Using an evidence-base to promote best practice

The case of Transitional Safeguarding with care experienced young people

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Mid and West Wales SAB, November 2026

We are still not getting it right

- OFSTED (2022) 'Ready or not': care leavers' views of preparing to leave care.
- Many feel that they left care too early and often abruptly.
- Even if they felt the time was right, many felt they did not have the skills to live independently and had not been taught essential skills.
- Many felt alone or isolated, and did not know where to seek help with their mental health or emotional well-being.
- Personal assistants were seen as helpful. Lack of trust of professionals.
- Statutory guidance was not complied with.
- Many had no control over where they lived and often felt unsafe in types and location of accommodation.
- Many felt unprepared to manage money, which could result in debts and loss of tenancies.
- Many did not feel sufficiently involved in plans, did not understand the options, and did not feel listened to.

Yet Again

- John-Baptiste, A. and Chamberlain, C. (2026) You really are on your own. A study of the early deaths of young people who were in care. DfE.
- Themes – being alone, cast adrift and without help to manage the transition.
- Recommendations – improved support, supported accommodation, and learning lessons.

The evolution of law and guidance in Wales for Transitional Safeguarding (1)

- All young people qualify for advice and assistance from the local authority (s.24, CA 1989) to promote their welfare when they cease to be looked after.
- The Children Leaving Care Act (CLCA) 2000 strengthens this with respect to eligible children: those in care aged 16 and 17 who have been looked after for more than 13 weeks since the age of 14. Children (Leaving Care) (Wales) Regulations 2001 revoked by the 2015 Regulations (see below)
- The 2000 Act creates a duty to assess and meet the care and support needs of eligible, relevant and former relevant young people. They must have a pathway plan, until they are at least 21, covering education, training, career plans and support.

The evolution of law and guidance in Wales for Transitional Safeguarding (2)

- The Homelessness Act 2002 requires that all young people aged 16 and 17, and those between 18 and 21 when leaving care, are regarded as vulnerable and in priority need for housing. The Act also advises that young people aged 16 and 17 should not be placed in bed and breakfast accommodation.
- Under the Housing (Wales) Act 2014 local authorities have a duty to help secure accommodation for all applicants assessed as homeless for a period of 56 days. After this period there is a continuing duty to secure accommodation for unintentionally homeless households in priority need.
- After this 56 day period, the local authority has a continuing duty under section 75 to secure accommodation (rather than to help to secure accommodation) for those in priority need who have not become homeless intentionally (where an authority chooses to apply a test of intentionality).

The evolution of law and guidance in Wales for Transitional Safeguarding (3)

- Priority need includes a person who is aged 16 or 17 when the person applies to a local housing authority for accommodation or help in obtaining or retaining accommodation.
- It includes a person who has attained the age of 18, when the person applies to a local housing authority for accommodation or help in obtaining or retaining accommodation, but not the age of 21, who is at particular risk of sexual or financial exploitation (or a person with whom such a person resides (other than an exploiter or potential exploiter) or might reasonably be expected to reside);
- It includes a person who has attained the age of 18, when the person applies to a local housing authority for accommodation or help in obtaining or retaining accommodation, but not the age of 21, who was looked after, accommodated or fostered at any time while under the age of 18 (or a person with whom such a person resides or might reasonably be expected to reside).

The evolution of law and guidance in Wales for Transitional Safeguarding (4)

- The 2014 Act introduced a duty on local authorities to provide housing advice and assistance to everyone within their local area, regardless of whether or not they are homeless or threatened with homelessness. These provisions are focused on getting local authorities, in partnership with other relevant bodies, to prevent and relieve homelessness wherever possible.
- The 2014 Act treats differently those assessed as homeless and those threatened with homelessness (likely to become homeless within 56 days). For applicants threatened with homelessness, the local authority has a duty to prevent them from becoming homeless under section 66.

The evolution of law and guidance in Wales for Transitional Safeguarding (5)

- The Social Services and Well-Being (Wales) Act 2014 contains specific sections on leaving care (sections 103-118).
- There is a duty to advise, assist and befriend to promote well-being when a young adult ceases to be looked after.
- The Act creates six categories of young people who are entitled to support.
- There are requirements about keeping in touch, personal advisers, pathway assessments and plans, and living arrangements (staying put).
- These duties are amplified in the Care Leavers (Wales) Regulations 2015.

