Fife Council

Fife Health & Social Care Partnership

Children in Fife
Every child & young person matters

Visit **children.fife.scot**

Multi Agency Guidance

Transition Planning for Children & Young People with Additional/Complex Support Needs

Document Date: 03/07/2026

Review Date:

Authorised By:

Contents

1. Introduction

Fife is committed to enhancing the transitions pathway for the young people who access it. Recent learning reviews suggested that the current process could be strengthened, and highlighted opportunities to make the pathway clearer and more consistent. To support this, a dedicated temporary post has been created to help guide and coordinate the development of the pathway.

These transition guidelines apply to young people who have additional/complex needs who have been identified by Education Services and/or Children and Families Social Work Services as requiring support post school. In Scotland, young people aged 16-17 years can be defined both as children and adults. They have adult legal capacity to make decisions, while remaining defined as children for the purposes of care, protection, wellbeing and children's rights until age 18.

For the purpose of this guideline, the definition of complex needs is as follows:

Individuals who 'need a high level of support with many aspects of their daily life, and relying on a range of health and social care services. This may be because of illness, disability, broader life circumstances or a combination of these. Complex needs may be present from birth or develop over the course of a person's life, and may fluctuate' (NICE).

When identifying those with complex needs, professionals should consider the level of risk the young person would be subject to without appropriate supports and the impact this would have upon their wellbeing. The stability and resilience of any informal support networks should also be accounted for.

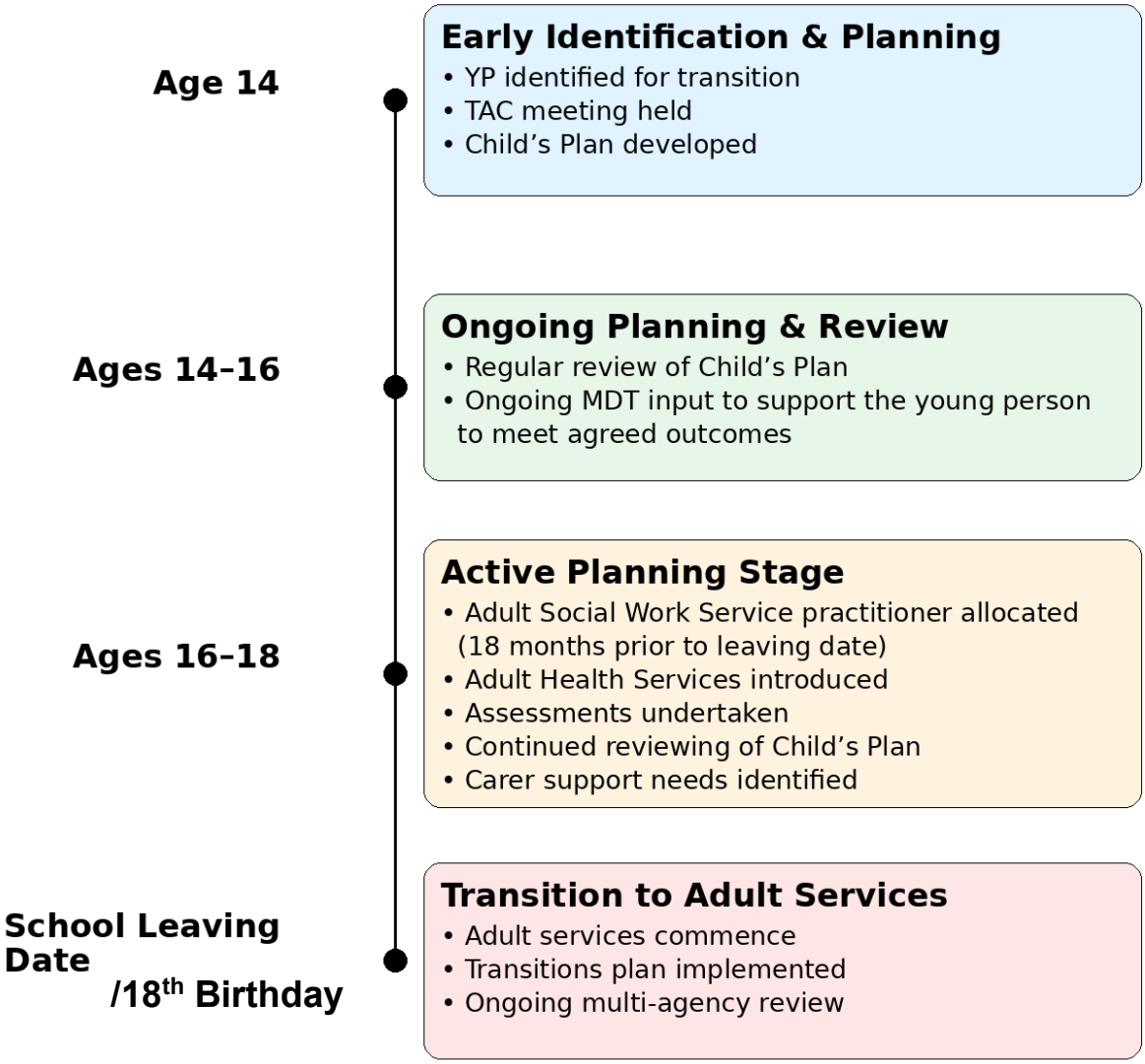
These procedures have been developed as a basis for ensuring that all those professionals supporting young people through the transitions process are clear about the roles and responsibilities and that this is managed effectively. The successful implementation of these procedures should provide a smooth transition for the young allowing them and their family/carer to feel well supported through this process minimising any detriment to their wellbeing.

