Medway Council
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Health and Adult Social Care Overview and Scrutiny Committee

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Transitions to Adult Social Care

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Summary

This report provides the Committee with an overview of the Transitions Team in Adult Social Care. It outlines the team's structure, roles, and responsibilities, as well as the referral pathways and criteria for accessing the service. The report details current demand levels and pressures, while also highlighting key strengths such as the team's commitment to person-centred planning, strong partnership working, and proactive efforts to improve data quality and forecasting.

It explores challenges faced, including resource constraints and complexities in meeting diverse needs during the transition from children's to adult services. Despite these challenges, the team continues to deliver positive outcomes for young people and their families, ensuring continuity of care and promoting independence wherever possible. Ongoing initiatives, such as earlier allocation, recruitment of additional staff, and development of new data sets, demonstrate a clear focus on improvement and sustainability.

1. Recommendations

1.1 The Committee is requested to note the content of this report.

2. Budget and Policy Framework

2.1 This service supports the One Medway Council Plan:

Priority 1: Delivering Quality Social Care and Community Services, and sub-priorities:

- Provide effective, targeted support for our most vulnerable residents to enable them to fulfil their potential and improve their quality of life
- Support people of all ages to live the most happy, healthy, independent life possible, utilising assistive technologies

- Support all adults, including those living with disability or physical or mental illness to live independently and stay safe

- People in Medway live independent and fulfilled lives into an active older age

Priority 4: Improving Health and Wellbeing for All, and sub-priorities:

- Empowering people to achieve good health and wellbeing through prevention, with access to local activities and services that will enable and support them to lead independent, active and healthy lifestyles

- Work in partnership with communities and organisations to address the issues that negatively affect health and wellbeing, making sure everyone has the opportunity to live long, healthy lives

3. Background

3.1 The Adult Social Care Transitions Team was formed in 2018 following an audit of young people being supported into adulthood and gaps identified in the referrals to Adult Social Care.

3.2 In June 2023 the 0-25 Team transferred all young people aged 18+ from Children's Services to the Adult Social Care Transitions and Targeted Review Team. The 0-25 Team became the Children and Young People with Disabilities Team (CYPD) who support children and young people up to the age of 18.

3.3 The Transitions Team accepts referrals for young people open to a children's social work team in Medway or other local authorities and from special education needs and disabilities (SEND) colleagues, in advance of their 18th birthday. Young people not known to Children's Social Care or SEND before their 18th birthday are referred to the Adult Social Care Locality Teams.

3.4 Following the restructure of Adult Social Care in March 2025, the Transitions and Targeted Review Team were split into two standalone teams. This has provided clearer focus and accountability, increased specialist expertise within the team and strengthened team identity within Adult Social Care. The team consists of:

1 x Operations Manager
1 x Team Manager
3 x Senior Social Workers
6 x Social Workers
1 x Newly Qualified Social Worker
1 x Social Worker Apprentice
2 x Social Care Officers (1 x completing Enablement and Prevention)

3.5 The Transitions Team work closely with children's social work teams and SEND to identify and discuss cases.

3.6 The Transitions Team also have 2 x Senior Social Workers who work with people with Learning Disabilities and Autism and a Transforming Care Co-Ordinator who supports people being discharged from inpatient settings. However these members of the team work with adults of all ages so detail is not included in this report.

3.7 The Children with Disabilities team works with children and young people up to the age of 18, this could involve safeguarding, court work, and supporting Children in Need. For some children, the team may be involved because they have a care package, and in those cases, we would only carry out annual reviews. One challenge with this is that children often have changes of social worker during their transition journey, and if this happens close to the time they move to Adult Social Care, it can make the transition difficult. A new worker may not know the child as well as someone who has worked with them for significant period, which can affect planning and continuity. There can also be several partner agencies working with the child and the work each partner undertakes, needs to be carefully coordinated to support the plan for transition. In Medway, we are working to make this transition smoother by starting to plan earlier, from the age of 14, by holding joint meetings with Adult Social Care so that the child's needs are considered well before they turn 18. It is important to understand that there are differences between the 2 services including legislation, eligibility criteria, funding for packages, which can create tensions and difficulties for families and professionals.

