Public – To be published on the Trust external website

Title: Transitions Procedure Child and Adolescent to Adult Services / Primary Care

Ref: CLIN-0023-v10.1

Status: Approved
Document type: Procedure

Contents

1 Introduction

The transition of a young person into adult health and social care services is defined as:

> '*The purposeful, planned process of transferring a young person's healthcare from a child-centred to an adult-orientated care setting that comprehensively addresses the medical, psychosocial, educational and vocational needs of that young person.'*
>
> *'This definition implies that a 'transition' happens over time. In contrast to a 'transfer' which is defined as a 'Move from one place to another''.*
>
> *(National Confidential Enquiry into Patient Outcome and Death (2023)*
> *'The Inbetweeners' - A review of the process of transition from child into adult healthcare services)*

The Public Sector Equality Duty (PSED) of the Equality Act 2010 states; Public Authorities including the NHS must not treat people worse (discriminate) because of their age, age group or any disability that they may have (including mental health, learning disability and/or autism). This means that all of our service users must have full and equitable access to services that meet their needs irrespective of age.

Transitions from Children's Services (including Child and Adolescent Mental Health Services (CAMHS) or Children's Learning Disability Services (CLD)) to Adult Services (including Adult Mental Health (AMH), Adult Learning Disability Services (ALD) or Forensic services) or back to the GP / Primary Care or adult services outside of the Trust can be a stressful period for the young person and their parents/carers. Young people that have been accessing CAMHS/CLD services for some time may have some anxieties around moving on to the unknown.

A period of transition and uncertainty can also be a time when young people are at their most vulnerable and risks can increase. Therefore, we must compassionately consider how we ensure that the process of transition from CAMHS/CLD to any of TEWVs adult services, adult services outside of the Trust or to their GP / Primary Care is the very best it can be for all involved. The timescales referred to in this procedure are such that they allow plenty of time for smooth transitions to be planned and take place.
lease note: young people and their parents/carers must also be well informed and supported throughout the transitioning period.

This procedure is underpinned by national and local service policies and principles relating to Child & Adolescent Services, Adult Mental Health, Adult Learning Disability and

Forensic Services, and by the Trust's policies and procedures identified (section 4 and reference list).

When young people are transferred from child to adult services their continuity of care is ensured by the use of the Care Programme Approach (CPA). Within the Trust all specialties are engaged in cross specialty ongoing work to move from CPA to personalised care planning, and there is a draft Care Planning Policy in development.

These policies and principles also recognise that there are variations across Local Authorities regarding Social Services Transitions Teams and Transitions Policies. Clinicians must also refer to these policies where appropriate/available.

- Our Journey To Change (OJTC)

This procedure is critical to the delivery of OJTC and our ambition to co-create safe and personalised care that improves the lives of people with mental health needs, a learning disability and/or autism. It helps us deliver our three strategic goals as follows:

  - This procedure supports the trust to co-create a great experience for our patients, carers and families by ensuring collaborative personalised care planning and shared decision making.
  - This procedure supports the trust to co-create a great experience for our colleagues by providing a framework for staff to understand how best to meet the patients' needs.
  - This procedure supports the trust to co-create a great experience for our partners by having joined up care in a wider system.

2 Purpose

This procedure aims to promote the smooth transition for young people approaching 18 years old from children's services to adult services or GP / Primary Care or other adult services outside of the Trust (i.e., Social Care and Voluntary Sector, Residential College).

This will support the individual to thrive and result in:

- preparation for young people (and their parents/carers) moving on from children's services
- greater continuity and higher quality of care for young people using, and transferring between teams/services
- better communication
- better experience and outcomes for young people

3 Who this procedure applies to

This procedure covers transitions of care from children's services for all young people provided by Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) which include:

- Child & Adolescent Mental Health Teams (including Getting Help/Mental Health Support Teams, Getting More Help, Specialist teams and Neurodevelopment assessment teams)
- Children's Learning Disability Teams

To

- Adult services provided by Tees, Esk and Wear Valleys NHS Foundation Trust (including Adult Mental Health Services, Forensic Adult Mental Health Services, Forensic Learning Disability Services, Adult Learning Disability Services and Neurodevelopment assessment teams)
- GP / primary care
- Adult Services outside of the Trust (including Social Care and Voluntary Sector, Residential College)

This procedure is to be implemented by all staff/key workers employed by the Trust in the relevant services (i.e., child and adult services) who hold key worker responsibility.