The evolution of law and guidance in Wales for Transitional Safeguarding (6)

- Care Leavers (Wales) Regulations 2015 set out requirements for involving young people and having regard to their views. Copies of assessments, pathway plans and reviews must be provide and explanations given.
- The Regulations set out timeframes for completion of assessments and reviews. Reviews must be completed every six months if not more frequently. The views of significant others must be sought.
- Written records must be kept.
- The Regulations specify the contents of pathway plans – education and training, employment, health, financial support, accommodation.
- The Regulations specify the functions of Personal Advisers, including providing advice and support, participating in assessments, planning and reviews, coordinating service provision and supporting the young person to use services, and visiting their accommodation, which must be suitable.

The evolution of law and guidance in Wales for Transitional Safeguarding (7)

- Homelessness and Social Housing Allocations (Wales) Act 2026.
- Definition of threatened with homelessness extended from 56 days to 6 months.
- Removes the tests for priority need and intentionality.
- For prevention, there is a single clear legal duty to secure appropriate accommodation.
- All public services are required to assist in the prevention of homelessness.
- There should be tailored support, including for young adults with complex needs.
- Provision for legally enforceable housing plans.

The evolution of law and guidance in Wales for Transitional Safeguarding (8)

- Ending Homelessness in Wales: A High Level Action Plan 2021-2026
- To identify people at risk of homelessness earlier, especially young people, and put a support structure in place.
- To increaser the understanding of the causes of homelessness, and solutions.
- To improve early intervention, targeted prevention measures, and pathways for tailored support.
- Youth homelessness coordinators.

BUT

- Concerns remain that local authorities are failing in their duties to young people leaving care.
- Decisions by the Local Government and Social Care Ombudsman regarding transitions from children's services continue to highlight failure to complete needs assessments prior to the age of 18 to ensure that services for a young adult were identified and in place (London Borough of Haringey 2025), delays in completing assessment of care needs and shortcomings in planning for transition (Birmingham City Council 2024; Suffolk County Council 2025).
- *Bolton Council v KL* [2022] advised that local authorities and health organisations must use a joined-up approach to ensure continuity of protection and support.

Evidence-based themes

- 9% of SARs (n=652) in the second national analysis featured transitional safeguarding (for example, see) Croydon SAB – Madeleine
- Having family and friends to turn to, and leaving care teams that negotiate on their behalf with housing services, can make a positive difference for care experienced young people.
- Support needed beyond housing need, especially for mental health and well-being, often as a result of significant trauma, family breakdown, and unsafe relationships.
- Law and statutory guidance was not complied with.
- Limited housing options.
- Needs extend beyond the list of eligible needs that local authorities must meet.
- Poor planning. Absence of multi-disciplinary and multi-agency meetings.
- Many have no control over where they live and often feel unsafe in types and location of accommodation. Many feel unprepared to manage money, which can result in debts and loss of tenancies. Many do not feel sufficiently involved in plans, do not understand the options, and do not feel listened to.

AND

- Shortcomings have been consistently highlighted by safeguarding adult reviews, namely:
  - Poor planning
  - Absence of agency policies and procedures
  - Poor risk assessments
  - Failures of children's social care and adult social care to work together
  - Absence of multi-disciplinary and multi-agency meetings
  - Unclear pathways for therapeutic and other forms of support
  - Lack of legal literacy, for example about mental capacity law for 16 and 17 year olds
  - Lack of agreements regarding strategic oversight between Sabs and Safeguarding Children Partnerships

BUT … and yet

- Some SARs report good practice in terms of relational practice, policies and procedures for transition planning, and evidence of pathway planning with, and support for young people.
- Some SABs report changes to practice, and the management of practice, as a direct result of SAR recommendations.

- Yet, concerns remain, for example about unregulated placements, about the lack of resources to accommodate young people with complex needs, and about the availability of services for young people/young adults with ongoing mental health needs as a result of trauma.

A pause for thought

- Are the legal rules strong enough to promote best practice with care-experienced young people?

The evidence base for direct practice (1)

- Personalised. Practice is relational and participative, tenacious and curious, needs-led, person-centred and rights-based: all aspects of that individual's situation are taken into account in the safeguarding process, including structural inequalities.
- Context and history. Practice considers the strengths and challenges in the young person's familial and social networks, working in collaboration to build circles of support.
- Developmental. Practice is not bound by age-determined boundaries. It also recognises the inconsistencies in age in the legal, policy and service frameworks and seeks to resolve tensions in these (Cocker et al., 2021a).
- Prevention, protection and recovery. Practice is trauma-informed, strengths-based and outcomes focused, aimed at promoting safety and wellbeing (Holmes and Smale, 2018). Practice offers flexible and integrated support.