4. Advice and Analysis

4.1 The Transitions Team are responsible for the following areas of work for the young people coming through the service:

- Signposting: If it is determined that the young person does not have eligible care and support needs, they are signposted to other agencies, such as Housing.

- Prevent and Enablement: Where possible, enablement is offered to ensure that young people are supported to build their skills for independence enabling them to lead independent lives.

- Care Act Assessment: This is a statutory process under the Care Act 2014 where local authorities assess an individual who appears to have care and support needs. The assessment is holistic, focusing on the person's wellbeing, desired outcomes, and how their needs impact daily life.

- Support Planning: Once eligible needs are identified, a support plan is developed collaboratively with the individual. The plan details how those needs will be met, including services, resources, and informal support networks.

- Review of Care and Support: Regular reviews ensure that the care and support provided remain appropriate and effective. Reviews check whether outcomes are being achieved, whether needs have changed, and if adjustments are required.

- Community DoLS Application and yearly renewals: Applications of the Mental Capacity Act's deprivation of liberty safeguards in non-hospital, non-care home settings, such as supported living or shared accommodation, ensuring that any restrictions on a person's freedom are lawful, necessary, and in their best interests.

- Safeguarding: Complete the statutory Section 42 and non-statutory safeguarding enquiries for the young people open to the team.

- Carers assessments: A statutory process under the Care Act that evaluates a carer's needs, wellbeing, and the impact of their caring role, ensuring they receive appropriate support.

- Carers reviews: A regular check to reassess the carer's situation, confirm if existing support remains effective, and adjust plans to reflect any changes in needs or circumstances.

- Duty: Manage queries and requests for support, for those without an allocated social worker.

4.2 Process for Transitions Referrals

4.2.1 A 14+ case tracking meeting is held monthly and is attended by the Adult Social Care Transitions Team, Leaving Care Team, CYPD Team, SEND, Integrated Care Board (ICB) and Commissioners. The purpose of this meeting is to discuss those children who may transfer to Adult Social Care.

4.2.2 A referral process on Mosaic (the system used by the service) has been developed and guidance rolled out to children's social care teams. A referral can be completed at any time by Children's Social Care, although it is expected when the young person turns 17. The Transitions Team endeavour to allocate the case to a member of the Team by 17.5 years at the latest, depending on complexities.

4.2.3 The Transitions Team adopts the 3 Conversation Model, which is a strengths-based approach. A Conversation 1 & 2 is completed (Enablement and Prevention), usually in conjunction with the Children's Social Care or SEN workers and where appropriate will progress to a Conversation 3 (Care Act 2014 eligibility assessment).

4.2.4 Care Act 2014 Eligibility Criteria for support from Adult Social Care:

4.2.4.1 An adult is eligible if:

1. Their needs arise from or are related to a physical or mental impairment or illness, and

2. As a result, they are unable to achieve two or more specified outcomes, and

3. There is, or is likely to be, a significant impact on their well-being.

4.2.4.2 Specified outcomes include:

- Managing and maintaining nutrition
- Maintaining personal hygiene
- Managing toilet needs
- Being appropriately clothed
- Being able to make use of the home safely
- Maintaining a habitable home environment
- Developing and maintaining family or other personal relationships
- Accessing and engaging in work, training, education or volunteering
- Making use of necessary facilities or services in the local community
- Carrying out caring responsibilities for a child

4.2.5 For those young people that do not meet the criteria, advice and guidance will be provided. This may include referrals to young people's supported accommodation, via mainstream housing.

4.2.6 One Social Care Officer in the team provides enablement and prevention work with young people who do not meet the criteria for long term care and support from adult social care. Enablement refers to short-term, intensive support designed to help individuals gain independence. It focuses on building skills and confidence so people can do things for themselves rather than relying on ongoing care. Examples include reablement services, occupational therapy, and assistive technology. Prevention is about avoiding or delaying the need for formal care and support by addressing issues early. This can include promoting healthy lifestyles, providing information and advice, offering community-based activities, and supporting carers. The aim is to reduce future dependency and maintain wellbeing.

