

APPENDIX 1

PROGRESS UPDATE: Review of Narrowing the Gap in Educational Attainment

SCRUTINY MONITORING – PROGRESS UPDATE	
Review:	Scrutiny Review of Narrowing the Gap in Educational Attainment
Recommendation Lead:	Amit Law

Updates on the progress of actions in relation to agreed recommendations from previous scrutiny reviews are required approximately 12 months after the relevant Select Committee has agreed the Action Plan. Progress updates must be detailed, evidencing what has taken place regarding each recommendation – a grade assessing progress should then be given (see end of document for grading explanation). Any evidence on the impact of the actions undertaken should also be recorded for each recommendation.

Recommendation 12:	Strengthening Transition Arrangements: Four 'stages' of Transitions have been identified to track the process of a young person throughout the education system. The first is from Early Years to Primary School, the second from Primary to Secondary School. These focus in the first two stages is on the change in social setting for the young persons, how this change can be planned with care and clarity to ensure that the adjustment for students is as seamless as possible. The third stage targets the development of students into the assessment stage of their education as select qualifications towards the end of Year 9 and progress to examinations in Year 10 and 11. The fourth stage is the Transitions from Secondary School to Post-16 settings. Whilst the social aspect of these stages remains a focus, here an aspect of planning for future qualifications and employment is introduced, to ensure that a holistic attempt to prepare young people for adulthood is being undertaken.
Responsibility	Amit Law
Date:	May 2025
Agreed Action:	General: • Strategic plan internally – Powering our future: 1. Review the current picture of Transitions at each identified stage, identifying both positives and negatives. 2. Create an internal Transitions function that provides clarity in advance for young people and staff. 3. Track Children from 14 years old applying a person-centred plan at key stages of the transitions process. 4. Review health needs. A Young Person's Care and Health Lead role has been created at SBC to track and respond to any potential health needs. The postholder will be a qualified Nurse identifying health needs early within education and social care. 5. Develop independent travel training program. In line with the aim to promote independence for young people at the earliest possible stages.

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	6. Integration of Education and Social Care Planning with Commissioning decisions • Transition from Earlier Years to Primary (EY-1): 1. Review current arrangement and identify good practice. 2. Work with educational institutions to identify the causes of issues, and what can be done to cushion any difficulties • Transition from Primary to Secondary (Year 6-7): 1. Identify good practice 2. Develop a Stockton approach to primary to secondary Transition. 3. Promote links between Primary and Secondary institutions, encourage pre-planning and cooperation. • Transition from Development to Assessment Years (Year 9-10): 1. Work with educational institutions and alumni networks to inform young people on the choices available and what those choices may mean going forward. 2. Engage with parents and carers to inform pupil decision making 3. Partner with local employers to think creatively about presenting post-16 opportunities. • Transition from Secondary to Post-16 (Year 11-12): 1. Develop a Post 16 strategic plan, with emphasis on the flexibility of choice for young people into education, employment or further training. 2. Develop a strategy to promote post 16 providers to all Stockton secondary schools and key stage 4 students 3. Work with institutions to review and enhance Marketing plan for Stockton colleges to increase local retention. 4. Review Transitions arrangements between secondary and post 16 options. Linking secondary and post-16 institutions with one another to cooperate on student plans pre-arrival. 5. Engage with parents and carers to impress on home networks the importance of decisions at this stage. 6. Partner with local employers to think creatively about presenting post-16 opportunities. Communication: All
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	• Create clear lines of communication between educational institutions and Health and Social Care officers. (this may involve training for frontline educational staff on continuing care procedures, focused on early intervention) • Co-work with educational institutions to produce a Stockton wide educational offer, embed this in an updated Local Offer page and online marketing materials • Develop a clear and direct line of information for parents and carers to access. This should include clarity on routes into social care, further education, employment. • Direct engagement with Education and Social Work staff to communicate the underlying logic of new proposals / options awaiting approval before detailed engagement. Primary to Secondary • Develop holistic information packs for parents and carers on local Secondary schools. (This should include details on geographical catchment areas, registration processes / deadlines, any specialised institutions available, notes on educational attainment / student satisfaction) Secondary to post-16 • Review websites and promotional material for Stockton colleges. • Review marketing plans / tools for Stockton post-16 institutions. • Engage local employers to develop clarity on roads into employment, ensure this forms part of communication strategies for educational institutions. Development to Assessment & Post 16 • Work with schools, parents and carers to ensure clarity on timelines for qualification selection. (GCSE / BTEC / A-Level / Apprenticeship) Events: All • Forum meetings and partnership engagement. Primary to secondary • Promote and help organise 'inset' days for new arrivals at secondary schools. Post 16 • Preparing for Adulthood Event – 06/02/25 @ Employment and Training Hub (40 Wellington Square TS18 1RG) • Host Stockton Post-16 engagement / transitions event in collaboration with parents and carers group.
Agreed Success Measure:	General: • Strategic plan internally – Powering our future: 1 – Establish what is a successful and where there is weakness in our current Transitions procedures. Appraise the best examples of Transitions across the area.