Care Planning Policy (DRAFT) states:

- The 'key worker' is a role that has been introduced as a replacement for the roles of 'care co-ordinator' and 'lead professional', and the Trust has decided to use this term whether the service is still using the CPA framework or not.
- For those people assigned to the CPA, the key worker role will be the equivalent of the 'care co-ordinator' and for those assigned to Standard Care, the key worker will be the equivalent of the 'lead professional'.

4 Related documents

- The Care Programme Approach (CPA) and Standard Care Policy
  (*will be superseded by Care Planning Policy which is under consultation/DRAFT*)
- Admissions, Transfer and Discharge Policy
- Harm Minimisation (Clinical Risk Assessment and Management) Policy
- Did Not Attend (DNA) Was Not Brought Policy (WNB)

5 Roles and responsibilities

Role	Responsibility
Trust Board	Overall responsibility for ensuring the Trust delivers high quality services that are efficient, effective, and safe.
Managing Director	Executive responsibility for ensuring that this procedure is implemented.
Care Group Board / General Management Leadership Tier	Ensuring this procedure is adhered to within their area of accountability.
Managers/Clinical staff	Implementation of this procedure within their area. All leaders have a responsibility to ensure staff are aware of this policy and its implications. The maintenance and monitoring of compliance with this policy within their area of responsibility.
Key workers	To comply with this procedure. Active participation in transitions of care. (note: this includes existing Care-Coordinators and Lead Professionals)

6 Criteria for considering transfer of care

The young person is in receipt of services identified in section 3 and is approaching their 18th birthday (or 14th birthday/asap where the young person is in a vulnerable group or has complex, long term needs (i.e. LD; LAC; criminal justice system; Autism/ADHD; Eating Disorders).

- **A young person needing transfer to adult Tees, Esk and Wear Valleys NHS Foundation Trust services**
  - has mental health and / or learning disability needs which are likely to continue into adulthood

- **A young person needing transfer to GP / Primary Care or adult services outside of the Trust**
  - does not have current mental health and / or learning disability needs which are likely to continue into adulthood or are currently considered clinically fit for discharge from TEWV services

6.1 Principles for good transfer of care

6.1.1 Process and responsibility

- The process of transition from child & adolescent services to adult services is complex as the needs of each young person are not identical and it is a critical period of anxiety and uncertainty where risks may increase for young people which need extra care / planning.

- Transition from child & adolescent services into adult services is the responsibility of both the key worker/team from which the young person is leaving as well as the responsibility of the receiving key worker/team in adult services.

6.1.2 Joint working

- Young people using mental health/learning disability services benefit from a flexible, managed transition of care between services that is carefully planned with the young person (and parents/carers where appropriate) which incorporates a period of transition and joint working between services to ensure continuity of care.

- Those young people who come into Trust services within 3 months of their 18th birthday – consideration should be given for a joint assessment between CAMHS/CLD and AMH/ALD.

6.1.3 Preparing for moving on

- Discussion with the young person (and parents/carers where appropriate) about their ongoing needs should commence as early as possible but no later than 6 months before transition (within 1 month if new to service post 17years & 6months). To prepare them for moving on, assess their readiness, develop their understanding of their needs and empower them to ask questions.
    - i.e., conversations with the young person and their parents/carers regarding transfer of care would begin at 17years & 3months of age (or 14years for those young people in CLD / with complex needs / in vulnerable groups (as outlined in the yellow box at the beginning of this section), or within 1 month if new to service post 17years & 6months) - to allow adequate planning time for transfer between teams and co-working for more difficult/complex cases, where required.

6.1.4 Planning for transition

- Where a young person is to be transferred to an adult service (internal or outside of the Trust) the CAMHS/CLD Key worker and young person (parent/carer as appropriate) will complete the template at **appendix 1**, save into the young person's electronic patient record (EPR) and send to the receiving service/team in preparation for the joint conversation/planning.

- Where a young person is to be transferred to an adult service (internal or outside of the Trust) CAMHS/CLD Key worker will have a conversation with the relevant professionals in adult services to discuss the need for transition of care, agree plans (ie name of adult key worker, dates / plans for meeting / joint working, date of transfer of care, etc). The above information (**appendix 1**) will be updated and saved into the young person's EPR.

  The conversation / meeting can take place using: panel meetings, huddles, telephone conferences or similar.

- A transition plan will be collaboratively produced with the young person (and where appropriate, their parents/carers) which will include the young person's transition goals and the information in above bullet point (ie name of adult key worker, dates / plans for meeting / joint working, date of transfer of care, etc).