5. Data for Referrals & Work within the Transitions Team

5.1 Tables 1 and 2 below illustrate the number of referrals and the source of the referrals from June 2023 – 18 December 2025. Table 3 provides data relating to the outcome of the referral at each stage in the process.

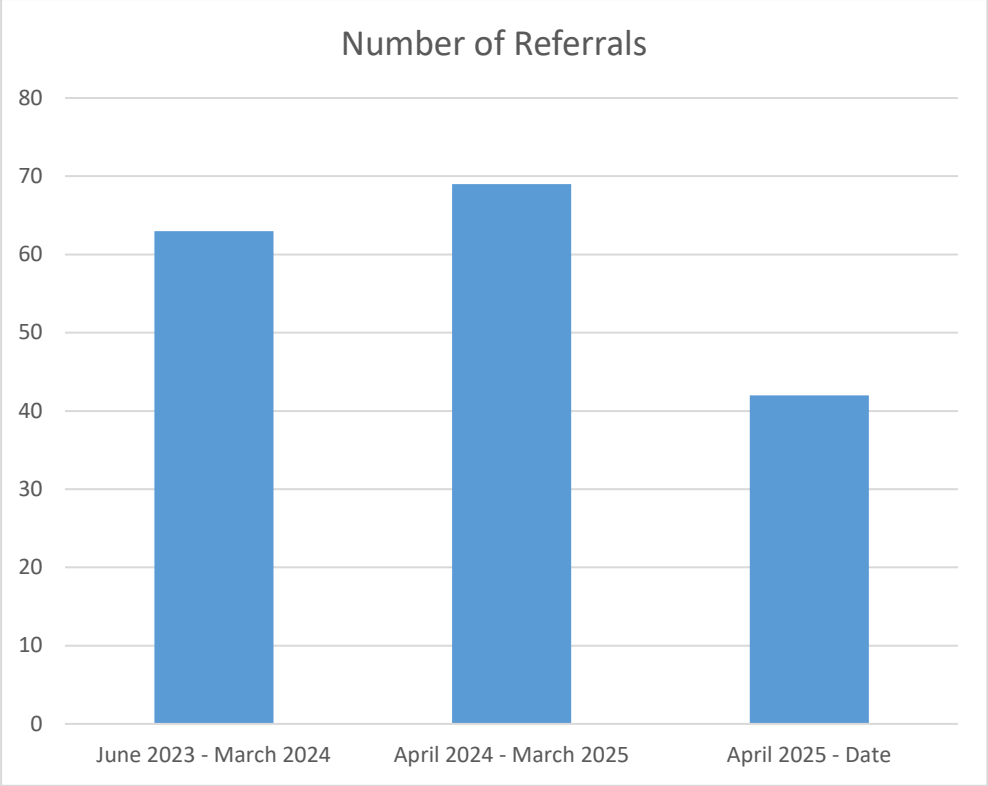

Table 1 – Total 174 referrals received since the team created.

