NHS Highland

The Highland Council
Comhairle na Gaidhealtachd
SERVING The Highland Community

Integrating Services for Young People and Young Adults with Additional Support Needs as a result of Disability and/or Complex Health

Joint Transitions Procedure

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TRANSITIONS PLANNING PROCEDURE

Highland Council and NHS Highland Services 2008 Version

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1. The purpose of the Transition Planning Procedure

The purpose of this procedure is to assist with transitions' planning for young people who have additional support needs as a result of a disability and/or complex health needs, to enable timeous planning for future resource commitments and commissioning of services as required.

The Procedure is informed by a substantial consultation with young people and young adults, which resulted in the document 'It's MY Journey'.

The consultation informed two other sets of documents, produced to improve transition planning. They should be consulted in conjunction with the Procedure. The first of these is the Transition Planning Policy for The Highland Council and NHS Highland http://www.highland.gov.uk/NR/rdonlyres/6F087043-0ABB-4302-AD17-6840F88D759A/0/JointTransitionsPolicy.pdf

The second sets of documents are the best practice guides 'My Transition Guide'. There is a version for Parents, Professional and Partner Services http://www.highland.gov.uk/NR/rdonlyres/C4A1C8E0-577A-431E-8C63-500DFDC4BF32/0/transitionguideppp.pdf
and a separate Guide for working with children and young people
http://www.highland.gov.uk/NR/rdonlyres/DEB47635-A8A1-46E6-8B86-F10BFA5BE46E/0/transitionguidecyp.pdf

http://www.highland.gov.uk/learninghere/psychologicalservice/projects/Transition.htm
which is a transitions planning tool about **how** to approach transitions planning and achieve the best outcomes for such young people.

The policy is relevant for all managers in Education, Culture and Sport and Social Work Services and also has application to other local authority services such as Housing.

It is also relevant for NHS Highland staff with responsibility for managing and supporting the transition of young people with additional support needs as a result disability and and/or additional complex health into life beyond school and into adulthood.

2. Policy Context and intended outcomes

The principle of inclusion asserts that all mainstream activities and services should be open and accessible to all young people, regardless of their disability. This is now strongly enshrined in the legislation of the Disability Discrimination Act 1995, with significant amendments in 2005 including the new Disability Equality Duty, which took effect in 2006. In addition the Special Educational Needs and Disability Act (2001) applies key responsibilities to Further Education & Higher Education institutes.

Support to all young people at this time should therefore aim to enable them to gain access to the broad range of mainstream activities and services open to all young people. In many instances there should be no requirement for involvement of Community Care Services.

For young people with additional support needs as a result of disability and/or complex health needs there may be a requirement for additional support from a range of services to secure or support access.

This Procedure clarifies the key tasks and expectations of staff in Education, Social Work and Health Services with responsibility for transitions planning, management of the transition itself and implementation of transitions plans.

The Children (Scotland) Act 1995 requires Local Authorities to provide services designed to minimise the impact of disabilities on children and allow them to lead their lives as normally as possible. A major thrust of the Education (Additional Support for Learning) (Scotland) Act 2004 (ASL) and the implementation of Getting It Right for Every Child (GIRFEC) is ensuring that services work effectively together so that children and young people get the help they need when they need it, with significant emphasis being placed on the universal services. Social Work services cannot provide alone. This is also important in adult services, where the key and complementary roles must be played by Careers, Further Education, Colleges, employment services and Enterprise Companies.

This is also reflected in the implementation of Fair Access to Community Care Services, (FAACCS) the eligibility criteria for Adult Social Work Services.

The Procedure clarifies **what** should happen **when** for young people with additional support needs as a result of disability and/or complex health to have a successful transition to adulthood, and gives **specific** advice for involving Adult Social Work Services for those with significant additional needs.

