Sussex Partnership
NHS Foundation Trust

# Safe and Effective Transfers of Care (Internal & External) for Young People Using Our Services
## (CAMHS to AMHS)

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| POLICY SPONSOR | Chief Medical Officer & Chief Operating Officer |
| POLICY AUTHORS | Lead Consultant Psychologist, AMHS; Occupational Therapy Professional Lead CAMHS |

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## 1.0 Introduction

When a young person currently receives a service from Child and Adolescent Mental Health Services (CAMHS), and is likely to need specialist mental health services into early adulthood, it is best practice to involve Adult Mental Health Services (AMHS) in transfer discussions as early as possible. This will ensure that young people with mental health problems continue to receive an appropriate service. This policy will facilitate this process but does not make the assumption that all young people will need adult mental health services. This decision should always be made in the light of all available information and the assessed clinical need. People who are already in receipt of services from the Trust are entitled to an ongoing duty of care and the Trust will explore all avenues for ongoing treatment wherever this is appropriate and avoid artificial age-related divisions of care.

This policy is underpinned by Trust policies and principles from both CAMHS and AMHS, and in particular by the policies and procedures of the Care Programme Approach (CPA), which will apply to all young people who transfer to Adult Services.

This policy focuses on ***safe and effective transfers of care*** for younger people moving from one mental health team (CAMHS) to another (AMHS). This time period is sometimes referred to as a 'transition' in the literature, but we are using the term 'transfer of care' because this is a better description of the actual process.

The principles referred to in this policy are applicable to *all* transfers of care for anyone, of any age, irrespective of the service used, including a 'transfer of care' back to the original referrer (*discharge)*. However, young people approaching adulthood present particular issues that will need to be considered as part of their transfer of care. These include their developmental age; change in social circumstances (e.g. leaving home, leaving care, going to university); changes in their relationship to their parents; and changes in legal rights that accompany getting older. This is a time that young people may be at risk of dropping out of services altogether, especially if the transfer of care is confusing or poorly managed.

A ***transfer of care*** represents the movement of people using our services into, out of, or between, internal or external services. This is a critical moment in time when care and responsibility changes from one team to another. An example is detailed below.

A young person has been in receipt of CAMHS services for several years and they have turned 17. They have a diagnosed severe mental health problem and there are ongoing risks. After discussing the person's needs in a team meeting, the Lead Practitioner is tasked with making contact with the local adult mental health team to talk through likely future needs. They begin to formulate a tentative plan and, given the risks and complexity, make a time to meet face-to-face with other members of their respective teams when the young person turns 17 ½. The Lead Practitioner agrees to talk to the young person and their family about the adult team and some of the differences between CAMHS and AMHS. Here, clear communication of needs and expectations will be really important for the success, or otherwise, of the transfer of care. Additionally, writing a good care plan to say who is doing what and who is responsible at this time is really helpful for the young person and their family, as well as the services around the young person.

The change in key working relationships for the young person represents a potential barrier as trust needs to be built up with the new service. The transfer of care potentially risks undoing progress, and if not managed carefully risks non-engagement and drop out, or exacerbation of previously well contained and managed risk behaviours. If the expectations of what the next service can offer are not clearly communicated to the young person and their family, there are additional risks of dissatisfaction, reputational damage and complaints.

In preparing for transfers of care, a key principle is to keep the young person and their surrounding family/care system involved in the planning, and to make sure everyone has clear expectations of what is going to happen by when. There should be a well-articulated risk management plan to avoid confusion as to who is responsible for what. This has to be ***collaborative***. Otherwise, there is real potential to waste time and resource planning for something that no-one has signed up for.

Managers and practitioners in children's and adults' services need to recognise the risk of young people disengaging from services during transition and understand the impact this may have in the future. ***Care leavers, young offenders and young carers may be at particular risk***. Opportunities should be maximised for young people who have disengaged, or who are not eligible for AMHS services, to access care and support

In summary, transfers of care in mental health often require liaison across multiple organisations with different roles, responsibilities or expectations on and of the person using the service, both statutory and non-statutory. A transfer of care represents opportunities and risk. Best practice outlined here is applicable to all CDS's and should form the basis of the way we work with everyone using our services, as well as their families/carers.