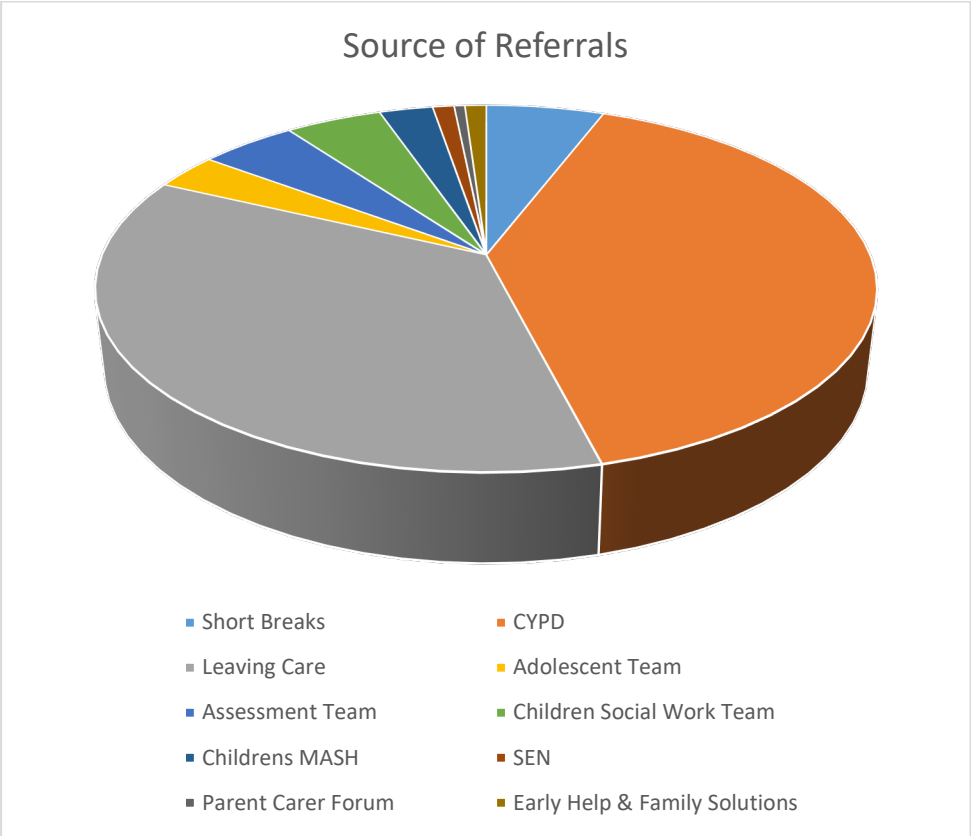

Table 2 – Details of referral sources since the team was created.

Outcome of Referrals	
Progressed to a Conversation 1&2	163
NFA	11
Outcome of Conversation 1&2	
NFA	4
Progressed to a Conversation 3	138
In Progress	21
Outcome of Conversation 3	
NFA	62
In Progress	28
Went onto Long Term Care	48

Table 3 – Outcome of the Assessments completed

5.2 The data indicates that 29.5% of referrals to the team result in individuals requiring long-term care and support from Adult Social Care. Although this percentage is higher than the overall rate for Adult Social Care services, it reflects the complexity of needs and the targeted nature of these referrals.

5.3 Table 4 shows the cases held by the Transitions Team as of 9 December.

Transforming Care	15
Allocated 16 – 18 year olds	18
Awaiting allocation 16 – 18 years old	27
First reviews	32
12 month review	129
S42 enquiries	10
COP DoLS active work	16
COP DOLs waiting	78
Total number of cases @ 9.12.25	**318**

Table 4

6. Strengths

6.1 The Transitions Team promote and endorse partnership work to further strengthen transitions and outcomes of young people and their families for example. There are number of regular meetings and forums in place with key stakeholders including parents and carers, children's social care teams, respite services and SEND schools.

6.2 The team have strong strategies in place to forecast and track young people coming into the service so resource can be planned and pressure on capacity identified early.

6.3 The team manage their own safeguarding work, providing continuity at a pivotal time in young people's lives.

7. Challenges

7.1 Whilst we track and forecast young people coming into the service there is always the possibility of unpredicted referrals being received, for example, young people moving into Medway from another local authority or late referrals.

7.2 The team are expecting a minimum of 35 referrals next year from CYPD and the Leaving Care Team alone. The service has 40 young people turning 25 during the next financial year and transferring to Adult Social Care Locality Teams. It is likely the number of referrals received will be higher than the 40 exiting the service, impacting the team's capacity and increasing pressure and demand on the team.

7.3 Budget pressures in Adult Social Care are further exacerbated when young people transition to the service. When they turn 18, tri-party funding often ceases, leaving Adult Social Care responsible for a larger share of their care and support costs. This is particularly evident in cases such as Continuing Health Care (CHC), where eligibility criteria differ between children and adults, resulting in the council taking over costs that were previously funded by health, and in the Learning Disability and Autism funding stream, which is only available until age 18.