'Transition is the period when young people develop from children to young adults. This is not a single event, such as leaving school, but a growing-up process that unfolds over several years and involves significant emotional, physical, intellectual and physiological changes. During this period young people progressively assume greater autonomy in many different areas of their lives and are required to adjust to different experiences, expectations, processes, places and routines. Transitions also impact on the family or on those who care for the child or young person' (Arc, Principle 3).

For some young people, they may require support in different areas of their life to support them to enable them to be as independent as possible in achieving their full potential. Any support should be person-centred ensuring that the young person's outcomes, goals and aspirations are central in decision making.

This process can be a particularly challenging time for young people and their family/carers. Consequently, it is important that young people and their family/carers receive appropriate support and information which is accessible, coordinated, comprehensive and well communicated.

2. Timeline


Age 14
Early Identification & Planning
• YP identified for transition
• TAC meeting held
• Child's Plan developed
Ages 14–16
Ongoing Planning & Review
• Regular review of Child's Plan
• Ongoing MDT input to support the young person to meet agreed outcomes
Ages 16–18
Active Planning Stage
• Adult Social Work Service practitioner allocated (18 months prior to leaving date)
• Adult Health Services introduced
• Assessments undertaken
• Continued reviewing of Child's Plan
• Carer support needs identified
School Leaving Date /18th Birthday
Transition to Adult Services
• Adult services commence
• Transitions plan implemented
• Ongoing multi-agency review

3. Key Principles

This guidance has been developed with consideration to the wider legislative and policy context which has been outlined in Appendix 2. Fife Council has made a commitment to Arc Scotland's Seven Principles of a Good Transition, which are nationally recognised as best practice guidance. These procedures are enshrined in the following principles:

1. Planning and decision making should be carried out in a person-centred way
2. Support should be co-ordinated across all services
3. Planning should start early and continue up to age 25
4. All young people should get the support they need
5. Young people, parents and carers must have access to the information they need
6. Families and carers need support
7. A continued focus on transitions across Scotland

4. Transitions Oversight Group (TOG)

The Transitions Oversight Group (TOG) is a multi-agency group that meets every six weeks with the purpose of providing ongoing strategic support to the transitions pathway. This also supports the local authority to fulfil their responsibilities to remain signed up to Arc Scotland's Principles into Practice Framework.

Core membership of the group includes:

- Children's Social Work Services
- Adult Social Work Services
- Education
- Adult Health Services
- Children's Health Services

Additional membership of the group includes:

- Performance Improvement Planning Team
- Social Work Contracts & Procurement
- Finance Representative

In addition, independent providers or representatives from other organisations e.g. further education, may be asked to attend meetings as required depending upon the agenda of the meeting.

The TOG has the remit to consider both strategic planning and operational arrangements regarding young people requiring transition planning. Responsibilities of the group are included below:

- Hold and monitor an overview of the transitions population from 14 years onwards to forecast future needs and support the allocation of workforce resource accordingly.
- Identify local trends and needs and support the development of resources to effectively meet these.
- Identify and match young people who could have shared support needs, supporting the development of shared support networks and packages to meet these needs in a different way.
- Provide assurance around the timely and consistent completion of assessment and support planning across Fife in accordance with the transitions guidance including the quality of this work.
- Lead on the continued assurance around Key Performance Indicators including initiating audits.
- Where any challenges have been identified in the delivery of support plans, provide a forum for resolution, escalation and ensure accountability in the adherence to the procedures.
- Act as a central point for resource allocation where a resource is specialist and sought after e.g. day centre placement.
- Discuss referrals and agree if these will progress, providing consistency in decision making.
- Fulfil commitments to remain a member of Arc's Principles into Practice framework.

The TOG will also be responsible for agreeing referral outcomes from the initial Team Around the Child (TAC) meeting.