### 1.1 Purpose of policy

This policy aims to improve clinical standards for safe, effective and quality transfers of care from CAMHS to AMHS. The emphasis is on ***co-production, collaboration*** and ***communication*** of a care pathway, where everyone involved in the transfer understands responsibilities and accountabilities. This forms the basis of a ***shared care and risk management transition plan***.

- People and their families/carers are supported to exercise **choice** in the type of service in which they are involved
- People and their families/carers are **empowered** to share in the decision making process
- People and their families/carers can exercise their right to **flexibility** from mental health services
- **Clinical responsibility** is clear and understood by all parties including the different agencies involved and the individual person and their family; transfers of care under the Mental Health Act must be clear with regards to the named RC
- The **Safeguarding** needs of the individual are kept in mind at all times
- There is **liaison with the Local Authority** at an early point in the transition process in order to ensure they can provide a transition assessment to support all individual service users and their families/carers as required under the Care Act 2014. This is especially important for Looked After Children where the Local Authority has a statutory duty of care as a **Corporate Parent** and must be involved in the planning process

The policy supports the 2020 Trust vision, in particular:

1. Safe, effective, quality patient care: *transfers have to be carefully planned and communicated and as such pose risks, both clinical and reputational, if not done well*
2. Local, joined up patient care: *people transferring into, out of, or between our services tend to have particular complex needs that, if not carefully planned, risk falling between service gaps*
3. Put research, innovation and learning into practice: *this policy is based on best evidence as detailed in NICE and SCIE*

4. Be the provider, employer and partner of choice: *transfers, if not clearly communicated, pose reputational risks and can escalate into complaints and dissatisfaction by all parties involved in this process*
5. Live within our means: *a poorly planned transfer risks being both clinically and economically ineffective and inefficient, wasting resources*

**Quality indicators**

- Care Programme Approach
- Risk and Risk Management policies and procedures
- Putting service users and carers at the heart of everything we do

## 1.2 Definitions

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| **AMH / AMHS** | Adult Mental Health / Adult Mental Health Services |
| **CDS** | Clinical Delivery Services: Coastal & NW Sussex CDS (adult & dementia); Brighton & Hove (adult & dementia); East Sussex CDS (adult & dementia); Children & Young People (ChYPs CDS); Learning Disability and Neurobehavioural CDS; Primary Care & Wellbeing CDS; Forensic Healthcare CDS; Care Home Plus CDS<br><br>Children and Young People's services (ChYPs) encompass Child and Adolescent Mental Health Services (CAMHS), Early Intervention in Psychosis Service (EIS), Perinatal Services, Specialist Children's Services and Children's learning disability services |
| **CAMHS** | Child and Adolescent Mental Health Services |
| **Corporate Parent** | A corporate parent is an organisation or person in power who has special responsibilities to care for looked after children and young people. This group includes those in residential care, those in foster care, those in kinship care, who live with a family member other than a parent, those who are looked after at home. |
| **CPA** | The Care Programme Approach is an established system within Mental Health Services for care planning, evaluation and risk assessment. Used to communicate care, risk and risk management plans to all parties. The electronic system used by the Trust to facilitate the use of the CPA and sharing of information is Carenotes. |
| **CTPLD / LD services** | Community team for people with learning disabilities |
| **Hand-over** | The final completion of the transfer between services, both internal to SPFT or including external providers |
| **Joint working** | When a person benefits from the skills and experiences of more than one individual worker. This can take on many forms, but in terms of transfer pathways, joint working may indicate a period of time, for instance six months, when CAMHS and AMHS identify named practitioners to work together |
| **Lead Practitioner** | A term for the named clinician who is responsibility for care co-ordination of a person's care and treatment through the CPA care planning process; the Lead Practitioner does not provide all aspects of a person's care, but has oversite of their needs and maintains contact with all services/teams involved in their care |
| **Transfer of care** | When a person moves from one CDS (Clinical Delivery Service) into another for example CAMHS to AMHS |
| **Transfer of care out of a service (discharge)** | This term may be preferentially used instead of 'discharge' and will encourage all services to see this as a potential point of risk and to plan for this carefully with the original referrer etc. |

### 1.3 Principles

This policy is based on the 9 guiding principles of how to achieve a good transition based on NICE guidelines for "Transition from children's to adult services for young people using health or social care services" (NG43, Feb 2016).