- A transition plan should be developed irrespective of whether the young person is transferring to AMH/ALD or GP/Primary Care or other services outside of the Trust. Which should also include relevant information of where to get support/help/crisis service numbers etc.

- The transition plan will be given to the young person and recorded on the young person's Trust EPR asap and at the latest by 17years & 6months (or within 1 month if new to service post 17years & 6months). See **appendix 2** for process.

6.1.5 Involving parents/carers

- The needs the young person's parents/carers should be considered and they should be offered a carer's assessment, where appropriate, which provides an opportunity to identify any problems and needs the carer may have.

6.1.6 Important considerations

- The young person (and where appropriate, their parents/carers) will be at the centre of the process and involved at all stages of planning, through regular consultation and dialogue with responsible clinicians.
    - Every young person is supported to plan proactively for their future.
    - Their parents/carers should be supported to prepare for their changing role.

- Clinicians will ensure that the young person and, with their consent, their parents/carers receive education, information and awareness of adult services.

- Children's and adult services are actively working together to enable a smooth transition.

- Throughout the transfer of care process, clinicians will continuously evaluate that expectations are being met.

- The final decision regarding date of transition will be discussed and agreed by all.

- There needs to be links to Education & Health Care plans (EHCP) where the young person has one.

- Where it is agreed that ongoing treatment by adult services within the Trust is not required, the CAMHS / CLD service will provide advice for the young person about any alternative sources of help and support, including crisis or out of hours services.

- The young person's GP and any referring agency should be informed where a young person is in transition to adult services or in the process of moving on from children's services in TEWV.

- There needs to be special attention to those young people who are an in-patient (in a CAMHS bed external to the Trust) and are transitioning to a Trust adult service (in-patient or community).
    - The young person will have a Trust CAMHS/CLD Key worker who will be keeping in touch with the young person and their parents/carers and the principles in this procedure are important to adhere to.

- The young person's in-patient care records are not part of the Trust EPR – so it is important for the CAMHS Key worker to co-produce (with young person, parents/carers and external in-patient provider) and save the documentation (appendix 1) and the transition plan on the Trust EPR.

6.2 End of transfer

- At the end of the transfer of care process, this should be clearly documented on the young person's electronic patient record (EPR) and a letter produced by CAMHS/CLD and sent to the young person and also circulated to GP/Primary Care and all agencies involved.

6.2.1 Settling into adult services

- If a young person has moved to adult services and does not attend appointments/meetings or engage with services, the adult key worker working within DNA/WNB policy and safeguarding protocols, should
  - Try to contact the young person and/or their parent/carer (as appropriate)
  - Follow up the young person
  - Involve other relevant professionals, including GP/Primary Care.

  Services need to keep in mind that a young person is moving from a service where they may have felt very supported to a service where they are expected to take a lot more responsibility to attend appointments etc. there possibly needs to be a bit more flexibility in approach when it comes to individuals not attending appointments.

- Ensure that the young person sees the same key worker in adult services for the first two attended appointments after transition.

6.3 Exceptions

Exceptions to transition of the young person at the age of 18 years may include:

- Young people where there is an agreed plan for the ending / completion of treatment and the key worker feels it would be clinically detrimental to the patient to transfer to Adult Services at this stage.

- Young person is still in full time education (i.e. date of 18th birthday is Sept, yet they don't finish school till the July of the next year)

- Education, Health Care Planning (EHCP) process is ongoing.

- EIP – see agreed protocol at **appendix 3.**

6.4 Transfer/Referral

- Where an internal transition between teams is being made the formal transfer/referral will be made using the electronic patient record (EPR) system and in line with requirements in the Care Planning Policy (DRAFT).

- The transfer/referral will not be treated as an external referral as the young person is already receiving services from the Trust. The exception would be where Adult Integrated LD Community Teams use Social Service's Record Systems not the Trust's electronic patient record (EPR).

- Where the transfer is between internal services and the young person is on a CAMHS/CLD waiting list (i.e. neurodevelopmental assessments) and they transfer to a respective waiting list in Adult Services, the date they were referred into the Trust will be the date used for their place on the 'new' waiting list, not the date of transfer.

- Where a transfer is being made to an external service the young person's Key worker will work with the new service provider to facilitate a smooth transition.

- In both cases the GP/Primary Care and any referring agency should be informed of this changed arrangement.