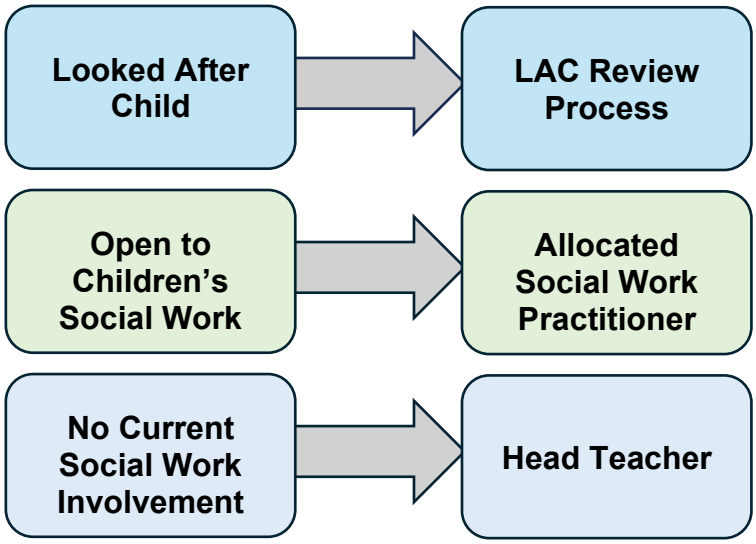
5. Transition Process

5.1 Early Identification and Planning Stage

Education and Children's Social Work Services will support the early identification of young people with complex needs who require a transition to Adult Social Work Services.

Responsibility for identifying young people and progressing with the planning stage is dependent upon the young person's service involvement.

- If a young person is looked after then transition planning should be included within the existing looked after review process (see section 5.4).
- If a young person is supported by Children's Social Work Services and not looked after then their allocated social work practitioner is responsible for progressing.
- If a young person is not supported by Children's Social Work Services then the Head Teacher is responsible for progressing.



Young people with additional/complex support needs who do not attend school should also be afforded access to the same level of transition planning as their peers.

An initial Team Around the Child (TAC) meeting should take place when the young person is aged 14 and focus on the young person's needs, strengths and challenges, both current and future. The purpose of this meeting should be to establish a shared understanding of the young person's needs and agree a coordinated planning approach. At this meeting a Lead Professional should be identified to co-ordinate the early planning stage and a timeline for actions and review meetings should be established.

Key professionals working with the young person should be invited to this meeting. The Adult Social Work Services Link Worker should attend the initial TAC meeting however they may not be required to attend review meetings. During this meeting there should be a discussion as to whether the young person is eligible for a referral to Adult Social Work Services. The transitions initial assessment document (see appendix 1) should be completed to identify eligibility.

The young person and their family/carers should be included in these meetings, and they should be actively supported to contribute to the development of the child's plan. Every effort should be made to include the young person in this meeting including consideration

of the provision of advocacy, however, should they choose to not engage then their views should be formally gathered and recorded and an agreed mechanism for sharing meeting outcomes should be discussed with them.

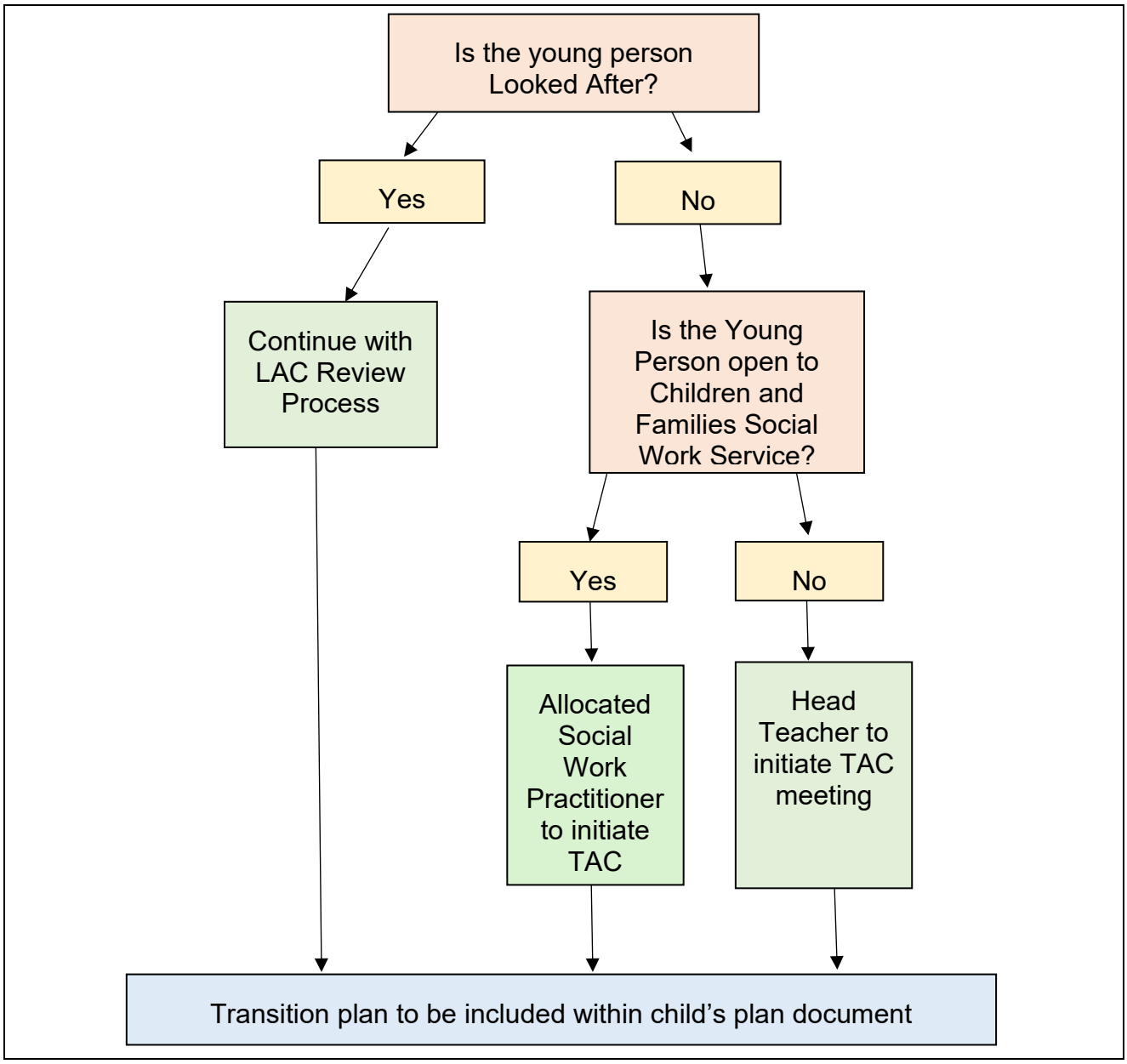
A Child's Plan should be developed from the identified needs and actions of the TAC meeting; this will act as the young person's transition plan. Consideration should be given to how outcomes will be achieved to promote the young person's independence and who should be involved in this including the young person and their family/carer.