7.4 Not all young people that require support from Adult Social Care meet the criteria for supported living. There is a lack of mainstream housing for young people on the edge of care, which means that supported living becomes the default option as the young people need somewhere to live.

7.5 Fee increases from care providers, particularly for young people with complex needs, also add significant pressure to budgets.

7.6 There is a lack of care provision in Medway to meet the needs of very complex young people, meaning we have to source out of area.

7.7 Access to robust data sets remains a key challenge for the Transitions Team. Currently, there is a lack of detailed information needed to drill down into performance, identify themes and trends, and use these insights to shape effective strategies. However, work is underway to address this gap, with new data sets being designed and implemented to provide the necessary intelligence for informed decision-making.

7.8 Allocating young people at 17.5 does not always give sufficient time to assess and implement support for young people. Improving our data sets will support with this. In addition, we are recruiting an additional social worker in the next

financial year to enable us to allocate from 16 to 16.5 years with a plan to have the assessment and support plan in place by 17 years and 9 months.

8. Risk Management

Risk	Description	Action to avoid or mitigate risk	Risk rating
Funding shift at age 18	Tri-party funding ceases; CHC criteria change; LD&A stream ends	Joint funding panels with ICB Finance forecasting and commissioning negotiations	BII
Insufficient mainstream housing	Supported living becomes default due to lack of housing	Housing pathway with partners Develop step-down/shared housing models	BII
Limited local provision	Due to lack of local care provision – we are sourcing care out of area for young people with complex needs	Stimulate local market Joint commissioning with ICB	BII

For risk rating, please refer to the following table:

Likelihood	**Impact:**
A Very likely B Likely C Unlikely D Rare	I Catastrophic II Major III Moderate IV Minor

9. Climate change implications

9.1 Placing young people out of area requires travel for assessments and reviews, which increases time and cost pressures and contributes to carbon emissions, impacting climate change. To minimise this, Adult Social Care encourage the use of public transport where practical to reduce emissions. We cluster reviews and assessments geographically where possible so multiple visits can be completed in one trip, minimising travel and we explore virtual reviews where appropriate to reduce the need for physical travel.

10. Financial implications

10.1 The transition of young people into Adult Social Care presents significant financial challenges for the Council for a number of reasons. The cessation of tri-party funding at age 18 due to the difference in Continuing Health Care eligibility criteria transfer costs to Adult Social Care, with individual packages for complex needs often running into tens of thousands of pounds annually.

10.2 Additional pressures arise from market dynamics and placement challenges. Provider fee inflation and the lack of local provision for highly complex young people result in higher placement costs, particularly when sourcing out-of-area options and these arrangements also incur additional travel expenses for social workers. The absence of mainstream housing means supported living often becomes the default, adding long-term strain on budgets.

10.3 Collectively, these factors add to the financial pressures in Adult Social Care.

11. Legal implications

11.1 The Care Act (2014) requires local authorities to begin transition planning from the teenage years, with a "child's needs assessment" under Section 58 to evaluate emerging adult care and support needs and ensure informed, supported passage into adulthood.

11.2 Section 9 assessment: The Care Act (2014) mandates an adult needs assessment for anyone transitioning who appears to have care or support needs, involving the young person in identifying their wellbeing goals and preparing for adulthood.

11.3 Section 42 safeguarding duties: Once a young person turns 18, if it is identified that an individual is experiencing or is at risk of neglect or abuse and cannot protect themselves due to care and support needs, the local authority has a statutory duty to undertake enquiries to ensure their safety.

11.4 Human Rights Act (1998): Transition processes must uphold human rights, such as respect for private life, non-discrimination, and protection from inhumane treatment, ensuring dignity, autonomy, and fairness as young people move into adult services.

11.5 Mental Capacity Act (2005): As young people turn 18, assessments under the Mental Capacity Act determine decision-making capacity; any restrictions on liberty in care settings require lawful authorisation through DoLS or Court of Protection Deprivation of Liberty Safeguarding for those living in the Community.

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Appendices

None

Background papers

None