7 Terms and definitions

Term	Definition
Panel meeting	Transition panel meetings are where child & adolescent services and adult services meet together to discuss/agree possible transitions of care.
Huddle	The daily process that considers the needs of the patients seen in the last 24 hours and those being seen that day where help and support may be required. It is attended by all practitioners of the team to have a shared appreciation of the caseload, staff wellbeing & support discussion.
Key worker	Key worker role will be the equivalent of the 'care co-ordinator' and for those assigned to Standard Care, the key worker will be the equivalent of the 'lead professional'.

8 How this procedure will be implemented

- The procedure will be published on the Trust intranet and website.
- Care Groups and Clinical Networks will disseminate this procedure to all Trust employees through a line management/network briefings.
- Team clinical leadership set will ensure that all staff understand the requirements of the policy.

8.1 Training needs analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
All CAMHS clinical staff who may be key workers	Awareness raising of updated procedure	Minimum 30mins	Once
All AMH/ALD/Forensic clinical staff who work with younger adults and who may be key workers	Awareness raising of updated procedure	Minimum 30mins	Once
All operational managers and clinical leaders	Awareness raising of updated procedure	Minimum 30mins	Once

9 How the implementation of this procedure will be monitored

Number	Auditable Standard/Key Performance Indicators	Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group).
1	95% young people who are 17y 6m (or within 1 month if new to service post 17years & 6months) will have a transition plan/goals on EPR	IIC3320 report - CAMHS team managers to check report on a weekly basis and report into SIDG	CAMHS Service Improvement and Delivery Groups (SIDG)
2	95% Adherence to procedure – to include quality of transition plans/goals	Clinical audit tool/plan agreed – to be implemented from Q4 2023/24. Audit programme will collect data every quarter x 2 yrs (i.e. 2024 & 2025)	Clinical audit and effectiveness team Fundamental Standards meetings Care Groups and Clinical Networks

10 References

- NICE guidance NG43 (2016) *Transition from children's to adults' services for Young People using Health or Social Care Services*

  Overview | Transition from children's to adults' services for young people using health or social care services | Guidance | NICE

- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) (2023) *'The Inbetweeners' - A review of the process of transition from child into adult healthcare services*

  The Inbetweeners

- Healthcare Safety Investigation Branch (HSIB) (2018) 'Transition from child and adolescent mental health services to adult mental health services'

  Transition from child and adolescent mental health services to adult mental health services (hssib.org.uk)

- CQC (2014) *'From the Pond into the Sea: Children's Transition to Adult Health Services'*

  From the pond into the sea: Children's transition to adult ...

11 Document control (external)

To be recorded on the policy register by Policy Coordinator

Date of approval	03 November 2023
Next review date	03 November 2026
This document replaces	v10
This document was approved by	CAMHS Clinical Network - 03 Nov 2023 ALD Clinical Network - 03 Nov 2023 AMH Clinical Network - 03 Nov 2023 Forensics Clinical Network - 03 Nov 2023
An equality analysis was completed on this policy on	24 August 2023
Document type	Public
FOI Clause (Private documents only)	n/a

Change record

Version	Date	Amendment details	Status
10.1	03 Nov 2023	Full review, with minor changes:- Transferred to current template; Messages strengthened to emphasise current national guidelines and strengthen culture; Rewording to make easier to understand; Language updated to reflect OJTC.	approved

Appendix 1 – CAMHS/CLD Preparation for Transition conversations between services

To complete this template in collaboration with the young person and their parents/carers. Save into Electronic Care record, send notification/copy to receiving team/service.

All areas need to be completed.

Name of service user	
ECR/NHS number	
Sending Service	
Receiving service	
Current key worker	
Contact Details	
Receiving service worker	
Contact Details	

Situation	• Young person (yp) approaching 17yr 6mth (or 14yr if in vulnerable group/complex needs) • Requires adult services (internal or external to TEWV)
Background	• Relevant & significant family, life events etc • Relevant & significant bio-psycho-social/mental health issues • History of trauma (ie domestic violence, abuse etc) • Any forensic history (ie involvement with police, past/pending convictions, risk to others etc) • Previous assessments (ie IQ, ASD, ADHD, in-patient etc) • Other agencies involved
Assessment	• Current mental health state, needs and diagnosis • Historic & current risk • Resilience (ie coping strategies etc) • Historic & current medication • Historic & current work/input client receiving from CAMHS/CLD (model used, how long, impact on well-being etc) • Any difficulties with engagement with services? What helps the yp to engage/attend appointments? • YP would prefer a Male/Female Key worker
Recommendation	• Individual goals (ie from yp, parents/carers etc)? • What does overall Transition plan identify? • Liaise with relevant services/yp
Decision	• Date of Transition meeting/panel • Individuals present • Named Key worker to be identified, & yp allocated to same, from adult service • What is the agreed plan of transition/period of joint working (YP, CAMHS/CLD & Adult Service)

Appendix 2 – Transitions plans/goals. Where to record on EPR

PARIS

The plan is a separate/specific Transition plan – found in care records

CITO

The plan is built as a form on CITO.