| | NICE guideline | Examples |
|---|---|---|
| 1. | Involve young people and carers in service design, delivery and evaluation related to transition by: | • Co-produce transfer policies<br>• Co-produce and pilot materials and tools<br>• Review, evaluate and feedback agreed outcomes |
| 2. | Factors to consider in planning a collaborative transfer of care: | • Developmental stage of the young person<br>• Maturity<br>• Cognitive ability<br>• Psychological and emotional functioning<br>• Long term conditions<br>• Social and personal circumstances<br>• Caring responsibilities<br>• Communication needs |
| 3. | Develop a support plan: | • Strengths-based, focusing on what is positive and possible<br>• Identify support available to the young person, including but not limited to their family or carers |
| 4. | Use person-centred approaches: | • Treat the young person as an equal partner, taking account of their views, needs and agreed goals<br>• Involve everyone (young person, family, services) in planning the transfer<br>• Consider outcomes related to education and employment, community inclusion, physical health and emotional wellbeing, independent living and housing options |
| 5. | Health & Social Care Organisations | Work together to plan for smooth and gradual transfers of care; for Looked After Children be aware of the Local Authority's Corporate Parenting role |
| 6. | Proactive identification of the needs of young people transferring across organisations | Service managers, in both adult and children's services, in health, social care and education, should proactively identify and plan for young people in their locality who are likely to require ongoing mental health support needs |
| 7. | Safeguarding | Share important information across the system to make sure everyone is safeguarded, in line with information-sharing and confidentiality policies. |
| 8. | Involving primary care | Check that the young person is registered with a GP |
| 9. | A named GP and clarify RC responsibilities if appropriate | Consider ensuring the young person has a named GP. If someone is being transferred under the Mental Health Act, ensure it is clear who is the Responsible Clinician (RC) and that the MHA Office is informed |

### 1.4 Scope of policy

This policy covers transfers of care from CAMHS to AMHS within the Trust, but the principles are applicable to all CDS transfers of care

### 2.0 Policy Statement

This policy has been informed by research, such as the TRACK Study (Singh, 2010), that highlights significant problems for young people with mental health problems transferring from CAMHS to AMHS. The majority of transfers do not result in serious incidents, but when they are poorly planned and conducted, there is lower engagement and reduced retention in services. This may lead to later crisis presentation or with more established mental illness as a result of lengthy periods of time when there is no active treatment.

For these reasons and for the reasons of satisfaction/quality of care before, during and after a transfer, it is imperative that services work collaboratively to improve the experience, reduce risk and ensure resources are correctly utilised.

### 3.0 Duties

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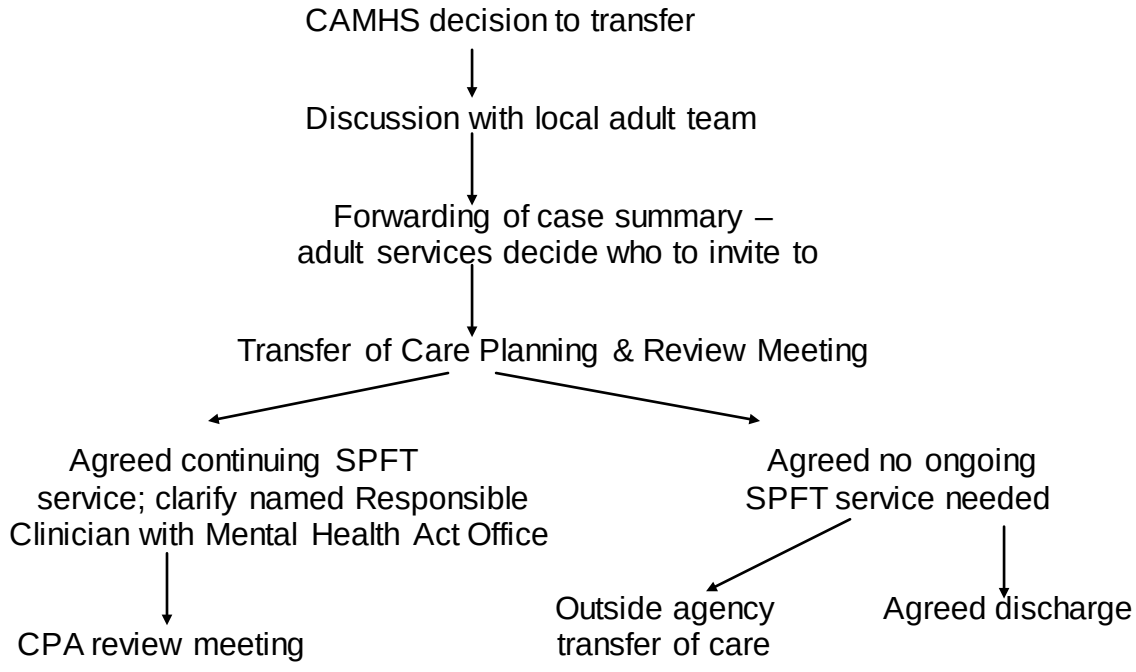
| ***Chief Medical Officer, Clinical Directors, and Service Directors & operational/team managers for each CDS*** | To ensure the clinical and operational aspects of the policy are followed and to intervene where differences of clinical opinion on the policy/local protocols occur |
| ***Clinical Leads and Operational Managers*** | To ensure all teams follow this guidance set out in this policy in a way which delivers optimum care |
| ***Professional Leads*** | In CAMHS, to ensure that transfers of care are a standing item in clinical supervision; in CAMHS / AMHS, to identify any training requirements during Appraisals |
| ***Lead Practitioners*** | To follow the policy when transferring young people from CAMHS to AMHS services, community and inpatient |