During the planning stage, the young person and their family/carer should be provided with relevant communication documents and signposted to the Arc Scotland's Compass resource.

Should during the early identification and planning stage, it be identified that the young person has complex needs that would result in challenges around transition planning and identifying an appropriate pathway, this should be highlighted to the Transition Oversight Group.

A process chart of the early identification and planning stage can be found in Appendix 5.

Pathway for identifying responsibility in initiating first transition planning meeting:



5.2 Active Planning Stage

Active transition planning should begin eighteen months prior to the young person's school identified leaving date. At this point, a referral should be made to the Adult Social Work Service where it has been agreed this is required. A practitioner from Adult Social Work Services should be allocated to support the progression of planning. This practitioner should be introduced to the young person, their family/carer and the multi-disciplinary team. The child's plan should continue to be reviewed every six months as a minimum however review dates should be set in line with the young person's needs. A focus on transition should continue to ensure that the Local Authority's statutory responsibilities for transition planning are met.

Health services should commence work to support and plan the transition from child health to adult health services where appropriate. Any new health professionals should be introduced to the young person and their parent/carer. For young people with complex and life-threatening health conditions, their transition will need to be underpinned by strong partnership working between children's and adult health services.

During the active planning stage, assessment should take place from Adult Social Work Services to determine the young person's assessed need and what support options are required to meet these. Should the young person be assessed as being eligible for funded services as outlined in the Supporting People Framework, young people and their families/carers should be advised of their options in relation to Self-Directed Support (SDS). Discussion around SDS options should consider the young person's level of capacity.

If a young person is in receipt of a service from Children and Families social work, then this assessment should be undertaken collaboratively with this service. Consideration should be given to the appropriate point for the introduction of an adult support provider to prepare for the transition, and the holistic assessment should encompass the needs of the carer to support and sustain them in their move to caring for an adult.

A process chart of the early identification and planning stage can be found in Appendix 4.

5.3 Transition to Adult Services

If the assessment identifies a role for adult social work services, then transition to Adult Social Work Services should take place on the date that the young person leaves school and/or Children's Social Work Services or upon their eighteenth birthday. This should involve the implementation of the agreed transition plan.

Following the plan being in place, this should be subject to regular multi-disciplinary review to ensure that the young person's needs are being met and that they are making progress towards meeting their outcomes. Ongoing planning and review should uphold the principles of GIRFE and provide a continued multi-agency approach to ensure support is personalised, consistent and coherent.

5.4 Care Experienced Young People with Additional/Complex Support Needs

The local authority continues to have a duty to provide relevant support to young people who are care experienced. Any young person with additional/complex support needs

continues to have the right to access any supports afforded to them because of being care experienced and this should feature in transition planning.

Where a young person is a looked after child and has additional/complex support needs, the planning process above should be included within the existing looked after review pathway that the young person will be subject to. As per the transitions pathway, an Adult Social Work practitioner should be invited to the LAC review at age 14 to engage in discussions around transition planning and complete the initial assessment to establish eligibility for support from Adult Social Work Services.

Looked after children have a right to access continuing care and this has an eligibility criteria. Continuing care allows eligible young people to 'stay put' under continuing care arrangements.

To be eligible for continuing care a young person must be:

a) At least sixteen years of age but not yet having reached their eighteenth birthday;
b) Looked after in residential, foster or LAC kinship care (where the placement is provided or purchased by Fife Council).

A young person is not eligible for continuing care where:

a) They do not fit the age criteria mentioned above.
b) They are in adoptive placements, looked after at home, or in kinship placement secured through S11 of the Children (Scotland) Act 1995.