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	2- Approval by PoF Board, implementation of new process, ultimately improved service experience for users and financial savings. 3- Clear Transitions plan for all children into adulthood. 4- Staff feel confident in making referrals and challenging ICB decisions. Seamless transitions into new settings for children with health needs. 5- Increase from current levels in independent travel. 6- Holistic Transitions planning process that encompasses commissioning, housing, education, independence support etc. In addition, improved appreciation of when ICB / Health funding would be appropriate. • Transition from Earlier Years to Primary (EY-1): 1&2 -Develop a framework and then work with schools to establish what the key gaps are in Transitions, and what may already be taking place that forms good practice. • Transition from Primary to Secondary (Year 6-7): 3- Strengthen the working relationship between Primary and Secondary institutions. Enhance framework for transition with better information to support transition. • Transition from Development to Assessment Years (Year 9-10): 1,2&3- Evidence from Schools, Parents / Carers and Students that choices are being presented clearly and made with the best information available. • Transition from Secondary to Post-16 (Year 11-12): 1&2 – Increased local retention of Stockton students in post-16 pathways. 3&4 – Feedback from Schools / Colleges / Parents & Carers that students are making informed and conscious choices on post-16 opportunities. Success in improved communication of Stockton post 16 offer Success in sharing this in all secondary schools and engagement with Stockton post 16 providers Communication:
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	All • Staff involved in all aspects of a young person's journey are clearly sighted on each other's roles and responsibilities and can respond accordingly to any changes in need. • A clear Local Offer, with clarity on the responsibilities of local institutions to support the aspirations of young people. • Clear communication materials made accessible. • Support from those who will be operating whatever system is put in place. Primary to Secondary • Clear communication materials made accessible Secondary to post-16 • Increased local retention of Stockton Students in post-16 pathways Post 16 • Increased local retention of Stockton students in post-16 pathways • To form part of the Local Offer. Development to Assessment & Post 16 • Clear communication materials made accessible Events: All • For all stakeholders to have a consistent forum for engagement Primary to secondary • For children to have Enhanced Transition into Secondary school Post 16 • Event to be well attended by children, adults and parents and carers • Event to have a wide range of stakeholder representation
Evidence of Progress: 16 September 2026	Since the establishment of the Transitions Team on 8 October 2025, significant progress has been made in developing the service, embedding effective processes, building strong partnerships, and improving outcomes for young people and their families. The focus during the first nine month has been on creating robust foundations, developing pathways and systems, supporting operational services, and ensuring young people experience a smoother transition into adulthood. <u>Phase 1: Service Establishment and Development</u> <u>October 2025 – January 2026</u> During the initial months, the team concentrated on service setup, stakeholder engagement, and creating the infrastructure needed to support young people effectively through transition.