### 4.0 Procedures

### 4.1 General Summary Flow Chart for practitioners



## 4.2 Transfer of care protocol: CAMHS to AMHS community

| Sussex ChYPS | [TRANSFER OF CARE PATHWAY FOR YOUNG PEOPLE] |
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Start of transition process

- At 17 years old
- Lead Practitioner (LP) to discuss transfer of care with YP into adult services (primary care; secondary care; voluntary services ; transfer of care to G.P) whilst considering their holistic needs, mental and physical health, social conditions, education and employment.
- **Psychoeducation:** YP (and their carer) revisit their awareness / knowledge about their mental health condition(s), associated risks, role of interventions/treatments etc.
- **Review of needs:** YP explores their current concerns and interventions with their LP, including any risk, safeguarding and the care and support they would require from services post 18. Carers can request a carer's assessment from the local authority.
- **Information:** information provided about local services (specialist and community services) that they can access directly or indirectly – at times of mental health crisis / emergency or during non-emergency.

Use 'My Care My View' for care planning

Ensure Safeguarding/CLA/LAC issues addressed

Signpost to appropriate service and discharge from ChYPS

YP (& carer if appropriate) and LP identify referral to Adult Mental Health Service or Learning Disability Services (AMHS/LDS) required.

Joint review with Adult Services

- LP with YP's consent , or following a Best Interest Assessment where the YP does not consent or lacks the capacity to consent; makes appropriate referral to adult team for post 18 provision and transfer of care support, shares information with relevant adult services by **17.5 yrs.**
- If YP is referred to post 17/17.5yrs old the process of referral should commence asap.
- Arrange joint Transfer of care plan review **no later than 17.9 yrs.**
- In some cases LP may need to make referral to more than one adult team and or adult mental health service / team to cover various interventions that YP may need .

Enter transition start date on care notes in the referral tab.

Record all transition activity using 03 transition code on care notes.

Inpatient | FEDS | LD | LAC/CLA

Refer to local team Transition Process for additional requirements

**Referral Not Accepted: Plan for Transfer of Care Pathway out of service or Follow escalation resolution process (see Trust Transition Process).**

**Referral Accepted:**

Transfer of care

- LP and identified adult worker to agree a **date of transfer of care and care plan** with the YP.
- On 18th birthday care is transferred to adult service with an agreed period of joint working .
- YP's file closed to CHYPS following transfer of care and joint working concluded.

Transition evaluation form

Enter Transition end date on Carenotes

Assessment and on-going support by AMHS/LDS

- YP seen by adult mental health worker who will review YP's needs alongside other information and jointly agree a ongoing care plan with the YP (and their carer if appropriate);
- soon agreed period after transfer to adult services and contribute towards audit of monitoring effectiveness of the transition protocol.

Post Transition evaluation form

**4.3 Protocol for Transfer of Care of young people from 17-and-a-half to 18 Years of Age from CAMHS In-Patient Unit to Adult Service**

When a young person reaches or is admitted from 17-and-a-half years of age, the CAMHS matron, ward manager, Urgent Help Service (if young person is placed in out of area bed) or possible allocated community lead practitioner will request a space on the **Local Transfer of Care Panel Meeting** (East, West Sussex and Brighton & Hove).

