than 300 differing conditions including cystic fibrosis, muscular dystrophy, severe cerebral palsy and certain types of cancer.[2]

7.1.5 The Children and Young People's Health Outcomes Forum published proposals in July 2012 on how to improve health-related care for children and young people. This included findings in relation to transition stating that poor transition can lead to poor health outcomes for both physical and mental health and at its worst could lead to a dropout from medical care altogether. The result from this was a commitment, from a number of organisations, to work on improving the experience and outcomes of transition to adult services for children and young people.

[1] From the pond into the sea: Children's transition to adult health services. Care Quality Commission. July 2014

[2] From the pond into the sea: Children's transition to adult health services. Care Quality Commission. July 2014

7.1.6 The National Institute for Health and Care Excellence (NICE) is currently developing guidance on transition. NHS England is developing a service specification for transition for specialised services. There are imminent changes as a result of both the Children and Families Act 2014 and the Care Act 2014. These include specific provisions designed to support more effective transitions to adult services for young people with special educational needs or disability, in health and social care respectively.

7.1.7 The Children and Families Act 2014 ensures that children, young people and their families must be involved in discussions and decisions about their individual support and local provision. The Act also replaces the current system of Statements and Learning Difficulty Assessments with 0-25 Education, Health and Care Plans (EHC), which reflect the child or young person's aspirations for the future, as well as their current needs. Within this young people have the right to request an (education) personal budget as part of the EHC planning process.

7.1.8 The Care Act 2014 also places a duty of care on local authorities to carry out a transition assessment for a young person or carer, in order to help them plan, if they are likely to have needs once they (or the child they care for) turn 18. There are 3 groups of people, under the Act, who have a right to a transition assessment:

- Young people, under 18, with care and support needs who are approaching transition to adulthood;
- Young carers, under 18, who are themselves preparing for adulthood;
- Adult carers of a young person who is preparing for adulthood.

Local Context

7.1.9 The Panel noted that between 2009-2015 the council operated a Futures Team, located within the then Health, Housing and Adult Services Directorate, which focused on individuals going through the transition process; it was essentially a team of Person Centred Planning facilitators who provided intense support to young people and their families between the ages of 14 - 25. The Futures Team worked in partnership with a range of agencies that included Children's and Adults Care Management and Assessment, SEN Team, Connexions, schools, colleges, Young Peoples Learning Agency, Job Centre Plus, Job Linkage, Remploy, Community & Cultural Services, Housing, health organisations and service provider organisations.

7.1.10 Members were also informed that recent restructures had meant that the service was no longer sustainable and there was the development of the new Lifespan Service; a single service for disabled children and young people aged 0-25, at which point young adults who require on-going support would be supported by the appropriate adult's team. A period of uncertainty currently exists as a result of the recent Ofsted inspection and the focus on children's safeguarding measures.

7.2 The Transition Process and Education and Health Care Plans

7.2.1 Transition planning with young people should begin at age 14 and upwards and should include issues around employment, independent living, community inclusion and Health. Members acknowledged that the Transition process can be extremely complex including multiple agencies' input, as well as that of the individual and their family or carers. Members also recognised that there was an expectation that the family would be able to understand all of the options available and the processes involved. The amount and variety of information can at times be

confusing. The further introduction of personalised budgets was another area where families were expected to fully understand the procedures involved.

7.2.2 From September 2014 Education, Health and Care (EHC) plans started to replace Statements of Special Educational Needs and Learning Difficulty Assessments. Members were informed that EHC plans would focus on what a child or young person wants to achieve and what support would be needed to do this. Currently, across the city, there are approximately 1,200 children and young people with a statement of educational need who would transfer to an EHC Plan over the next 2 years.

7.2.3 Members were informed that EHC plans can begin anytime between 0-25 with preparation for transition starting at Year 9 (14 years old). This usually takes place in the school setting with the young person, family and key agencies including health and social care meeting and discussing the key aspects of the EHC plan. Importantly this review process helps to ascertain what a young person wants and how that can be enabled. This view was emphasised by the Person Centred Planning Development Officer as it was crucial to understand what was important to each individual young person going through the transition process. It was also noted that each EHC plan was reviewed at a minimum of 12 months to ensure that the plan was still current and that nothing had changed.