Young people with additional/complex support needs who do not have capacity have the same rights to continuing care, subject to the exceptions noted above. Discussions around the provision of continuing care should be undertaken through the LAC review process and the continuing care guidance states this should occur at the age of 15. Capacity assessments, guardianship considerations and decisions regarding continuing care should be considered together. Where agreement to progress with Adult with Incapacity (Scotland) Act 2000 is reached, it will be the responsibility of the Adult Social Work Service to progress this.

As per the protocol of case transfer and financial responsibility between Children and Families and Adult Social Work Services and the Continuing Care Guidance, at the point of transfer, Adult Social Work Services will meet the financial costs associated with the young person remaining in their placement through continuing care if this is being assessed as required for them to continue to meet their outcomes.

Fife Council has a Continuing Care Policy and Guidance document which should be referenced in conjunction with the above. A flow chart detailing the continuing care process is included in appendix 3.

When a young person is placed in Fife by another Local Authority, Education should provide the placing Local Authority with guidance around the process in Fife. However, any responsibility for Social Work intervention will remain the responsibility of the placing authority.

When Fife Council have placed a child in another Local Authority, the allocated Social Work Practitioner has a responsibility to establish the process for transition in the placed Local Authority and actively engage in this planning.

For young people with additional/complex support needs who are not looked after children at the point of transition but are care experienced then they are able to access their rights to financial support and guidance through the Aftercare Team. However young people are not required to have ongoing involvement with the Aftercare Team to access these supports.

6. Roles and Responsibilities

6.1 Adult Social Work Services

- A representative from Adult Social Work Services will participate in meetings during the active planning stage.
- Provide up to date and accessible information to young people and their family/carer.
- Identify a Post 16 Transition Link Worker for each Secondary School and Specialist Provision.
- Record client category of Post 16 Transition on young person's LAS.
- Allocate a practitioner within 18 months of the young person's school leaving date
- Provide an assessment of need for a young person identified as meeting criteria for assessment.
- Discuss assessment outcomes with young person and their family/carer identifying appropriate provision and/or community-based supports.
- Provide consistent and regular communication to young people and their family/carer to ensure they are informed and included.
- Ensure relevant supports are identified for the carer, arranging for a carers assessment to be undertaken where appropriate.

6.2 Children and Families Social Work Services

- Support with the identification of young people who may require post school support.
- Where allocated, attend TAC meetings.
- Record category of Post 16 Transition on LCS.
- Children's Services work in partnership with Education, Adult Social Work Services and other partner agencies in the lead up to transition. They may provide ongoing support and assessment during the transitions process.
- Work collaboratively with Adult Social Work Service to introduce workers, share knowledge and provide consistency for young people and their family/carers.
- Where possible engage in joint assessment and planning to identify where a young person's skills could be maximised to promote independence.

6.3 Education Services

- Discuss and prospectively identify young people who should be preparing for transition at the age of 14. It would be beneficial for the Post 16 Transitions Link Worker to be included in these discussions.
- Schools initiate TAC meeting and invite relevant professionals.
- Refer those identified as leaving school to Adult Social Work Services.
- Introduce the topic of transition to the young person and their family/carers.
- Liaise closely with any receiving services to ensure relevant sharing of information and the young person's needs to ensure that they experience a positive transition. This includes contributing to Adult Social Work Services assessment.

6.4 Children's Health Services

- Key professionals from Health will attend TAC meetings for a young person with complex health needs as appropriate.
- Young people and their families will be offered support and guidance in relation to health needs to support the transition from children's to adult services.
- Health professionals from children's services will support the transition to equivalent health care services that will offer post-transition support.
- Introduce the topic of transition to the young person and their family/carers ensuring discussion around their views.
- Identify the receiving service and ensure they receive a full written case summary, developmental history and risk assessment where appropriate. Highlighting the professional bodies that may be required to avoid waiting list delays.
- Agree a timetable for transition and a key worker with the receiving adult service.
- Where appropriate, arrange joint meetings involving both children's and adult services with the young person and their family/carers.
- Ensure clear documentation in care record that all the above is discussed, when and by whom.
- Notify GP early of the plan for transition and the timing and ensure that they receive contact information for the identified receiving adult service.
- Contribute to Adult Social Work Services Assessment.

6.5 Adult Health Services

- Ensure up-to-date patient friendly information is available.
- Identify and prepare resources required by the young person, adding details to relevant waiting lists in advance of transition.
- Liaise closely with the Children's Health Services team to ensure smooth advance planning of formal handover.
- Provide ongoing review and/or intervention in line with the young person's needs and care plan.

6.6 Third Sector

- Work with members of the multi-disciplinary team to develop an understanding of the young person's needs.
- Develop support plans as to how the young person's outcomes will be met and ensure this is regularly reviewed.
- Contribute to regular social work and/or health service reviews.
- Engage in relationship building work with the young person and their family/carers.