The evidence base for direct practice (2)

- Whole-person. Work with young people/young adults is characterised by a holistic view of the person rather than defining their needs, vulnerabilities or strengths according to age or eligibility.
- Equalities. Practice recognises protected characteristics arising from gender, sexuality, race and disability. Practitioners acknowledge inequalities, recognising the impact on their lives, and addressing unconscious bias.
- Exploitation. Practice recognises the impact on decision-making of coercion and exploitation. It challenges any assumptions about lifestyle choice (Holmes and Smale, 2018). Practitioners explore with young people/young adults their decision-making, offering support and advocacy.
- Mental capacity. Practice is informed by a legally literate understanding of the Mental Capacity Act 2005 (Preston-Shoot et al., 2020).
- Assessment. Assessments are timely and fulfil statutory requirements. Assessments of care and support needs are incorporated into other processes, such as looked after children reviews, to minimise the need to repeat information (Holmström , 2020). Assessments of care and support focus not just on eligible needs but also on wellbeing and prevention. Assessments of risk are completed.

The evidence base for direct practice (3)

- Planning. There is evidence of early and proportionate planning (Holmström , 2020). Planning is not limited by a focus on eligibility criteria and thresholds (Preston-Shoot et al., 2020). Care plans are followed through and reviewed. Contingency planning also occurs. There is clear evidence of pathway planning, with key worker/personal adviser offering continuity and a sustained relationship that incorporates insight into the young person's feelings and experiences.

- Meeting need. Placements and accommodation provision are suitable. The impact of transition, of moving on, on mental health is recognised (Preston-Shoot et al., 2020). Practice is characterised by wrap-around support aimed at meeting accommodation need but also enhancing physical and mental wellbeing, and supporting young adults into training and/or employment. Options are considered, with adherence to the young person's preferences unless contraindicated.

The evidence base for the team around the person

- Working together. Agencies work together across service and geographical boundaries rather than in silos to offer an integrated system of planning and support, recognising the inter-connected nature of harms and risks (Holmes and Smale, 2018). There is a clearly agreed lead agency and key worker to facilitate and coordinate planning and decision-making (Preston-Shoot et al., 2020).
- Information-sharing. There is early and proportionate sharing of information about risk and the range and level of support required (Holmström, 2020). Information is shared without consent when this is necessary to safeguard a young adult at risk.
- Legal literacy. There is less focus on eligibility and more on preventative work and wellbeing. Advice and support are sought to address the inconsistencies in age in the legal, policy and service frameworks regarding young people's transitions to adult services (Cocker et al, 2021a). Legal rules are used to prevent and to disrupt sources of harm.
- Safeguarding literacy. Adult safeguarding concerns are referred appropriately using the criteria in section 42(1) Care Act 2014, including without consent when necessary to safeguard a young adult at risk, and decision-making regarding the duty to enquire is robust and lawful (Preston-Shoot et al., 2020).
- Multi-agency meetings. Practice is characterised by the use of multi-agency, multi-disciplinary meetings to share information, identify needs and risks, and agree a coordinated plan, with a lead agency and key worker clearly identified. Pathways for convening multi-agency meetings are clearly stated and understood (Preston-Shoot et al., 2020).
- Recording. Reasons for decisions, including of mental capacity assessments and best interest decision-making, are clearly recorded (Holmström, 2020).

The evidence base for organisational support for the team members (1)

- Supervision. Practitioners are offered reflective, trauma-informed supervision, to enable them to manage the emotional impact of the work, and explore any unconscious bias. Supervision enables practitioners to maintain a person-centred approach in complex cases where a young person's engagement may be ambivalent (Preston-Shoot et al., 2020).
- Training. Practitioners and managers are offered training to develop their knowledge of and skills for transitional safeguarding. This includes understanding the developmental needs of young people, proportionate risk-taking, legal literacy, mental capacity, trauma informed practice, and development of skills of professional curiosity and enquiry into young people's lived experiences (Preston-Shoot et al., 2020).
- Specialist advice. Practitioners and managers across services have access to specialist advice and guidance, for instance from lawyers and mental capacity and mental health specialists (Holmström, 2020).
- Co-production. Commissioners and providers involve young people/young adults in co-design/co-production of services for safeguarding young people.

The evidence base for organisational support for the team members (2)

- Commissioning. Commissioners (health, housing and social care jointly), providers and young people/young adults regularly conduct needs analyses and review available services to identify any gaps in provision, ensuring that planning is responsive and evidence-informed. Commissioning recognises the importance of services that are developmental, that are not bound by rigid age-determined boundaries, and that offer flexible support. Commissioners escalate concerns about shortages of accommodation and other resources, and contribute actively to the assessment of suitability of proposed placements (Preston-Shoot et al., 2020).
- Management. Senior managers demonstrate leadership that spans boundaries, essentially embracing a life-course and contextual/ecological approach. The setting of a clear vision across different service areas and having 'a 'listening' senior management open to change' are managerial strengths and necessary enablers to facilitate improvement in transitional safeguarding approaches to working with young people (Cocker et al., 2021b).
- Policies and procedures. There are agreed multi-agency procedures and practice guidance for transitional safeguarding (Preston-Shoot et al., 2020). This includes clear pathways for victims of exploitation, including access to therapeutic and mental health support.
- Staffing. Caseloads allow for the development of relationship-based practice as transitional safeguarding cannot be time-limited work (Holmes and Smale, 2018). Staff have sufficient knowledge and experience to manage case complexity. Recruitment and retention of staff enable continuity of relationships with young people/young adults (Preston-Shoot, 2020).