Links

Quality Indicators for Learning Disability. NHS Quality Improvement Scotland (2000). (http://www.nhshealthquality.org/nhsqis/1262.html)

Adolescent Transition Care Guidance for Nursing Staff. Royal College of Nursing. (2004). (http://www.rcn.org.uk/__data/assets/pdf_file/0011/78617/002313.pdf)

Transition: getting it right for young people. Department of Health. (2006). (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4132145)

A transition guide for all services. Department of Health. (2007). (http://www.dh.gov.uk/en/Healthcare/NationalServiceFrameworks/Children/Transitionfromchildrenstoadultservices/index.htm)

Transition: moving on well. Department of Health. (2008). (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083592)

More Choices, More Chances (http://www.scotland.gov.uk/Publications/2006/06/13100205/0)

Changing Lives. Summary Report of the 21st Century Social Work Review. Scottish Executive (2006). (http://www.scotland.gov.uk/Publications/2006/02/02094408/0)

Getting it right for every child. The Highland Pathfinder Guidance. Consultation Document. March 2008. (http://www.forhighlandschildren.org/htm/girfec/gir-publications/GIRFEC%20Guidance%20Mar%2008%20separate%20sections/girfec-hpguidance-part1.pdf)

3. Assessment of need

All staff in Children's Services will use the Child's Plan with children and young people for assessment of needs, action planning and review. The term 'Young Person's Plan' can be used to refer to the same document the nearer the young person is to transition to adulthood.

This will also be the key document for planning the transition to adulthood.

4. The Child's Plan Meetings during Transitions Planning

The Education (Additional Support for Learning) (Scotland) Act 2004 requires that the Education, Culture & Sport Service (ECS) carry out Transitions Planning Meetings no later than one year before the young person plans to leave school. The Child's Plan meeting will fulfil this purpose.

When the Child's Plan identifies likely or potential additional support requirements which require resource or funding decisions by Adult Care, Adult Mental Health or Health Services, it will be made available to those Services, no later than 18 months prior to the young person leaving school.

5. When to begin Transition Planning and trigger the involvement of other agencies

The Education, Culture and Sport (ECS) Service must seek the consent of the young person and his/her parents before seeking information and advice, or when passing on information.

The sharing of consent based information is the bedrock of good transition planning.

Provided that consent is given as above, the ECS Service has a duty to ask the designated Appropriate Agencies, and other agencies it thinks necessary, for advice and information about any provision they are likely to make to meet the needs of a young person once they leave school. This must be done no later than one year before the young person plans to leave school. It is therefore essential to establish when a young person intends to leave school.

Young people and their parents need to be thinking about life after they leave school long before they actually intend to move on. Using It's My Guide for earlier transitions will help to build up skill and competence in the child and young person in planning and contributing to decision making.

When a young person has significant additional support needs it is vital that such plans are made well in advance to ensure that support is in place as they make the move to adulthood. All Education Authorities must help young people with additional support needs make the transition from school to adulthood.

The Education (Additional Support for Learning) (Scotland) Act 2004 states that there should be a Transitions Plan in place no later than one year before a young person plans to leave school.

Highland Council and NHS Highland decided that it is too late to make a successful transition if there are significant additional support needs if the actual planning and

associated meetings are left until the final year: transition should be gradual, developmentally staged and in consultation with young people.

The following are essential requirements of the Joint Procedure:

- Transition planning must be initiated no later than two years before a young person's 18th birthday or planned leaving date if sooner.

- Young person's intended school leaving date established as early as possible and not assumed.

- For children and young people with significant additional support needs as result of disability and/or complex health planning is required begin no later than three years before.

- Initial details of transition planning actions to be in the Child's Plan no later than 18 months prior to 18th birthday or planned leaving date if sooner.

- Initial details of resource implications for Social Work or Health Services to be in the Young Person's Transition Plan no later than 1 year prior to 18th birthday or planned leaving date if sooner.

- Social Work Services required to be represented at Child's Plan meetings which incorporate transition planning from 14years on for young people with **significant additional support** as a result of disability and/or complex health, regardless of whether there is any current Social Work Service involvement.

- Such young people once identified are the priority of the Social Work Service**.**

6. Responsibility for Transition Planning and Review

The person with overall responsibility for Additional Support Needs in each school is responsible for ensuring that an appropriate member of staff is allocated to lead transition planning with the young person & their family.

They may also be required to clarify who is responsible, e.g. in e) and f) below, where negotiation between Education, Health & Social Work Services may be required to decide who should take lead responsibility.

a) For a young person who has an IEP with input only from ECS the person responsible will be their **Named Person in their school.**

b) For a young person who has an IEP with multi agency input the person responsible is likely to be their **Lead Professional or other person as named in their plan.**

c) For a young person who requires a significantly high level of input and coordination of education planning, the person responsible is likely to be their **Lead Professional or other person as named in their plan.** This may be the **Coordinated Support Plan (CSP) Coordinator.**

d) For a young person who is looked after and accommodated, i.e. subject to a supervision requirement or using residential or fostering Resources the Social Work Service will be involved in reviewing their needs on a statutory basis. The Lead Professional or other person named in their plan, along with the **Quality**

Assurance and Review Officer will be responsible for ensuring that transition planning is included in their Plan.