6.7 Joint Responsibilities

All agencies should endeavour to apply the principles of best practice whilst acknowledging the benefit of adopting a flexible, individualised approach.

All agencies have a responsibility to have an awareness of appropriate safeguarding measures inclusive of the Vulnerable Young Person's Social Work Guidance. Where safeguarding concerns are identified and there are challenges engaging the young person and/or their family/carer, workers should have an awareness of the Engagement Escalation Guidance.

Ensure that decision making is centred around the voice of the young person and that they are given opportunities to share their views in a communication style that meets their needs.

To work collaboratively with multi-agency partners to ensure the best outcomes for the young person including attendance at TAC meetings.

6.8 Quality Assurance, Evaluation and Continuous Improvement

This multi-agency guidance reflects the shared commitment of all partners across Fife to deliver safe, timely, coordinated and person-centred transitions for children, young people and adults. Effective transitions require more than well-written guidance; they depend upon consistent implementation, strong partnership working, effective communication and a culture of continuous learning and improvement. To provide assurance that this guidance is achieving its intended outcomes, the Public Protection Service will lead a structured programme of quality assurance and evaluation following implementation.

The guidance will be implemented at the end of August 2026. A formal multi-agency evaluation will be undertaken approximately twelve months following implementation to allow sufficient time for the guidance to become embedded across children's social work, adult social work, education, health services and wider partner agencies. The review will seek to evaluate both compliance with the guidance and, more importantly, the extent to which it has improved outcomes and experiences for children, young people, adults and their families during periods of transition.

The evaluation will include a multi-agency audit of a representative sample of transition cases from across the partnership. The audit will consider the quality and timeliness of transition planning, evidence of effective information sharing, multi-agency collaboration, management oversight, assessment of risk and need, involvement of individuals and families in decision-making, and the effectiveness of arrangements for moving between children's and adult services. Particular consideration will be given to whether transitions were person-centred, strengths-based and outcome-focused, and whether statutory duties and locally agreed practice standards were consistently applied.

The quality assurance methodology will draw upon relevant Care Inspectorate Quality Frameworks and recognised self-evaluation approaches to support consistent assessment of practice across agencies. Audit findings will be supplemented by qualitative feedback from practitioners, operational managers, strategic leads and partner organisations. Wherever possible, the experiences and views of children, young people, adults, parents and carers will also be sought to ensure that the evaluation captures the lived experience of those directly affected by transition planning.

The findings of the evaluation will be reported through Fife's established governance arrangements, including the Public Protection governance structures, providing assurance to senior leaders regarding the effectiveness of the guidance and identifying any emerging risks, themes or opportunities for improvement. The evaluation will consider patterns of practice, barriers to implementation, workforce development requirements and examples of effective practice that can be shared across agencies.

Where improvement actions are identified, these will be incorporated into a multi-agency action plan with clearly identified leads, timescales and outcome measures. Progress against these actions will be monitored through existing governance arrangements to ensure that improvements are implemented and sustained. Consideration will also be given to the development of performance indicators that enable ongoing monitoring of transition activity, including the timeliness of planning, quality of multi-agency involvement and feedback from individuals and families.

This guidance should be regarded as a living document that will continue to evolve in response to learning from practice, changes in legislation, national policy developments and emerging evidence of best practice. Following completion of the twelve-month evaluation, the guidance will be formally reviewed and updated where necessary to reflect the findings of the audit, stakeholder feedback and any agreed improvement actions. Through this commitment to robust quality assurance, continuous self-evaluation and collaborative learning, partner agencies across Fife will continue to strengthen transition arrangements, promote consistency of practice and improve outcomes for children, young people, adults and their families.

6.9 Conclusion

This guidance has been developed in consideration of lived experience, to help multi agency professionals, parents, carers and young people understand the approach to transitions in Fife. This is underpinned by a commitment to Arc Scotland's Seven Principles of a Good Transition and aims to strengthen the delivery of multi-agency practice, support a culture of proactive planning, and consistent experiences for local families.

Appendix 1 - Transitions Process Chart

Process for Early Identification and Planning Stage

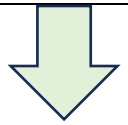
The following represents the process for young people who access the transition pathway. There are two possible outcomes:

1. The young person will be referred to Adult Social Work Services
2. The young person will not be eligible for support from Adult Social Work Services.

The timescales identified below can vary depending upon a young person's circumstances.

All young people accessing additional support			
Step	**Process**	**Who**	**When**
1	Young person identified as requiring post school support	• Education • Children's Social Work Services • Children's Health Services	Age 14
2	Initial Team Around the Child Meeting and Child's (Transition) Plan developed. Young person identified as meeting eligibility for Adult Social Work Services	• Young Person • Carer • Education • Children's Social Work Services • Children's Health Services • Adult Social Work Services • Other relevant professionals	Age 14
3	Continued review of Child's (Transition) Plan at a minimum of every six months.	• Young Person • Carer • Children's Social Work Services • Children's Health Services • Other relevant professionals	Age 14-16

4	Progress to Active Planning Stage	• Young Person • Carer • Children's Social Work Services • Children's Health Services • Other relevant professionals	Age 16 or 2 years before young person leaves school



Young Person not eligible

Young Person referred to Adult Services

Process for active planning for young people identified as eligible for referral to Adult Social Work Services

The following steps outline the process for young people who are eligible for an assessment of Adult Social Work Services and the steps towards school leaving date.