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**Transfer of Care Panel Meetings (East, West Sussex and Brighton & Hove)**

Panel to consider and plan for options. In some cases this may mean planning for 2 scenarios (inpatient and community care) depending on young person's progress on the CAMHS Unit. If the transfer of care panel meeting does not occur in a suitable timely manner, team to follow the process for 'Transfer of care requires further planning or decision making' (below).

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Either/OR

**Transfer of Care Plan agreed for Transfer from CAMHS to AMHS:**

CAMHS Matron, Ward Manager or Urgent Help Service to discuss clinical presentation and plan from Transfer of Care Panel with Head of Nursing (Adult Acute). Agree clear plan of treatment for when YP transferred.

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Telephone call between Chalkhill matron, Ward Manager, Urgent Help Service and identified adult service to take place. To discuss care needs of the transition between services.

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Member of staff from adult ward (primary nurse or matron) or adult community team lead practitioner to attend a 'transfer of care planning & review meeting' on CAMHS inpatient unit or via Skype.

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If appropriate, plan a visit for the young person and their carer to the allocated adult ward or service. This can include a tour of the ward and introduction to a primary nurse or a point of contact (possibly matron). An alternative option would be for a staff member from adult ward or community team to visit the young person on the CAMHS unit.

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If young person is transferring to an In-patient unit, transfer of care to occur within 7 days of young person's 18th birthday.

**Transfer of Care requires further planning or decision making:**

Bespoke planning meeting to be arranged with CAMHS acute lead (matron / ward manager) and Head of Nursing (adult acute) with other services identified e.g. social services team, specialist assessment multi professional team (SAM) as required.

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If further negotiations required then escalate to CAMHS head of service, CAMHS clinical lead, CAMHS & AMHS transitions lead and adult general managers.

### 4.4 Lines of accountability

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| **Age equality reference group** | Strategic overview of CAMHS to AMHS services to ensure quality and lines of accountability within the organisation |
| **CAMHS to AMHS Quarterly Transition Panel meeting** | For each locality (East Sussex, West Sussex and Brighton & Hove) to meet quarterly to plan transfers of care from CAMHS to AMHS and to enable good working relationships across these services. Appendix 1 outlines the Terms of Reference for these meetings |
| **Operational Managers and Team Leaders** | Ensure that transfers of care are a standing item on all referral and clinical team Meetings. Ensure incoming and outgoing transfers can be tracked over time |
| **Practitioners** | Identify appropriate transfers from CAMHS and begin discussions with other services at the earliest opportunity. Talk to the young person, get their views and those of their family/carers and provide resource information packs; Six months prior to planned transfer, make a formal referral to AMHS and arrange to meet and formalise any planned transfer, updating the care and risk plans |

## 5.0 Development, consultation and ratification

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| **Trust Executive Board** | This policy has been sponsored through the Trust Executive Team |
| **Cross Trust CDS workstreams** | This policy was developed through various transfer of care reference groups, utilising cross-Trust CDS representation, service user, family and other partner organisation representation through conferences, workshops and the development of the National CQUIN CAMHS to AMHS working group |
| **CDS participation** | As key stakeholders, through representation of the CDS's at key events and as part of the National CQUIN workstreams |
| **Service user and family/carer consultation** | This policy will continue to be reviewed with the Patient Experience groups and forums across all services for feedback and advice on wording |

## 6.0 Equality and Human Rights Impact Assessment (EHRIA)

- An equality and human rights impact assessment has been undertaken
- With regards to the outcome of this assessment, clinicians and manager should be sensitive in particular to the needs of travelling communities when planning a transfer from one service to another

## 7.0 Monitoring Compliance

- Internal annual audits
- National CQUIN (2017-2019)
- The Age Equality Reference Group will oversee Trust compliance with quality standards

## 8.0 Dissemination and Implementation of policy

- Broad dissemination and cascading through each CDS Board and through local leadership and team meetings
- Each CDS to identify training needs and feed this back to the Trust Education and Learning Team
- It is expected that this policy will be implemented by teams and overseen by managers and clinical & professional leads
- This policy will be uploaded to the Trust intranet policy pages and advertised in the Partnership Bulletin. Staff will also be alerted of this review via the Report and Learn Bulletin

## 9.0 Document Control including Archive Arrangements

This policy will be reviewed, stored and archived in accordance with the Trustwide Procedural Documents Policy.