The Quality Assurance and Review Officer will usually lead the review of the Child's Plan. When there is a Coordinated Support Plan in place, it will be reviewed in the same context to ensure that statutory and procedural requirements are met in an integrated way.

e) In some cases where the primary need is not educational the responsibility for planning and review may be with the Named Person in either Health or Social Work Services, e.g. where there is requirement for respite and other resources. In such instances the person with overall responsibility for Additional Support Needs in each school may be required to clarify who is taking responsible for leading transition planning with the young person & their family. Where there are particular health needs, a formal, supportive and comprehensive handover of care between child and adult health services will be undertaken. A summary of previous care and a condition specific, programme of anticipated care will be provided.

f) Consideration also needs to be given young people with additional support needs whose needs are well met within the school context e.g. a young person with Asperger Syndrome, who may need more planning and support as they move into the Adult world. In such instances responsibility for planning and review rests with their named person or Lead Professional.

   Consideration also needs to be given to who should take on the role of **Lead Professional** at each Review as it may need to change, for example to Careers Service in the later stages.

7. Involvement of Health Services

Health and Education deliver a concurrent universal and/or targeted service to individual young people. The school nurse, paediatrician and other health professionals must ensure that appropriate, consent based, information is shared with education colleagues to maximise educational potential for young people; and similarly education professionals must engage with health professionals where educational constraints may impact on a young person's health and well-being.

Following the implementation of GIRFEC the **named person** will ensure that *"the child has the right help in place to support his or her developmental well-being*" and **where** a **lead professional** has been identified they will ensure that **"***the right help is in place to support his or her developmental well-being*" and that the agencies "*work together to safeguard the needs of the child".* Furthermore where a **lead professional** has been identified, there is a requirement to ensure that appropriate services are provided, the child and family are supported and that all plans for the young person are reviewed and monitored.

The transition from child to adult health services and child health to adult care services should be developmentally age appropriate, flexible, gradual, and with the participation of the young people in the decisions which affect them. The multidisciplinary team should facilitate the process by collaborative working and joint planning, and with appropriate, consent based, information sharing.
Health clinicians and managers should ensure appropriate and timely engagement between child and adult services which are child centred, planned and meet individual need at the point of transition.

8. Communication between Education and Social Work Services

a) Where a young person has significant additional support needs as result of disability and/or complex health needs their Named Person or Lead Professional will ensure that the representative from Children's Social Work Services is invited, for the first Child's Plan meeting after the young person's 14th birthday, ensuring that a minimum of 4 weeks notice is given of the date.

b) Where a young person is in an Out of Authority Placement where there is no ongoing Social Work Services involvement, the educational psychologist who has been liaising with the school on behalf of the Local Authority will ensure that the representative from Children's Social Work Services is invited, for the first annual review after the young person's 14th birthday, ensuring that a minimum of 4 weeks notice is given of the date.

c) Where there is a CSP in place, the CSP Coordinator will ensure that the Children's Social Work Services representative is invited, for the first review of the CSP at a Child's Plan meeting after the young person's 14th birthday, ensuring that a minimum of 4 weeks notice is given of the date.

9. Social Work Services – 2 year handover period from Children's to Adult Care Services.

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Whilst transition planning and management is a corporate responsibility across the agencies outlined above, Social Work Services have a key role in supporting the transition to adulthood of young people with significant additional support needs as a result of disability or complex health.

Highland Council Community Care Services for adults are now organised in to Area based Teams for Younger Adults, aged under 65 and Community Mental Health Teams, as well as Area Teams for older adults, aged over 65.

The term 'Adult Care Service' used in this Procedure refers to Younger Adult or Mental Health Teams.

(a) The 2 year handover process

The Joint procedure specifies a minimum 2 year handover period from firstly making Adult Care Services aware of the likely requirement for services to completion of the handover and transfer of responsibility. It will begin no later than 2 years before a young person's 18th birthday or on their school leaving date when responsibility transfers to Adult Care services.