7.2.4 The guiding principles of EHC Plans were that children, young people and their parents/carers were at the heart of the process through person centred and key working approaches used flexibly. Plans were also a streamlined approach, which avoided repetition and invested time in joint agreement, as well as a focus on the key outcomes for children and young people. The EHC Plans also built on the processes currently being used to support and plan with children, young people and their families, adapting and aligning those that were working well with the EHC Planning process and developing new processes where required.

7.2.5 Members clearly understood that person centered practices were at the heart of the reforms and that young people and their families had far greater choice and control which allowed for the raising of individual aspirations and a greater focus on outcomes. Although Members also acknowledged that parents were not always aware of the resources and services available to them post-transition and that EHC plans helped to explore the detail around aspiration and level of need.

7.2.6 Sunderland also provides a Local Offer, a statutory requirement in the Children and Families Act 2014 Section 3 for local authorities to have one accessible place for information about services and opportunities available to children and young people with SEND aged 0-25. This Local Offer must also include information about the EHCP process and importantly about how to challenge decisions arising from the transition process. The local offer is really important part of the transition process and clearly defines what universal, targeted and specialist services and opportunities are available to children and young people. The local offer plays a very important role in prevention and ensuring that a graduated approach to supporting all young people is taken and meeting their needs appropriately.

7.2.7 In a visit to Portland Academy it was reported that the EHC plans were now into a second year of operation and that as a school they were more comfortable with them. The academy further explained that EHC plans were designed to bring together a number of agencies to discuss each individual child's needs and

outcomes. However it was reported that agencies did not always attend meetings, and it was very important to ensure the effectiveness of EHC plans that key agencies were in attendance. It was also reported that the level of work required to develop the EHC plans was resource intensive and Portland Academy has had to develop the capacity to deal with the review meetings and associated work.

7.2.8 A multi-agency Transition Management Group also meets monthly to identify young people moving through transition. All young people who are in receipt of a service from Children's Disability services are discussed in terms of their needs and which Adults team is best placed to support that young person and their family as they make the transition to adulthood. The group also receives referrals for those young people who are not in receipt of a service from the Children's team. The Connexions service, Leaving Care Team and Transition Nurses provide referrals where appropriate. Sunderland City Council representatives attend as many annual education reviews as possible that take place at the specialist schools in the City to provide information about the support on offer from Adult Social Care, the reviews are also an opportunity to identify young people who may require Social Care support post-18.

7.2.9 EHC plans were acknowledged as an improvement from the previous statement process as a promising way of supporting disabled young people preparing for adulthood. In terms of monitoring and reviewing transitions, it was reported to Members, that existing processes were being integrated with a new system and approach and the real challenge now was to ensure that this provided a smooth and transparent way to proceed in the future.

7.3 Adult Services

7.3.1 As already outlined young people with complex needs will have been receiving services from children's services for a number of years through schools and other mechanisms. However as they move into adulthood young people will make the transition to adults' services where there are very different statutory responsibilities. The transition can be complicated by the fact that many young people with multiple needs receive services from a number of different sources, including children's health, social care and criminal justice services, and can be identified as 'children' or 'adults' at different times.

7.3.2 The division of children's and adult's services has seen challenges in overcoming boundaries and both cultural and organisational differences between services. Local authorities still need to understand the services that people will need over their lifetime. This view was supported by Sir Ian Kennedy in 2010 as an issue of concern in the NHS[3]. Members were informed during evidence gathering that the communication between adult and paediatric services still remained an issue and that greater collaboration or integrated working could aid transition. Throughout the evidence gathering Members acknowledged the very clear difference that existed between children's and adult care services. Children's services were identified as being more inclusive, supportive and flexible while in adults' services there was an expectation of greater independence from patients, with professionals having larger caseloads and limited time for patients.

[3] Local Government Association 2015

'Our transitions social worker made frequent contact and visited our son at home and at school, making a good relationship with him and his family. We felt very supported. Also their work integrated health and social services seamlessly'.[4]

A research example of the transition experience.