## 10.0 Reference documents

- Sussex Partnership policies: CPA, Mental Health Act and Mental Capacity
- Moving on Well (DH 2008)
- Getting it right for children and young people. Overcoming cultural barriers in the NHS so as to meet their needs - A review by Professor Sir Ian Kennedy (September 2010).
- Nice Guideline (NG43, 2016) Transitions from children's to adults' services for young people using health or social care services NICE guideline, available at https://www.nice.org.uk/guidance/ng43
- Caring for Better Health.Care Leavers Association. DfE 2017
- Social Care Institute for Excellence - Mental Health Service Transitions for Young People (2011)
- South East Coast Strategic Clinical Network Documents 2014
- South West Strategic Clinical Network – Service Specification CAMHS version 3 2014 Draft
- Care and Support Statutory Guidance – Issued under Care Act 2014 DoH
- Transition protocol: child and adolescent mental health services (CAMHS) to adult mental health services, document ref TWC105 (November 2015) (South West London & St George's Mental Health NHS Trust)
- Transitions, Young Adults with Complex Needs Social exclusion unit -Office of the Deputy Prime Minister
- New Horizons, A Shared Vision for Mental Health DoH (2009)
- Vocational services strategy. Sussex Partnership NHS Trust
- NSF for Children Young people and Maternity services. DoH
- Every Child Matters
- West Sussex Transition principles and protocol for young people with special needs disabilities who are moving into adult hood. Local Authority West Sussex
- Sussex Partnership NHS Foundation Trust previous Transition protocol –Sussex CAMHS – AMH/LD
- Standards For Better Health DoH
- White Paper Valuing People (2001)
- Young Minds Transition (2011)

## 11.0 Appendix 1 Terms of Reference for Local Transfers of Care (Transition) Panel Meetings

NHS
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| Transfers of Care (Transition) Panel Meetings | | | |
|---|---|---|---|
| **Ratification Date** | | **Owner** | |
| **Purpose** | | | |
| The joint panel meetings provide a forum that recognises young people approaching transition date might require specific care planning to support them through this period of care. They enable services to plan for people leaving children's mental health services in a timely manner and allow local services to identify appropriate support and provision and to provide this in a timely manner. This forum is also an opportunity for services to build relationships, learn from each other and work collaboratively. | | | |
| **Duties** | | | |
| • To meet quarterly as a minimum standard.<br>• To operationalise the Transition Protocol using existing procedures.<br>• To provide space to discuss the needs of young people working towards significant transition in relation to their mental health care.<br>• To identify an appropriate care pathway that might include a number of different providers. | | | |
| **Authority** | | | |
| The Transition Panel Meeting is authorised by The Care Delivery Services with SPFT to take any decisions which fall within its' terms of reference and are in accordance with the Scheme of Delegation. | | | |
| **Members** | | **Quorum** | |
| Complete names by local panels please<br><br>Meetings will be chaired by the [manager or clinical lead]. The [team lead/senior clinician] will be the Deputy | | The meetings must have representation from both children and adult services. | |

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| Chair. The chair and deputy chair will ideally be from CAMHS and AMHS to model joint working.<br><br>(You may also wish to include the following terms:<br><br>Other members may be co-opted as required, or other managers may be invited to attend for particular items.<br><br>Deputies may attend with the prior agreement of the Chair, but will not count towards the quorum.<br><br>If a panel meeting cannot attend for any reason they will be expected to provide an appropriate deputy to attend and represent the views of their service. | |
| **Frequency** | **Calling Meetings** |
| Meetings will take place quarterly.<br>All meetings are in accessible venues, taking account of the needs of all attendees | There is an expectation that panel meeting dates will be set at the beginning of each year. Any further meetings required to be organised locally.<br><br>Attendees of the panel meetings will be expected to come prepared to discuss relevant cases. |
| **Reporting** | **Communication** |
| The group reports to their local operational managers +/or team leaders, and will present an update on progress through the CDS leadership structures. | The notes of the meeting will be agreed by the Chair within five working days of the meeting. Action points will be circulated to members within 10 working days of the meeting.<br><br>The panel will expect updates on progress for previous actions as a fixed agenda item at the start of each meeting. |
| **Review** | |
| These terms of reference will be reviewed in March annually.<br><br>These terms of reference can be made available in alternative formats if required | |