Clearly responsibility can transfer at an earlier date if a young person chooses to leave school at 16 or 17 so it is essential to establish their intended school leaving date and accordingly begin planning for 2 years earlier.

For those with the most significant needs it is recommended that the planning period is 3 years to reflect the range of potential issues to be considered and planned for.

Good practice dictates that transfer of responsibilities will vary with the individual circumstances of the young person and their family and ensure that they do not experience a break in service and are supported to prepare for and manage the various transitions requirements placed upon them.

This period involves flagging up potential future requirement for services with Adult Care Services, sharing of assessments and where appropriate, parallel working.

This should be done on a case by case basis through agreement between Adult Care and Children's Services Team Managers for involvement and planning for a sensitive handover of responsibilities.

There needs to be recognition that whilst the need may not have changed, the ways of meeting those needs may change and families and young people should be supported and prepared to meet new modes of service delivery.

The Team Manager (Children) is specifically responsible for ensuring that the Team Manager, (Young Adults/Mental Health) is made aware of the case, that the paperwork is up to date and negotiating transfer of responsibility. They are also responsible for ensuring that the young person and their family are fully informed, consent to the sharing of information and are partners in the transition process.

Team Manager (Young Adults/Mental Health) is responsible for accepting responsibility, identifying a worker and ensuring that the appropriate assessment material is completed in time to initiate application for and approval of any necessary additional resources.

The focus for the most complex transitions needs to be on getting the right people collaborating and if the young person requires support and funding to meet need into adulthood, both Children's Services and Adult Social Workers or Managers should be involved.

(b) The essential planning stages

Many young people attend Special School until the age of 19 through choice and use the period constructively to develop skills and confidence. Others remain till this age through of the lack of choice or options beyond school.

It is to be hoped that changing practice and opportunities will provide more choice and practitioners have to be open and prepared to transition plan with young people for an earlier school leaving date.

(c) Action in the event of failure to secure involvement of Adult Care Services.

In the event of the Team Manager (Young Adults/Mental Health) failing to allocate a worker by the 17th birthday or 6 months after the initial alert by the Team Manager (Children), the latter will request that the respective Area Community Care Manager take action to secure involvement.

If there is no active involvement within 3 months, the Area Children's Service Manager or Development Officer Disability will escalate the requirement for involvement to the Head of Service.

<table>
<tr><th colspan="5">Leaving Date
(Establish intended leaving date as early as possible)</th><th rowspan="3">Timeline of planning stages</th><th rowspan="3">Planning Stages</th></tr>
<tr><td>S6 Jun</td><td>S6 Dec</td><td>S5 Jun</td><td>S5 Dec</td><td>S4</td></tr>
<tr><td colspan="5">Age when each stage of planning must start (Planning should begin 3 years before leaving date for young people with significant needs)</td></tr>
<tr><td>16</td><td>15.5</td><td>15</td><td>14.5</td><td>14</td><td>Planning begins</td><td>▪ College Options and Vocational Pathways discussed
▪ Careers Scotland Key workers begins assistance
Social Work involvement – Raising Awareness
▪ Children’s Service Team Manager alerts Adult Care Service Team Manager to likely need for services.
▪ Adult Service Team Manager acknowledges receipt of alert within 1 month
▪ Children’s Service Team Manager ensures Young Person’s Plan completed and made available to Adult Care Team Manager during this period.</td></tr>
<tr><td>16.5</td><td>16</td><td>15.5</td><td>15</td><td>14.5</td><td>6 months into planning process</td><td>Social Work involvement – Active Involvement
▪ Adult Care worker allocated
▪ Assessment continued from Adult Services perspective in partnership with young person and in parallel with children’s services worker.
▪ Direct Payments reviewed.
▪ Disability Living Allowance reviewed.</td></tr>
<tr><td>17</td><td>16.5</td><td>16</td><td>15.5</td><td>15</td><td>12 months into planning process</td><td>Social Work involvement – Seeking Resources
▪ Adult Care assessment completed, handover plan made and communicated to young person and family.
▪ Request for additional resources made to the appropriate body, e.g. Area Resource Allocation Panel in Social Work Services, NHS Highland.</td></tr>
<tr><td>17.5</td><td>17</td><td>16.5</td><td>16</td><td>15.5</td><td>18 months</td><td>Social Work involvement – Resource Allocation
▪ Final funding decision made in principle.
▪ Application made to Independent Living Fund etc</td></tr>
<tr><td>18</td><td>17.5</td><td>17</td><td>16.5</td><td>16</td><td>End of 2 year planning process</td><td>Social Work involvement – Handover/transfer of responsibility
▪ Life Plan Continuum meeting
▪ New phase of activity as a young adult begins. Funding accessed for services now if required.</td></tr>
<tr><td colspan="7">Young Person Leaves School or may remain till aged 19</td></tr>
<tr><td>18.5/ 19</td><td>18</td><td>17.5</td><td>17</td><td>16.5</td><td>Ongoing Life Planning</td><td>▪ Care and support packages resulting from the above process are reviewed at 6 weeks, 3 months and then at yearly intervals or at the discretion of the case worker but no longer than yearly intervals between reviews.
▪ Careers Scotland can offer advice to all ages.</td></tr>
</table>