7.3.3 The Local Government Association in its paper on Transitions highlights the Revolving Doors agency, which works predominantly with people with multiple problems, and has identified seven good practice principles in working with young people in transition, following research with young people themselves. They are based on the following:

• quality of relationships with staff who can give stability, guidance and act as role models;
• continuity of care, for example by providing personal advisers for care leavers and care coordinators and transition plans for young people with mental health and drug problems;
• personalised support – ensuring that the principles of personalisation in adult social care operate during the transition period;
• meeting basic needs – including education, housing and life skills;
• information, misinformation and challenging stigma – particularly for young people with mental health problems and learning and physical disabilities moving into post-school education and employment;
• getting involved – engaging young people in transition in the design, planning and delivery of services;
• aiming higher – supporting young people in developing ambitious, achievable aspirations and self-esteem and not giving up on them.

7.3.4 The NICE guideline on transition from children's to adults' services for young people using health or social care services found evidence that adults' services do play a crucial role in sustaining the effects of transition-focused initiatives provided in children's services. However there was limited evidence about how, specifically, adults' services should be working to support effective transition for young people, with some evidence indicating that the adults' services role needed to be active in advance of the transfer.

7.3.5 Consultant physician, Peter Winocour, East and North Hertfordshire NHS Trust referred to local audits which illustrated that at the time of and after transfer to adults' services was a major pressure point. He further stated that young adult care required the same level of commitment from adults' services (and the same resources) as those made available to transition services. Although there was significant variation in how joint services operate, the major challenge is in the care of those aged >19 at the time of transfer. All adults' services should have at least 1 lead consultant and designated specialist nurse to support transition and ensure continuity in a young adults' service after transfer[5].

7.3.6 Members were pleased to note that in Sunderland Transition Nurses offered health needs assessments and support to young people with a learning disability and complex healthcare needs to make the transition from child to adult acute health

[4] Models of Multi-agency Services for Transition to Adult Services for Disabled Young People and Those with Complex Health Needs: Impact and costs. Social Policy Research Unit, University of York 2010

[5] National Institute for Health and Care Excellence: Transition from children's to adults' services for young people using health or social care services. February 2016.

services. It provides a key role in liaising with other health professionals and agencies to ensure that the healthcare received by young people throughout the transition process is coordinated and uninterrupted. Health Transition Nurses will usually attend from the beginning of the review process, to assess the young person and following assessment nurses will decide how they can help the young person and their families/carers through completion of a Health Action Plan, if the young person wants one, and where if appropriate the development of a Health Transition Plan as part of their broader Education Health and Care plan.

7.3.7 Transition Nurses worked collaboratively with a range of health professionals and other agencies in order to co-ordinate person centred healthcare as young people move from one service to another. This can include schools, children's services, adult services, Connexions and City Hospitals Sunderland. Members in discussion with health transition nurses noted that they attended meetings of the Transitions Management Group where the majority of young people were discussed. It was highlighted to Members that many parents were unaware of many of the services available to them and the transition nurses can help to signpost parents and young people. There was a clear message to members that the earlier work can begin with young people then the stronger the relationship becomes, and in bridging the gap of on-going health needs the transition nurses looked to ensure that there was a seamless transition.

7.3.8 The Transition Nurses also reported that young people and parents often struggled with respite care post-18 and that there was often a break before receiving any adult respite care, with this provision allocated on an assessment of need basis. Members were also informed that young people and parents struggled with payments and the use of personalised budgets and direct payments. The Transition Nurses also reported that they had undertaken a lot of interaction with schools and social workers to promote and raise awareness of their role and the service they provided in terms of transition.

7.3.9 General Practitioners are also a key factor within the transition process and interaction with the family doctor can ensure early identification and signposting to key services required during and post-transition. Parents of young people who are still receiving children's care services often do not see the need to visit their GP. Research from the CQC[6] identifies visits to GP surgeries as often difficult due to access, environment, waiting times and stress. Parents saw it as easier to go straight to A&E where they could access more familiar paediatric services. Therefore many GPs are not involved in the transition arrangements for young people according to the CQC. The other issue in relation to this is following transition GPs suddenly are the initial point of contact for highly complex health needs with little previous knowledge of the person.