Young Person identified as eligible for referral to Adult Social Work Services			
Step	**Process**	**Who**	**When**
5	Referral to Adult Social Work Services	• Lead Professional for TAC	18 months before school leaving date
6	Social Work Practitioner allocated by Adult Social Work Services	• Adult Social Work Services	18 months before school leaving date
7	New members of MDT including health professionals introduced to young person and their carer	• Children's Health Services • Adult Health Services • Any other relevant professionals	18 months before school leaving date
8	Adult Social Work assessment to be commenced	• Adult Social Work Services	12 months before school leaving date
9	Where eligibility criteria is met for a funded service, financial resources to be requested and providers identified	• Adult Social Work Services	6 months before leaving school date
10	Any new providers, groups or community resources to be introduced to the young person	• Education • Adult Social Work Services • Any other relevant professionals	3 months before school leaving date
11	Young person leaves school, transition plan implemented, commencement of Adult Social Work Services Support Plan	• Adult Social Work Services • Any other relevant professionals	School leaving date
12	Continued review of support plan to ensure young persons outcomes are being met	• Adult Social Work Services	6 weeks post school leaving date

Process for active planning stage for young people not eligible for Adult Social Work Services

The following process outlines the steps for young people not eligible for Adult Social Work Services.

Although the young person is not eligible to transition to Adult Social Work Services, Education and Children's Services support the young person and carer through signposting to relevant services and organisations to help them fulfil their future aspirations.

Young person not eligible			
Step	**Process**	**Who**	**When**
5	Where financial resources are required to support young person to meet the outcomes identified in the Child's (Transition) Plan, an application to the ILF Transitions Fund should be considered	• Education • Young Person • Carer	Age 16
6	Signposting and support with referrals to relevant supports and opportunities including supported employment, volunteering and further education opportunities	• Education • Any other relevant professional	2 years before school leaving date
7	Introduction of some community supports/groups and further education opportunities	• Education • Any other relevant professional	12 months before school leaving date
8	Ongoing exploration of preferred community supports and groups to build a routine of activity post school	• Education • Any other relevant professional	6 months before school leaving date
9	Finalisation of transition plan	• Education • Any other relevant professional	3 months before school leaving date
10	Transition plan implemented. Young person commences education/employment/training with community support	• Education • Any other relevant professional	School leaving date

Appendix 2 - Transitions Flow Chart

Timeframe	Transition Planning Procedure	
Age 14	Age 14-16 young people are identified by Children's Services and Education who require transition planning	
	Team Around The Child meeting initiated and a Child's (Transition) Plan is developed. Transition plan to be reviewed every sixth months at a minimum	
	Initial assessment (see Appendix 1) undertaken at initial TAC Meeting to determine eligibility	
	Eligible for Adult Social Work Services Assessment	Not Eligible for Adult Social Work Services
Age 15-16	Where capacity concerns have been identified, progression of Adults with Incapacity (Scotland) Act 2000 legislation	Application to ILF transitions fund where it is identified that financial resources are required to support progress against the Child's Plan
18 months before	Referral to Adult Social Work Services – Adult Social Work Practitioner allocated	Continued TAC meetings measuring progress against transition plan
	New members of MDT to be introduced to young person and their carer	

12 months before	Adult Social Work Service assessment to be started	Introduction of some community supports/groups and education opportunities
6 months before	Where eligible, financial resources to be requested to confirm budget	Ongoing exploration of preferred community supports and groups to build a routine of activity post school
3 months before	Any new providers and groups to be introduced to young person	Finalisation of transition plan
School Leaving Date/18th Birthday	Transition plan implemented. Commencement of Adult Social Work Services support plan.	Transition plan implemented. Young person commences education/employment/training with community support
Post Transition	Ongoing review of support plan and identified outcomes	Ongoing access to community supports and education/employment/training opportunities
	For all young people, the Child's (Transition) Plan should be reviewed every six months as a minimum in addition to the identified actions above	

Appendix 3 – Transitions Initial Assessment

	Guide
Young Person's Goals	• What would the Young Person (YP) like to achieve? • What would they like their life to look like? • What are their dreams and aspirations?
Current Support Networks	• Who currently provides the YP support? • How stable are these support networks? • Are there any other support networks available? E.g. wider family, neighbours. • Can the YP and their carer be supported to expand their support network?
Current Social Network	• Does the YP have meaningful relationships? • Do they spend time with others? • Can they engage in activities with these individuals?
Housing/ Accommodation Needs	• Does the YP have access to stable accommodation? • What rights do they have to their current accommodation? • Will they continue living here after they transition? • Is there a need to explore alternate housing options? • Is a housing application required?
Finances	• Does the YP have any money management skills? • Do they have a bank account? • What will their future income be? • Do they require support to apply for benefits? • Is advice and guidance around benefits required?
Capacity	• Are there any concerns about the YP's capacity? • If so, is there an intention to apply for guardianship or Power of Attorney? • Does the family/carer require further advice/guidance? • Can you the young person engage in supported decision making?
Educational Opportunities	• Does the YP have any goals for further education? • What do they wish to achieve? • How can they be supported to achieve these? • What other skills can the YP be supported to develop?
Vocational/Voluntary Opportunities	• Could the YP be supported to engage in any occupation either voluntary or paid? • Should a referral to the Supported Employment Service be made?