The evidence base on governance

- Safeguarding Adults Board (SAB). The SAB routinely exercises its statutory mandate by seeking assurance regarding how transitional safeguarding is being developed and embedded in policy and practice locally.
- Strategic response. The SAB works closely with the Community Safety Partnership (CSP) and with the Children's Safeguarding Partnership (CSP) to ensure system-wide, coordinated oversight of transitional safeguarding locally. This might involve shared chairing arrangements, shared work groups or shared objectives between SABs, SCPs and CSPs (Walker-McAllister and Cooper, 2021). It might include a cross-age strategic group to direct activity for both children and adults, with a shared vision of purpose, clear terms of reference, multi-agency membership and clearly defined responsibilities (Preston-Shoot et al., 2020).
- Quality assurance. Regular case audits of transitional arrangements are conducted (Holmes and Smale, 2018).
- Reviews. Safeguarding Adult Reviews and Child Safeguarding Practice Reviews are used to develop arrangements for care leavers. Boards and Partnerships track the impact of reviews.

The evidence base for the fifth domain

- SAR authors highlight where the national legal, policy and financial context created barriers or obstacles for services in aligning practice with the evidence base.
- SABs regionally and nationally should collate SAR findings and escalate concerns about the impact of this national context to the Welsh government, Department of Health and Social Care, Ministry of Justice, Home Office and DWP as appropriate.
- SABs are clear in their advocacy when and where parts of this overarching system are not working.

Conclusion

Seen in this light, SARs are human stories, rooted in an understanding of what matters deeply for service users and those working with them (Preston-Shoot, 2003), that aim for a system turn, the development of understanding that takes practitioners, managers and policymakers beyond incremental tinkering with present practice and its context, to an envisioned future.

(Preston-Shoot, Cocker and Cooper, 2022, p98)

What next for you? When you leave the webinar …

- Reflection: what have been the key points from today?
- What needs to come next? Identify how you will develop your own practice. Action steps could be related to
  - Strategy and governance
  - Interagency communication and decision-making
  - Work patterns in your team
  - Your own knowledge or skills in practice



Further Reading

- Bateman, F. and Cocker, C. (2021) *Safeguarding Adults Review: Madeleine.* Croydon Safeguarding Adults Board, London. Available at: *https://www.croydonsab.co.uk/wp-content/uploads/2022/03/PDF-Madeleine-SAR-Final-Report.pdf*
- Cocker, C., Cooper, A., and Holmes, D. (2021) Transitional safeguarding: Transforming how adolescents and young adults are safeguarded. *British Journal of Social Work*. Available at: https://academic.oup.com/bjsw/advance-article/doi/10.1093/bjsw/bcaa238/6102523?guestAccessKey=78b38361-28be-48b8-b591-9f2edff7fff4
- Cocker, C., Cooper, A, Holmes D, and Bateman F. (2021) Transitional Safeguarding: Presenting the case for developing Making Safeguarding Personal for Young People. *Journal of Adult Protection* 23(3), pp. 144-157 https://doi.org/10.1108/JAP-09-2020-0043
- Holmes, D. and Smale, E. (2018) *Mind the Gap: Transitional Safeguarding – Adolescence to Adulthood.* Dartington, Research in Practice
- Holmes, D. (2021) *Bridging the Gap*: *Transitional Safeguarding and the role of social work with adults.* London, Chief Social Work Office for Adults/DHSC. Available at: *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/990426/dhsc_transitional_safeguarding_report_bridging_the_gap_web.pdf*
- Holmes, D. (2022) Transitional Safeguarding: the case for change, *Practice*, Vol. 34 No. 1, pp. 7-23, https://www.tandfonline.com/doi/full/10.1080/09503153.2021.1956449
- Preston-Shoot, M. Cocker, C. and Cooper A. (2022) Learning from Safeguarding Adult Reviews about Transitional Safeguarding: Building an evidence base. *Journal of Adult Protection* Vol. 24 No. 2, pp. 90-101. https://doi.org/10.1108/JAP-01-2022-0001