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	Service Development Established the Transitions Team and began developing operational processes and working practices. Implemented manual data collection processes to capture activity, monitor demand, and understand emerging trends. Engaged extensively with internal and external partners to understand what was working well within current transition arrangements and identify areas requiring improvement. Consulted directly with young people and families to gather feedback regarding their experiences of transition services, ensuring that service development was informed by lived experience. Systems and Data Designed and created a bespoke database to track young people through the transition process. Developed an accompanying performance dashboard, enabling oversight of caseloads, assessment activity, outcomes, and demand. Established systems for recording and monitoring transition activity to support future service planning and performance reporting. Casework and Assessment Activity Began identifying young people who would benefit from transition support. Initiated transition planning and assessment work, ensuring young people approaching adulthood were identified at an earlier stage and supported appropriately. Partnership Working Developed relationships with professionals across: • Health services • Adult Social Care • Children's Social Care • Education • Voluntary and Community Sector organisations This networking created stronger links between services and improved opportunities for collaborative planning. Governance and Procedures Developed comprehensive policies and procedures for the Transitions Team. Submitted documentation to Legal Services for review and approval to ensure compliance with statutory and organisational requirements.
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	<u>Phase 2: Embedding and Service Growth</u> <u>February 2026 – July 2026</u> Following approval from Legal Services and senior management, the focus shifted towards embedding the service, strengthening preventative work, and developing strategic partnerships. Policy Implementation Shared and implemented the approved Transitions Team policies and procedures across partner services. Established clear pathways and guidance to support consistent practice. Supporting Adult Services Assisted Adult Learning Disabilities and Mental Health teams by picking up transition cases already allocated to those services, which; helped reduce waiting times for young people transitioning into adult services and contributed towards reducing pressures on existing adult social care caseloads. Workforce Development Developed and launched an online Transitions e-learning package to enhance staff knowledge and understanding of transition processes and statutory responsibilities. Delivered a range of presentations and awareness sessions to professionals across multiple sectors including: • Tees Safeguarding Adults Board (TSAB) • Social Work Week events • Communications (COMMS) events • South Tees Health Conference • Children's Social Care • SEND partnership events These sessions have significantly increased awareness and understanding of transition planning both internally and externally. <u>Improving Multi-Agency Working</u> Complex Transition Panel Introduced and established the Complex Transition Panel to improve multi-agency planning for young people with complex needs. Improved oversight, joint decision-making, and earlier identification of support requirements.
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	SEN and Education Partnerships Worked closely with Special Educational Needs (SEN) services to: Working with SEN, education provision and parents/carers to develop Independent Travel Training opportunities. Identify potential transition cases earlier, including young people not currently known to social care. Support preparation for the SEND Ofsted inspection. Systems and Pathway Development A significant area of progress has been achieved in relation to systems development: Worked alongside systems teams to develop a comprehensive transition pathway. Successfully launched a live demonstration version of the pathway. Linked Children's (LCS) and Adult (LAS) systems to improve information sharing and reduce duplication. Reviewed and amended the Transition Assessment to align more closely with the requirements of a Care Act Assessment. These developments will improve efficiency, reduce duplication for families, and strengthen the transition process. Young People and Family Engagement Developed a draft information leaflet in partnership with parents and carers to ensure information is accessible, relevant, and meaningful regarding independent travel training. Attended No Limits Hub sessions to engage directly with Children in Our Care (CIOC) and gather feedback. Participated in: • Preparing for Adulthood (PfA) events • School open days • Transition launch and open day events These activities have increased awareness of the service and strengthened engagement with young people and families. Mental Capacity and Specialist Support Supported Children's Social Care and the Respite Unit with Mental Capacity Assessments (MCAs). Completed multiple MCA decisions for young people approaching adulthood. Continued providing advice and support to Children's Social Care teams, establishing the Transitions Team as a recognised point of contact for guidance and consultation.
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	Health Partnership Working Worked collaboratively with Continuing Healthcare (CHC) services to ensure Decision Support Tools (DSTs) are completed at approximately six months earlier. For example; before involvement from the team they were completed at 17.6 and now these are being completed at 17. This proactive approach aims to reduce delays in decision-making and improve transition planning outcomes. This will also allow for time should a dispute occur during the DST. Prevention and Early Intervention A key achievement of the team has been the emphasis on prevention and early intervention. Through early identification, information, advice, and targeted support, the team has: • Reduced unnecessary referrals into Adult Social Care. • Signposted young people and families to appropriate community-based support. • Prevented escalation of need where suitable preventative services could be implemented. Examples of signposting and alternative support include: • CGL services • Leaving Care Local Offer • Universal mental health support services • Steps services • Supported internships • Community and voluntary sector provision • Outcomes Achieved • Preventing High-Cost Residential Care A few examples; The team supported a young person who was previously expected to move into residential accommodation costing approximately £7,000 per week. Through coordinated planning and partnership working, the young person has instead been successfully supported into an individual tenancy with an appropriate care package that will continue into adulthood. This has resulted in: • Improved independence and quality of life. • Better long-term outcomes. • Significant cost avoidance for the Local Authority.
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- Preventing Future Service Dependency

The team identified a supported internship opportunity for another young person who had been anticipated to require adult social care support. As a result:

- The young person achieved a more positive and independent pathway into adulthood.
- The anticipated need for ongoing Adult Social Care services was prevented.
- Better outcomes were achieved at a lower long-term cost.

Carers Support

The team has strengthened support pathways for both young carers and adult carers by:

Developing links between Eastern Ravens and Adult Carers Services. Reviewing and updating Transition Assessment documentation to ensure carers are identified consistently.