10. Financial Responsibilities during and after transition to adulthood and the relevance of thresholds of needs

Work is ongoing Within the Getting it Right Team in establishing thresholds for matched entitlement to resources and ensuring that they follow the child or young person; prioritising those individuals who have most need and least ability and resource to meet that need.

Work has also been done to review and refine 'Fair Access to Care' to promote a more sophisticated approach to prioritisation of need. Reference to this can found in Housing & Social Work Committee papers for 21 May 2008.

When the transition to adulthood is reached there is a requirement to communicate and engage with the new set of systems pertaining to adulthood in a planned, gradual and flexible way.

There needs to be recognition that whilst the need may not have changed the ways of meeting those needs may change and families and young people should be supported and prepared to meet new modes of service delivery.

As already outlined above, Local Authority Services have key responsibilities for ensuring a seamless transition to adulthood for young people with significant additional support needs as result of disability and/or complex health.

Good transitions practice involves a wide range of key activities, underpinned by the principles set out at in the Transitions Policy and equally apply when seeking resources to support a young person's transition.

Key activities at this stage are:

- Making families and young people aware of the implications of impending changes, e.g. on use of Disability Living Allowance.
- Action to maximise income through assessment for benefits.
- Making young people and their families aware of FAACCS
- Ensuring early review of a Direct Payment and involvement of or communication with an Adult Care Services practitioner.
- Ensuring awareness of financial assessment for Adult Care Services.
- Ensuring timeous applications to other sources of funding such as the Family Fund, Independent Living Fund etc.
- Considering the role of NHS Highland in supporting a funding package.

  See Financial Responsibility Flow Chart below

a) **Young people in education whose programme involves part time college, placement or training.**

Young people attending a local Further Education College, Work Placement or Training on a part time-time basis, whilst still at school, will normally have any necessary fees met by Education, Culture and Sport (ECS) Area held budgets.

Other appropriate costs in relation to attendance at a local Further Education College, Work Placement or Training up to age 19, while the young person continues in school, including escorts and transport to school/college, will be met by ECS Area held budgets.

Where ECS Area Managers refuse to fund requests for travel there is a requirement to clarify the reasons why the young person is considered ineligible.

b) **Residential Care and Education for Young People Aged under 18.**
Fees associated with residential care and education for young people aged under 18 must be approved by the Residential Placement Group (RPG) in Children's Services.

Associated Travel and escort costs will be met by the Area. Area Managers will clarify responsibilities dependent on the individual case.

c) **Residential Care and Education for Young People Aged post 18.**
Where an Education resource continues post 18 the costs will be split between the RPG and the Resource Allocation Panel (RAP) in Community Care Services, but the case will not have to be formally presented to the RAP.

Where a placement which is providing care only (not education) continues post 18 the costs will pass to Community Care Services at 18 years. Formal monitoring, planning and review will be presented to RAP.

Out of Council placements will be tracked by the Administrative Assistant for Children's Services, making contact with his/her counterpart in Community Care at the young person's 17th Birthday, either the Administrative Officer, Adult Planning and Review Team or the Area Officer of which ever Area holds the case.

The Information compiled for RPG will require to be made available by the Administrative Assistant for Children's Services for the Contracts Section of Community Care Services.

d) **Young people who are full time at a local Further Education College.**
Young people who attend a local Further Education College on a full-time basis will normally have their education and any necessary additional support funded by the College.