7.4 The Role of Education in Transition

7.4.1 Within schools, planning the transition to adulthood for all young people is part of the general school activity. Additional planning for SEN young people should be set within this wider context. Any young person may leave full time education at the age of 16[7], continue in their school if it offers post-16 provision (i.e. school sixth form), seek a placement at a mainstream college or in the case of SEND young

[6] From the pond into the sea: children's transition to adult health services. Care Quality Commission. June 2014

[7] Though under Raising the Participation Age (RPA) they must remain in either education or training until they are 18.

people seek a placement at an Independent Specialist Provider (ISP). The EHC plan and key support workers would be fundamental to helping identify appropriate placements for the young person.

7.4.2 It was identified that the majority of students with SEN leaving school at 16 continued to access provision at either their school sixth form or at Sunderland College. This was certainly evident at the visit to Portland Academy where young people were very well supported up to 19 years old, in the vast majority of cases. It was also highlighted that further education and sixth form colleges had a statutory responsibility to meet the needs of young people with SEN and to secure the special educational provision a learner needs and to make reasonable adjustments to prevent them being placed at a substantial disadvantage.

7.4.3 In discussions Members understood that work was on-going to map out the processes between children's services, adult services, Connexions, social care and SEN services to ensure effective working and transition from child to adult care services. This has included reviewing current transition protocols and ensuring that both schools and parents/carers are fully aware of the transition process and most importantly that the young person is involved in the decision making along with their parents/carers.

7.4.4 As previously mentioned EHC plans can begin anytime between 0-25 with preparation for transition starting at Year 9 (14 years old). This planning usually takes place in the school setting with the young person, family and key agencies including health and social care meeting and discussing the key aspects of the EHC plan. Importantly this review process helps to ascertain what a young person wants and how that can be enabled.

7.4.5 Students and parents will often visit a number of potential facilities across the North East and look to make the best choice for their post-19 lives. However the ultimate decision remains with the resource panel, which will make a decision taking account of all the available evidence. This can of course create some anxiety for young people and their families, particularly if those facilities are at the higher end of the cost spectrum. At times when there is disagreement of certain aspects of the plan there can be processes of negotiation and in rare cases mediation and ultimately a tribunal if aspects of the plan cannot be resolved. Although Members acknowledged that this was a rare occurrence.

7.4.6 In discussions with Portland Academy it was worth reporting that parents with the time, knowledge and/or resources had a much greater chance of success in securing their preferred placement over those parents who do not. Being a parent of a young person with SEND involves many challenges and the support provided by specialist schools such as Portland and Barbara Priestman Academies can be invaluable. It was noted that young people at Portland Academy were very well supported in health, social care and education and were supported through the transition process from children's to adult services. The Academy would coordinate the transition plan and identify the support required to meet their adult needs including education, social care, financial support, equipment and health requirements. However outside of this supported educational environment things can be very different and the move to adulthood can emphasis this change in support arrangements. This may be a contributing factor to parental preference for specialist colleges for further education and training.

'My son is now 19 and his clubs are now saying they have to drop him. Where do we go from here? Everything is a hardship, no-one seems to know what is going on or who is doing what and parents of special needs children do not need the added stress, the only way we can get things done is by causing a stink and being forceful. When we try to contact our social workers they are always 'out on business' or doing course and rarely do they bother phoning back'. [8]

A research example of a transition experience.

7.4.7 Specialist education and training provision is clearly designed around students with specific needs and can boast impressive facilities whereas mainstream colleges, by their very nature, are designed with mainstream students in mind. Although some mainstream colleges will have facilities designed specifically for students with SEND. It is interesting that at Sunderland College out of a cohort of 11,000 students aged 16-18 there were 165 students with an EHC plan, 580 students with a declared support need and 41 looked after children. In having students with SEND working alongside those in mainstream provision it can help to create an inclusive environment for the benefit of everyone, and not just those with SEND. Keeping children with SEND of all ages learning alongside other students within a mainstream setting can aid transition into adult and independent life where people live, work and interact together.