Considering young carers at every referral stage and making referrals where appropriate.

Identifying carers through Care Act Assessments and creating clearer pathways into adult carers support services upon reaching adulthood. Continuing to work with systems to better identify/forecast. Improving the ability to forecast future demand for carers services.

Strategic Planning and Commissioning

The team has established itself as an important contributor to future planning across the Local Authority through:

Regular attendance at Accommodation Panels.

Attending regular meetings with finance to ensure high-cost packages are planned for in the budget.

Active involvement in Complex Commissioning Panels.

Working closely with commissioning colleagues to identify and project future demand.

Supporting strategic discussions regarding future housing and accommodation requirements.

Contributing intelligence regarding future service development and commissioning priorities.

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	<u>Performance and Activity Data</u>		
	Activity/Outcome	Number	Notes
	Active cases for Transition Assessment/Planning	81	Young people actively receiving transition support and planning.
	Cases Being Monitored	11	Young people identified as potentially requiring future transition intervention and being proactively overseen by the team.
	Transition Assessments Completed	38	Assessments completed to identify transition needs and outcomes.
	Care Act Assessments Completed	35	Statutory Care Act assessments completed.
	Carers Identified Through Care Act Assessments	35	Carers identified and considered for support and referral pathways.
	Mental Capacity Assessments (MCAs) Completed	23	Multiple assessments may have been completed for some individuals depending on specific decisions required.
	Young People Eligible for Adult Social Care	2	Identified as having eligible needs following assessment.
	Signposted/Prevented Cases	20	Cases where information, advice, guidance, or alternative support prevented the need for Adult Social Care intervention.
	Cases Currently Being Supported Through Prevention Work	9	Transition Assessments identified potential eligible needs; however, early intervention and preventative support may reduce or remove the need for ongoing Adult Social Care services.
	<u>Examples of Signposting and Preventative Support</u>		
	Service/Support	Purpose	
	CGL Services	Specialist support and intervention services.	
	Leaving Care Local Offer	Information and support for care leavers moving into adulthood.	

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	Universal Mental Health Services	Access to community-based mental health support.
	STEPS	Early intervention and wellbeing support services.
	Supported Internships	Employment and independence opportunities for young people.
<u>Looking Forward: Priorities for 2026/27</u> As the service continues to develop, the key priorities for the next phase include: Service Development Develop a comprehensive transitions resource for young people, families, and professionals. Further embed the Transitions Team across the Local Authority and partner agencies. Establish formal feedback mechanisms to inform continuous service improvement. Areas of service development where there are identified needs and no provision to meet i.e. independence work/building skills etc. Data and Systems Enhance the dashboard to better identify and monitor housing demand and future accommodation needs. Fully implement and embed the new transitions pathway and supporting systems. Continue collecting, analysing, and reporting performance data to identify trends and support strategic planning. Engagement and Participation Develop new approaches to strengthen the voice of young people within service development. Improve communication methods and accessibility for young people and families seeking support. Continue attendance at networking events, educational settings, and community engagement opportunities. Strategic Partnerships Continue strengthening relationships across health, education, social care, housing, commissioning, and the voluntary sector. Support earlier identification of young people likely to require transition planning.		

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Continue developing preventative approaches that maximise independence and reduce future reliance on statutory services.

Young Person Health and Care Lead

The Young Person Health and Care Lead has become a critical partnership role, bringing together the functions of the Designated Social Care Officer (DSCO) and the Children's Continuing Care Lead. This integrated approach has strengthened collaboration across health, education, and social care, ensuring that children and young people receive more coordinated support. Social care advice is now provided consistently through the front door, and the service remains on track to meet demand and manage referrals effectively. From a Children's Continuing Care perspective, the role has enabled the earlier identification of children with unmet health needs. This ensures that health partners are involved at the earliest opportunity, supporting joint funding arrangements where appropriate and, most importantly, placing the child's needs at the centre of decision-making.

The role has also improved our ability to identify young people approaching adulthood who are likely to be eligible for Continuing Healthcare (CHC). This early planning supports smoother transitions into adult services, reducing delays and ensuring continuity of care.

Overall, the Young Person Health and Care Lead role continues to be a significant success, strengthening partnership working, improving early intervention, and supporting better outcomes for children, young people, and their families.