If a young person has personal support needs which cannot be met by a College Classroom/Learning Assistant, application will require to be made to Adult Care Services 6 months prior to them leaving based on the assessment of needs in the Child's Plan.

The need for this, i.e. that a young person's support needs will not be met by the College, must be established and the assessment process leading to the request for funding initiated no later than one year before the young person leaves school.

e) **After leaving school**
All potential users of Adult Care Services need to be aware that after they leave school the Assessment of Needs process will be accompanied by a Financial Assessment.

Depending on the outcome they may be required to make a financial Contribution to the cost of a service received. In addition, there is an expectation that Mobility and Motability allowances will cover some transport costs.

f) **Costs associated with support for young people accessing work, work-related or vocational training and further education after leaving school.**

Costs associated with support for young people to access work, work-related or vocational training, or education after they have left school may be met by Adult Care Services, subject to assessment, as in d) above.

Some costs may also be met by Supported Employment Providers and Further Education Colleges.

(g) **Young people requiring assistance with personal care**

The transitions planning process must capture the need for personal care support needs which may require to be met to facilitate access by a young person to an adult environment.

As stated above, application will require to be made to Adult Care Services for the assessment of needs to begin. This process must be initiated 2 years before the young person intends to leave school or their 18th birthday.

Where a young person has significant personal care needs as a result of their disability or complex health, it is likely that they will be entitled to resources from the Independent Living Fund.

It is particularly important in these instances that the Child's Plan is completed timeously and available to Adult Care Services in plenty of time to inform an application to the Adult Care Services Resource Allocation Panel (RAP) so that the decision regarding funding can be made 6 months prior to the young person leaving school. This enables decisions about the likely level of funding for personal and other care, to be agreed in principle, in advance of the date when it is actually required.

11. Direct Payment and self Directed Care and Support

Where an application is made for the first time for a Direct Payment during the transition stage, and where that application is approved on the basis of assessed need, the part of the Social Work Service (i.e. Adult Care or Children's Services) which takes the lead in this will meet the cost.

When Children's Services have approved a Direct Payment, it will be reviewed on a six monthly basis and inform the Child's Plan which in turn must inform the planning and assessment process in Adult Care Services, at least 6 months before the young person intends to leave school.

Families need to be made aware of the various changes in regulations which apply. There should therefore not be an assumption that the Direct Payment will continue as it was in Children's Services.

Changing Lives report, the 21st Century Social Work Review (Scottish Executive (2006) emphasised that Social Work Services cannot do it all alone and that more of the same practices will not make the changes required.

All statutory agencies are clearly on a journey towards greater personalisation of services and self directed care, where service users are able to exercise more control.

12. Implications of The Adults with Incapacity Act (Scotland) 2002

The Act is designed to ensure that Adults who lack the capacity to manage their own welfare and/or financial affairs are properly protected and safeguarded.

Where this may be relevant, families need to be made aware of the legislation and the number of different interventions available to meet a variety of situations. Guardianship is the most complex intervention and is only considered if there is no other way of protecting or managing the affairs of an adult.

Please refer to the guidance for more detail about applications for Guardianship by the Council or the family. http://www.highland.gov.uk/NR/rdonlyres/8200CBE0-AE75-4489-83D8-A2961E2FCB4A/0/guard_leaflet.pdf

13. Continuing health care needs

A NHS Highland Transition Protocol is being developed and consultation is ongoing on the specifics of the care pathway; including multidiscipline and partnership working, quality assurance and review processes. The protocol will endorse a structured, supported and comprehensive handover of care between child and adult health services, which is gradual, person and family centred, and needs focused. A summary of previous care and a condition specific, programme of anticipated care will be provided. The NHS protocol will support and build on existing health, condition specific, care pathways and transition and protection protocols developed with partner agencies.
The Transition Protocol, quality assurance mechanisms, will monitor the inclusion of children and young people and their families in the planning and delivery of their care and the planning and delivery of services, both specialist and generalist; and respond to individuals and their families within an ethical decision making framework.

In the meantime, the cost of continuing health care needs must be agreed with NHS Highland through its representation on the RAP, Area Children's Service Forum or RPG (as appropriate).