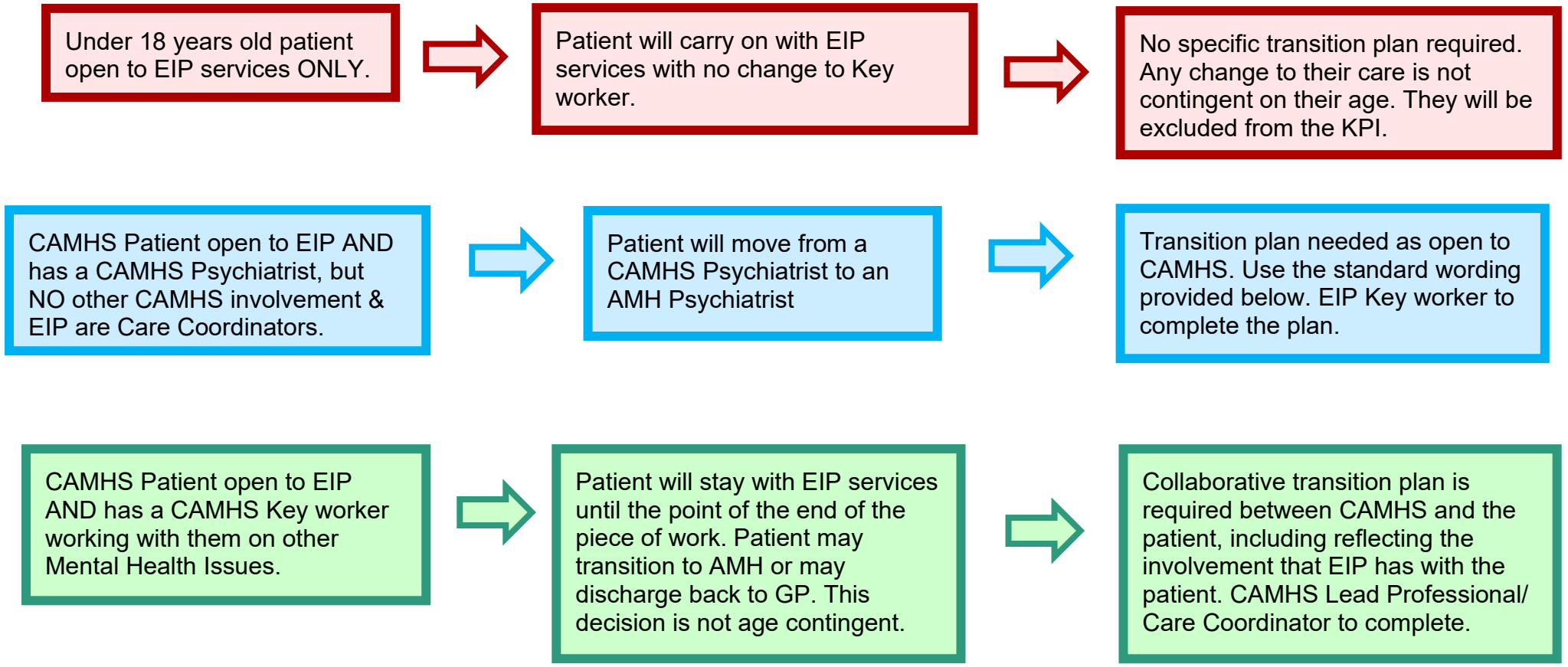
Staff record the basics of the transition plan goal in the care plan goals Matrix and select transition plan as the category.

They will then complete the transition plan form on CITO, when this is saved it will then show in the care plan additional plans section and staff will be able to click to view the full plan.

When staff write a progress note and want to evidence progress towards this goal (or not) they will then tag the transition goal at the top of the progress note.

Staff will then be able to filter down on all notes that are tagged as transition to review overall progress.

Appendix 3 – Transitions process flow for under 18yr old patients with E.I.P. involvement



Transition Care Plan standard wording for patients reaching 18 years old whilst under the sole care of EIP but with CAMHs psychiatric involvement.