7.4.8 In discussing the 19-25 provision with Portland Academy, Members were informed that the school had set up a project with Sunderland College called 'Select Sunderland', providing further education on the Portland Academy site. It was reported that there had been some difficulties with the partnership particularly around the ability to forward plan in terms of intake number. Currently the further education unit had 19 pupils within it.

7.5 Transition in Other Groups: Looked After Children

7.5.1 Under the Children Act 1989, a child is legally defined as 'looked after' by a local authority if he or she:

- is provided with accommodation for a continuous period for more than 24 hours
- is subject to a care order; or
- is subject to a placement order .

7.5.2 A looked after child ceases to be looked after when he or she turns 18 years old. On reaching their 18th birthday, the status of the child changes from being looked after to being a young adult eligible for help and assistance from the local authority. Such help and assistance is usually provided in accordance with the various aftercare provisions of the Children Act. There are a wide range of policies and guidance related to looked after children and young people. Of key note is The Children and Families Act 2014 which introduces reforms to improve the life chances of looked after children and young people. This is through giving children in care the option to stay with foster families until 21and introduced a single education, health and care plan for children with special education needs and disabilities up to the age of 25.

[8] Models of Multi-agency Services for Transition to Adult Services for Disabled Young People and Those with Complex Health Needs: Impact and costs. Social Policy Research Unit, University of York 2010

7.5.3 There were 69,540 looked after children at 31 March 2015, an increase of 1% compared to 31 March 2014 and an increase of 7% compared to 31 March 2010. The numbers have increased steadily over the past 6 years.

	2010	2011	2012	2013	2014	2015
England	**64,470**	**65,500**	**67,070**	**68,060**	**68,840**	**69,540**
North East	**3,650**	**3,830**	**4,110**	**4,220**	**4,250**	**4,290**
Darlington	145	185	205	210	190	200
Durham	510	535	655	630	605	620
Gateshead	300	365	385	390	360	340
Hartlepool	165	165	175	185	205	165
Middlesbrough	320	330	355	360	355	360
Newcastle Upon Tyne	525	530	550	550	555	505
North Tyneside	275	280	295	295	305	305
Northumberland	285	265	280	315	325	370
Redcar and Cleveland	155	150	170	175	175	185
South Tyneside	295	320	315	320	310	300
Stockton-On-Tees	285	290	335	360	380	375
Sunderland	390	410	385	435	490	570

Figure 1: Children looked after at 31 March 2015 – By Local Authority
Department for Education

7.5.4 Moving to independent living and starting the journey into adulthood are landmark steps for most young people. Young people who have been looked after are more disadvantaged and face more difficulties than their peers in achieving independence. They become independent at a younger age and have to cope with major changes in their lives in a much shorter time and with less support than their peers. Physical and mental health problems can increase after they leave care. Outcomes can be more serious and enduring for some looked-after young people who have very damaging pre-care experiences or multiple placements, or who leave care early.

7.5.5 Access to accommodation and employment opportunities are crucial for the successful transition into adulthood of young people leaving care. As well as good mental health, in particular, which was strongly associated with employment. Also without adequate support many young care leavers can feel marginalised within the wider community and still experience the stigma of having been in care. Without an adequate knowledge of their rights and entitlements they are ill-equipped to cope with their move into the outside world.

7.5.6 In the current economic climate it is essential that agencies are mindful of the additional pressures that young people leaving care are likely to experience. Agencies will need to sustain support to reduce the impact of these extra pressures, which are likely to be felt by many young people leaving care for some time to come.

7.5.7 In terms of transition the leaving care service operates through a service level agreement with adult social care services, this process was currently being developed and enhanced. It was noted that planning for transition into adult

services would commence with looked after children at 14 years of age. It was also reported that the leaving care cohort ranged from those leaving residential care at 18, up to 21 in foster care and to a maximum of 25 if in full time education.