14. Young people known to be at risk

Where there are known risks to a young person, this information must be passed on at the time of transfer of the case, in line with Child Protection or Protection of Vulnerable Adults Procedures (PoVA) as follows:

For those between the ages of 16 and 18 years who present as a new case or where new concerns are raised in an existing case that is not on the Child Protection Register:

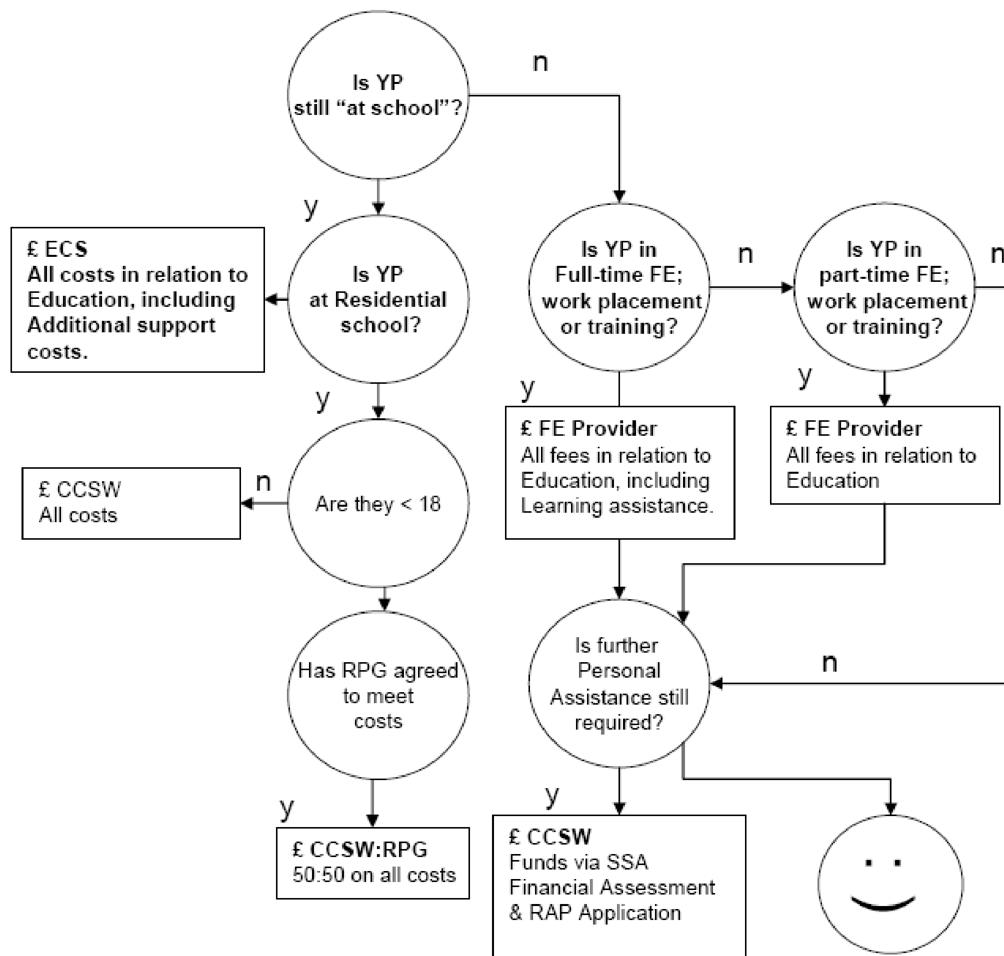
- At the point of referral, Area Community Care and Children's Social Work Services Managers in consultation with colleagues in Health and Northern Constabulary should agree which Guidance would be most appropriate to manage the case.
- Whichever Guidance is followed, the initiation of the procedure should also be flagged to the other system.

For those who are on the Child Protection Register at their 16th birthday:

- At the next Review Conference, where it is determined that the young person should continue to be registered, consideration should be given to which Guidance would be most appropriate to manage the case.
- If there is a consensus that the PoVA Guidance should apply, responsibility can only be transferred if formal agreement of the Area Children's Services Social Work Manager and Community Care Manager is confirmed at the Review Conference or the subsequent Core Group Meeting. These meetings also have the responsibility for agreeing and documenting the necessary transfer arrangements in management processes.
- Whichever guidance is followed, the initiation of the procedure should also be flagged to the other system.

APPENDIX 1

TRANSITIONS PLANNING FLOWCHART – FINANCIAL RESPONSIBILTY



THE PROCEDURE WILL CONTINUE TO BE UPDATED IN LINE WITH CHANGES IN POLICY AND LEGISLATION.