Reason for Assessment: SELECT: REV1 SCHEDULED REASSESSMENT

Need: Ongoing psychiatric involvement with care

Aim: Continuity of psychiatric care through AMH - CAMHS transition

Intervention: Next CPA or medical review will be joint session with CAMHS and EIP AMH Psychiatrist and EIP Key worker. This meeting will be held at AMH/EIP clinical base. X will be made aware he/she can invite anyone else who is important to him/her to this meeting also.

Evidence Base: TEWV CAMHS-AMH transitions policy

Outcome: SELECT: ONGOING CARE REVIEW

Appendix 4 - Equality Analysis Screening Form

Please note: The Equality Analysis Policy and Equality Analysis Guidance can be found on the policy pages of the intranet

Section 1	Scope
Name of service area/directorate/department	Child & Adolescent services and Adult services
Title	Transitions Procedure Child and Adolescent to Adult Services / Primary Care CLIN-0023-v10.1]
Type	Procedure
Geographical area covered	Trustwide
Aims and objectives	To review and update current protocol.
Start date of Equality Analysis Screening	4 August 2023
End date of Equality Analysis Screening	24 August 2023

Section 2	Impacts
Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?	Young people in receipt of TEWV services and are approaching their 18th birthday.
Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups?	• **Race** (including Gypsy and Traveller) **NO** • **Disability** (includes physical, learning, mental health, sensory and medical disabilities) **NO** • **Sex** (Men, women and gender neutral etc.) **NO** • **Gender reassignment** (Transgender and gender identity) **NO**

	• **Sexual Orientation** (Lesbian, Gay, Bisexual, Heterosexual, Pansexual and Asexual etc.) **NO** • **Age** (includes, young people, older people – people of all ages) **NO** • **Religion or Belief** (includes faith groups, atheism and philosophical beliefs) **NO** • **Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave) **NO** • **Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners) **NO** • **Armed Forces** (includes serving armed forces personnel, reservists, veterans and their families) **NO**
Describe any negative impacts	None
Describe any positive impacts	This will support the individual to thrive and result in: • better preparation for young people moving on from CAMHS/CLD • greater continuity and higher quality of care for young people using, and transferring between teams/services • better communication • better experience and outcomes for young people

Section 3	**Research and involvement**
What sources of information have you considered? (e.g. legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)	• see Related documents section and References Section
Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the protected groups?	yes

If you answered Yes above, describe the engagement and involvement that has taken place	This is an update of the existing protocol. Young people's voices have been sought via the above national guidance and reports and local reports (i.e., Niche recommendations).
If you answered No above, describe future plans that you may have to engage and involve people from different groups	n/a

Section 4	**Training needs**
As part of this equality analysis have any training needs/service needs been identified?	no
Describe any training needs for Trust staff	n/a
Describe any training needs for patients	n/a
Describe any training needs for contractors or other outside agencies	n/a

Check the information you have provided and ensure additional evidence can be provided if asked

Appendix 5 – Approval checklist

To be completed by lead and attached to any document which guides practice when submitted to the appropriate committee/group for consideration and approval.

	Title of document being reviewed:	Yes / No / Not applicable	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Y	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Y	
2.	**Rationale**		
	Are reasons for development of the document stated?	Y	
3.	**Development Process**		
	Are people involved in the development identified?	Y	
	Has relevant expertise has been sought/used?	Y	
	Is there evidence of consultation with stakeholders and users?	Y	See above
	Have any related documents or documents that are impacted by this change been identified and updated?	N/A	
4.	**Content**		
	Is the objective of the document clear?	Y	
	Is the target population clear and unambiguous?	Y	
	Are the intended outcomes described?	Y	
	Are the statements clear and unambiguous?	Y	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Y	
	Are key references cited?	Y	
	Are supporting documents referenced?	Y	
6.	**Training**		
	Have training needs been considered?	Y	
	Are training needs included in the document?	Y	

	Title of document being reviewed:	Yes / No / Not applicable	Comments
7.	**Implementation and monitoring**		
	Does the document identify how it will be implemented and monitored?	Y	
8.	**Equality analysis**		
	Has an equality analysis been completed for the document?	Y	
	Have Equality and Diversity reviewed and approved the equality analysis?	Y	AH 27 Sept 2023
9.	**Approval**		
	Does the document identify which committee/group will approve it?	Y	
10.	**Publication**		
	Has the policy been reviewed for harm?	Y	No harm
	Does the document identify whether it is private or public?	Y	Public
	If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	n/a	