7.5.8 The Head of Looked After Children reported that a number of policies had been developed to support young care leavers in their transition to independence including a financial policy to ensure appropriate funding for young people and also an increased accommodation option across the city. Members were informed that suitable accommodation options ranged from supportive lodgings, staying put or semi-independent facilities. The Council currently had 2 semi-independent facilities at Chester Road and Burlington Close in Hendon, which offered 6 and 5 bedroomed self-contained flats with staff on site 24/7 to offer guidance, support and security. The Council also commissions accommodation from a number of providers including Forever Care and YMCA. MB reported that the commissioning service did work extremely hard to find suitable accommodation for the leaving care service.

7.5.9 Members enquired how many young people leaving care 'dropped off the radar' and the head of looked After Children reported that up to 18 years old each young person had a designated social worker and post-18 they would have a leaving care Personal Advisor. The duty to remain in contact with these young people was with the leaving care Personal Advisors to ensure accommodation is suitable, that the young person is accessing employment, education or training opportunities and generally adjusting to independent living.

7.5.10 In discussions with Sunderland College it was noted that previous transition arrangements for looked after children had not been effective. However, since August 2015, there have been positive steps to address this with Sunderland College entering into a partnership agreement with Sunderland Council which has seen strengthened links and regular communication between the college and the virtual school, social workers and post-16 coordinator.

8 Conclusions

The Committee made the following overall conclusions:-

8.1 All children need to prepare for adult life; and some will face more challenges than others. Children with complex physical health needs will not only have to face the general rigours of moving into adulthood but will also need to overcome the additional challenges of moving from child to adult service provision. This will impact all involved with their development and there will be a lot to learn and understand about what adult life will mean for them.

8.2 The key philosophy in relation to transition is around ensuring that young people are empowered to make the most of their future by putting their needs and ambitions at the very heart of the transition process. There is also an underlying principal of social inclusion, integration and supporting young people's independence. The basic aims identified throughout this review, in relation to transition, were:

(a) to ensure that young people do not fall through the gap between children's and adult services;
(b) enable planning of future service need by the early identification of young people;

(c) to ensure a smooth and seamless transfer from children's to adult services, and,
(d) to ensure a managed process that is fair and transparent.

8.3 Education Health Care Plans have replaced Statements of Special Educational Needs and rather than purely addressing their educational needs also take account of the broader health and social care needs of a young person. EHC Plans involve a wide range of professionals collaborating with young people and their families to ensure that the transition process is seamless and the support, needs and aspirations of individuals are met. The importance of bringing together a number of agencies and professionals to discuss an individual's support needs is crucial to any successful transition. While the EHC Plans and associated meetings encourage collaboration there are still barriers that can exist to transition including the variety of information sharing protocols that professionals and organisations adhere to. Information sharing protocols were identified as a clear barrier in Member discussions with professionals and therefore children's and adult care services need, in ensuring a smooth and seamless transition, that their work for young people is integrated and complimentary. It is also good to acknowledge that a transition protocol is currently in development for use across the health and social care arena.

8.4 Local GPs have an important role to play in transition and can often be overlooked by young people, parents and care services alike. The advantages of having GPs involved in transition meetings helps to create better understandings of the young person's health requirements as they move into adult care services. However it is not merely as simple as providing an invite to GPs, as depending on meeting times they may clash with their other work commitments. Clearly there is value to be had from a long-term relationship with GPs who are familiar to families and/or young people, as well as ensuring that young people have a named GP.

8.5 The City is well served in terms of specialist education provision through Portland and Barbara Priestman Academies, who both look to maximise the potential of their students both academically and socially. Transition planning in these schools is well co-ordinated and EHC plans are well developed to ensure that young people leaving are moving into further education or employment. There is general agreement that some student's needs cannot be met locally, so there will always be some requirement for Independent Specialist Provision. There is also agreement that many students with some degree of SEND fare well in mainstream settings with an appropriate support package in place, and Sunderland College certainly provides this provision in Sunderland.

8.6 It is often parental expectations that proved most difficult to manage in terms of post-school care packages which would typically cover approximately 3 days of the traditional 5 days experienced while in school. Although in discussions with Portland Academy it was seen that having good relationship with parents can help to, not only allow parents to express their anxieties and worries, but also for the academy to explain many of the options available through the transition process. Clearly parents are not always aware of the resources and services available to them post-transition and EHC plans can assist in exploring the detail around aspiration and level of need.