Leisure Opportunities	• How does the YP like to spend their time? • What makes them feel happy? • Are there any activities they could join that reflect these?
Engagement with Community and Social Inclusion	• Is the YP a member of their community? • Could their inclusion within the community be promoted? • What is available within the community that they could participate in?
Independent Skills (Personal Care)	• Is the YP able to undertake their own personal care? • If not, who provides this? Is the caring arrangement stable? • Can the YP be supported to further develop their skills in this area?
Independent Skills (Household)	• Can the YP manage the maintenance of their personal environment? • Can they read and manage their own correspondence? • Can they follow a routine? • Can they be supported to further their skills in this area? • Can they attend appointments independently? • Can plans be put into place to promote this?
Travel Skills	• Can the YP self-travel? Including public transport and by foot. • Can they be supported to further develop these skills? • Do they have a mobility vehicle? Or are they receiving benefits to promote their mobility?
Food and Drink Preparation	• Can the YP prepare themselves a light snack and drink? • Can they use some kitchen appliances? E.g. microwave, air fryer. • Are they able to eat and drink independently? • Can they further develop these skills?
Health Needs Including Medication Management	• Does the YP require support to manage their health needs? • Can they manage their own medication? • Can their independence in this area be promoted? • Which professionals are involved?
Emotional Needs	• How is the YP's mood? • Can they emotionally regulate? • Do they receive any support in this area? • Can they be supported to develop their resilience?
Mobility	• Does the YP have any mobility needs? • Do they have moving and handling needs? • Do they have any equipment in place at school? • If so, which professionals are involved?

Communication	• What is the YP's preferred communication method? • Do they require support to communicate with the world around them? • Does the YP have Speech and Language (SALT) input? • Is advocacy required?
Technology Skills	• Can technology be used to support the YP to meet their needs?
Personal Safety	• Does the YP have an awareness of the risks of others? • Does the YP have an awareness of the risks from their environment? • Can they be left unsupervised? • If not, how can this be promoted?
For young people aged 16 and above, the use of the ILF transitions fund can be utilised to assist with any financial costs associated with the young person meeting outcomes that promote their independence.	

Appendix 4 - Policy and Legislative Context

The current guidance is led by the core practice principles embedded in key legislation and policy supporting transition planning and the promotion of children and young people's rights in Scotland. A summary of key policy and legislation is included below:

Additional Support for Learning (Scotland) Act 2004 (amended 2009) outlines the duties and responsibilities of the education authority to identify, meet and keep under review the needs of the young people for whom they are responsible.

Adults with Incapacity (Scotland) Act 2000 provides a framework for safeguarding the welfare and managing the finances of adults (people aged 16 and over) who lack capacity.

'A Time of Change' National Transitions to Adulthood Strategy for Young Disabled People 2025-2030 is the government strategy aiming to ensure that all young disabled people have a smooth transition to adulthood.

Carer (Scotland) Act 2016 places a legislative requirement to provide support, information and advice to carers and protects their rights.

Children (Scotland) Act 1995, Section 23 places a duty on the local authority to carry out an assessment of the child, or any other person in their family, in order to ascertain the child's needs in so far as they are attributable to his or her disability or that of any other person.

Children and Young People (Scotland) Act 2014 provides a legal framework to ensure the coordination of support and planning for young people.

Getting It Right for Every Child (GIRFEC) is the national approach to supporting and upholding the wellbeing of children and young people.

Getting It Right for Everyone (GIRFE) is a multi-agency support framework that helps adults from young adulthood to end of life care with a primary focus being on personalised, consistent and coherent care across life stages, tailored to individual needs.

Social Care (Self-Directed Support) (Scotland) Act 2013 enables people who are eligible for social care support to have greater choice and control over they receive their support.

Social Work (Scotland) Act 1968 places a duty on the local authority to assess a person's community care needs and determine the appropriate support or services.

The Promise acts as a commitment to implementing the recommendations of the Independent Care Review (2017). This work involves evolving the care systems across organisations and services to ensure that every child in Scotland is respected, safe and cared for.

United Conventions on the Rights of the Child (UNCRC) is a legal framework ratified by the United Nations which outlines the rights of all children up to the age of 18 to be heard, to non-discrimination, to protection from harm and the duty for all parties to act in the best interests of the child.

Appendix 5 - Continuing Care Flow Chart