Independent Travel Training

We have now reached the stage where a business case will be developed to determine which delivery model(s) should be taken forward. This is a key piece of work that will support our wider preparation for adulthood agenda, helping young people to develop the skills and confidence needed to travel independently and access their communities.

Independent Travel Training has the potential to improve outcomes for young people by increasing their independence, reducing reliance on specialist transport where appropriate, and supporting greater participation in education, employment, and social opportunities. The forthcoming business case will explore the available options, associated costs, expected benefits, and implementation requirements to inform future decision-making.

In school Transitions Update

The Education Transitions Co-ordinator is now in post and will lead the key transition activities required to support pupils during school transitions. This work has already commenced, with the Education Transitions Co-ordinator actively participating in all regional meetings. They will also begin working closely with schools to develop a consistent transition framework that supports effective planning and delivery across the system.

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Assessment of Progress: (include explanation if required) 16 September 2026	2 – On track. The first nine month of the Transitions Team has been characterised by significant service development, strong partnership working, and an emphasis on early intervention and prevention. The team has successfully established core systems, processes, and governance arrangements while simultaneously supporting young people, carers, and partner services. Early outcomes demonstrate improved planning, reduced delays, increased collaborative working, and evidence of both cost avoidance and improved life outcomes for young people transitioning into adulthood. As the service continues to mature, its focus will remain on delivering person-centred, preventative, and outcome-focused support that enables young people to achieve greater independence and successful adult lives.
Evidence of Impact: 16 September 2026	Evidence of Impact Improved outcomes for young people • 81 active transition cases supported, with 38 Transition Assessments and 35 Care Act Assessments completed, ensuring young people receive earlier and more coordinated planning for adulthood. • The team helped a young person avoid a residential placement costing approximately £7,000 per week by supporting them into an individual tenancy with an appropriate care package, leading to greater independence and better long-term outcomes. • A supported internship opportunity enabled another young person to follow a more independent pathway, preventing the need for ongoing Adult Social Care support. Prevention and demand management • 20 cases were signposted or prevented, where information, advice, guidance, or alternative support avoided the need for Adult Social Care intervention. • A further 9 cases are currently being supported through prevention work, with early intervention potentially reducing future reliance on Adult Social Care services. • Earlier identification and support have reduced unnecessary referrals and prevented escalation of need. Improved partnership working • Establishment of the Complex Transition Panel has improved multi-agency planning, oversight, joint decision-making, and earlier identification of support needs. • Stronger collaboration across health, education, children's services, adult social care, and the voluntary sector has created more coordinated transition pathways.

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	Improved systems and processes • Development of a bespoke database, performance dashboard, and linked Children's and Adult systems has improved tracking, information sharing, and reduced duplication for families. • Continuing Healthcare Decision Support Tools are now being completed around six months earlier, reducing delays and allowing more time to resolve disputes and plan support. External validation • The SEND inspection identified transition planning as effective, stating that young people typically receive continuous support and services when moving from children's to adult services. Concise impact statement The Transitions Team has demonstrated measurable impact through earlier intervention, strengthened multi-agency working, reduced demand on Adult Social Care, significant cost avoidance, improved planning for young people approaching adulthood, and positive external recognition from inspectors, senior leaders, and families. SEND report good comments "Transition planning for children and young people with SEND, who are known to social care, is effective. This means young people typically receive continuous support and services as they move from children to adult services." <u>Service user comments</u> <i>... "We are both very happy so far and with the plans in place for the future and support on offer."</i> <i>... "We are very happy with the work the team has done with us. They have been very supportive and have made sure that we were happy with all decisions made. They have been very supportive of the immediate family as well as the service user. They have provided a very comprehensive service that we all appreciate."</i> <i>... "I wanted to send a quick note of thanks following our meeting and the assessment for my son. Navigating the support system for learning disabilities is really overwhelming at this stage, but the clarity and expertise made the process feel much more understandable."</i> <i>... "I am very grateful for the support plan outlined. It's reassuring to know that my son will have these resources in place, and we look forward to working closely with you to ensure he has everything he needs to thrive and live to the fullest."</i> <i>... "It is very reassuring to know that a professional is leading the changes to a care package, and we were never left to figure things out for ourselves. She has been an excellent Social Worker for us."</i>
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	“Yes, she has consistently demonstrated that she has her service user’s best interests at heart and has followed through on all the things she has said she would do to support them.” “Perfect, thank you for your continued support, you’re amazing!”
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Assessment of Progress Gradings:	1 Fully Achieved	2 On-Track	3 Slipped	4 Not Achieved
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