8.7 While the majority of students will move into further education it was highlighted that Portland Academy had seen success in gaining employment for students with in the

restaurant sector, City hospitals and Gentoo. The Academy worked very closely with local businesses to explore the possibilities of work placements although clearly the ultimate success of placements and potential employment centred on the desire and ability of employers. There is potential for the local authority to help facilitate further dialogue between local businesses and the specialist academies within the City, to further enhance the opportunities available.

8.8 While transition arrangements and EHC plans are predominantly centred on those young people with special educational needs and disabilities there are other groups of young people who face challenges in making the transition from a supported childhood into adulthood. Perhaps the most obvious are those young people in local authority care, who even if they have had a stable placement or social worker during their time in children's services, transition is a period when their social care support is likely to change. Certainly following criticism of the Leaving Care Service during the recent Ofsted inspection has resulted in the appointment of an Interim Head of Looked after Children and the development of a number of policies and procedures, including working with care leavers, suitable accommodation, financial management to ensure appropriate funding for young people pathway planning and completion. It is important that that the approaches taken do contribute to a planned transition for looked after young people. There is potential for the scrutiny function and members, as corporate parents, to develop a greater understanding of the process around young people leaving care.

8.9 Change is never easy and the particular change that every child experiences in becoming an adult, and being recognised as such, is perhaps one of the hardest of all. This is even more of a challenge for those young people who have a special educational need or disability or who are within the looked after system. It is important that these young people, just like every other young person, can make that transition to adulthood and have a similar opportunity to realise their aspirations, just like any other child.

9. Draft Recommendations

9.1 The Shadow Health and Wellbeing Scrutiny Committee has taken evidence from a variety of sources to assist in the formulation of a balanced range of recommendations. The Committee's key recommendations to the Cabinet are as outlined below:-

(a) That the development and implementation of any transition protocol enhances information sharing across services and organisations to improve transition planning and further promotes a seamless transition process;

(b) That during the transition process greater opportunities are provided, where appropriate, to allow for GP involvement in health transition planning, as well as ensuring that young people in transition have a named GP;

(c) That the local authority promotes and supports a dialogue between employers, local businesses and the specialist academies within Sunderland to further enhance the potential for work placement opportunities;

(d) That the appropriate scrutiny committee receives regular updates from the leaving care service to develop a greater understanding and involvement in the

transition process and arrangements of young people leaving the local authority's care.

10. Acknowledgements

10.1 The Committee is grateful to all those who have presented evidence during the course of our review. We would like to place on record our appreciation, in particular of the willingness and co-operation we have received from the below named individuals and organisations:-

(a) Martin Birch (Interim Head of Looked After Children)
(b) Lynden Langman (Service Manager)
(c) Ben Rosamond (Person Centred Planning Development Officer)
(d) Paul James
(e) Peter Nicol (Team Leader – Connexions)
(f) Annette Parr (Lead Support and Intervention Officer)
(g) Denise Geary (Health Transition Nurse)
(h) Nigel Harrett (Deputy Principal – Sunderland College)
(i) Rachel Wiles (Student Services Manager – Sunderland College)
(j) Lennie Sahota (Head of Service Adult Social Care)
(k) Staff and Students of Portland Academy

11. Background Papers

11.1 The following background papers were consulted or referred to in the preparation of this report:

Care Quality Commission (July 2014) From the pond into the sea: Children's transition to adult health services;

Social Policy Research Unit, University of York (2010); Models of Multi-agency Services for Transition to Adult Services for Disabled Young People and Those with Complex Health Needs: Impact and costs;

National Institute for Health and Care Excellence (February 2016): Transition from children's to adults' services for young people using health or social care services;

Local Government Association. (November 2015): Transitions: must know on adult social care;

Kelly, B. (2013) 'Don't Box Me In': Disability, Identity and Transitions to Young Adult Life. Belfast: Queen's University Belfast in partnership with Barnardo's NI;

Social Care Institute For Excellence (September 2014) Care Act 2014: transition from children's to adults' services – key resources.