CLINICAL POLICY
Integrated Policy for Transition of Care from Children and Young People Service to Adult Services

Policy	CLP155
Version:	V1
Purpose:	The policy sets out the agreed transition of care process within Gloucestershire Health and Care Trust (GHC) and between children's and adult services for all young people aged 17.5 and older who are likely to require ongoing health services beyond their 18th birthday.
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Approved by:	Clinical Policy Group
Date approved:	16th March 2022
Author:	Diana Scully, CAMHS Deputy Service Director
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Review date:	March 2025
Audience:	This policy applies to all staff who are employed by the Trust
Dissemination:	This policy is held under the Clinical Policies section on the Trust Intranet.
Impact Assessments:	This Policy has been subjected to an Equality Impact Assessment. This concluded that this policy will not create any adverse effect or discrimination on any individual or particular group and will not negatively impact upon the quality of services provided by the Trust.

Version History

Version	Date	Reason for Change
V1	Mar 2022	Merge of Physical Health and Mental Health Policies CPR015 and CLP273 – Integrated and Updated

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1. INTRODUCTION

1.1 Transition planning for young people approaching their 18th birthday is complex and the number of changes young people face are often daunting and can create huge apprehension, as one young person stated "You stand in front of an unknown future". Due to differing service provision and threshold criteria, young people in receipt of a children's health service may find that on reaching adulthood, their condition and presentation does not change but adult health services (especially mental health services) may not be commissioned nor configured to provide a service (NMHDU 2011).

1.2 Child and adolescent mental health services are designed to meet the needs of a wide range of mental health and emotional disorders for children and young people aged 0-18 years, including those with a moderate to severe learning disability. Most mental health problems start before the age of 24 and many young people first experience mental health problems in late adolescence. This often coincides with the age cut-off for accessing CAMHS (Williams & Hewson 2009).

1.3 Physical health services also meet a broad range of needs for children and young people. When these needs cross the age span into adulthood health care providers will likely change and this has a range of knock on effects; from logistical issues such as location of treatment to more complex factors such as the expectations of the young person's skills to self manage their health needs and the role of parents/ carers.

1.4 Transition of care for all health needs of young people approaching their 18th birthday is a multi-dimensional and dynamic process, marked by joint responsibilities and MDT work to maximise their health and life opportunities. Research studies have identified that up to 40% young people with ongoing needs fall through gaps when transitioning to adult health services. Young people with continued health problems who do not transition well are more likely to present in crisis and struggle to maintain their independence and remain in education or employment.

2. PURPOSE

2.1 The policy sets out the agreed transition of care process within Gloucestershire Health and Care Trust (GHC) and between children's and adult services for all young people aged 17.5 and older (14 years for GRIP) who are likely to require ongoing health services beyond their 18th birthday.

2.2 This policy aims to provide guidance to staff on the process of transitioning young people with continuing health problems to adult health services. It aims to ensure that young people are effectively supported in a planned and co-ordinated and timely way during this critical time when they are faced with a range of personal and developmental changes. The policy acknowledges that the vast majority of young people who access GHC Children's services will complete their treatment within the service and will not require ongoing health services beyond their 18th birthday.

2.3 This policy also recognises that many young people will require transfer to services provided outside of GHC, including Primary Care, Social Care, Youth Support Services, college and university pastoral care, specialist gender identity services and other statutory and non-statutory provision.

2.4 This Trust Transition of Care Policy should also be guided by the principles and current practice outlined within the current Trust Assessment and Care Management Policy.

3. SCOPE

3.1 This policy applies to all staff who are employed by the Trust, and they are responsible for adhering to this document. It covers necessary processes to ensure that the transition of care between services is seamless and simple to navigate for the young person.

3.2 This policy endorses that working in partnership with young people, parent/carers, and their families to provide care and interventions that not only make a positive difference, but also do so in ways that respect and value diversity including age, disability, gender, sexual orientation, race, ethnicity and religious beliefs. It also seeks to ensure that transition support is developmentally appropriate, taking into account the person's; maturity, cognitive abilities, psychological status, needs in respect of long-term conditions, social and personal circumstances, caring responsibilities and communication needs.

'Transition from children's to adults' services for young people using health or social care services' NICE guideline [NG43] Published: 24 February 2016.

4. DUTIES

4.1 Responsibility for the development, maintenance, review and ratification of this document lies within the Director of Nursing, Therapies and Quality who has board level responsibility for the development of this document and may delegate this responsibility to a subordinate.

Trust Quality Assurance Group (QAG)
The Quality Assurance Group will be notified of the ratification of this policy

All Staff

All staff who have contact with service users are responsible for using the policy correctly to ensure patient safety and adherence to best practice.

5. WHAT YOUNG PEOPLE IN GLOUCESTERSHIRE HAVE TOLD US THEY WANT

5.1 Members of the Young Gloucestershire Youth Forum who have experienced transition between services in Gloucestershire when they turned 18 have highlighted key issues that are important to them:

"Being involved in the information passed on to adult services when the referral is made"
"To have a copy of the referral to adult services so we know what's said"
"Not having to repeat our stories and not always focussing on things from the past but what is going on right now"
"Including information on what helps us engage with services so that adult services know how to engage with us"
"If we have to wait to be seen, make contact with us so we don't feel forgotten"
"Joint sessions with CAMHS and AMHS workers during transition"
"Workers checking we know where we have to go and maybe taking us or meeting us there"
"Better communication not only between services but better in every aspect. Service users' needs must always try to be met"

These guiding themes underpin and are weaved throughout this Transition of Care Policy.

6. TRANSITION PRINCIPLES

6.1 Engaging with the Young Person and Ensuring Their Voice is at the Heart of the Process

Involving the young person (and where appropriate their parents/carers/family) in the planning and delivery of their care should be at the centre of the process. The transition of care pathway should be sensitive and supportive to their unique needs to enable them to reach their life potential and remain healthy (NHS England 2016). The transition of care process should have all reasonable adjustments made to meet the developmental needs of the young person (i.e. maturity, cognitive abilities, psychological status as well as social and personal circumstances). It is crucial that transitioning care to adult services is a person centred and holistic process which builds a shared understanding of the young person's difficulties rather than merely focussing upon service transfer. The young person should be supported to develop a sense of ownership around their future care planning and next steps

Engaging and building trust with young people who have experienced difficult family backgrounds and instability, Adverse Childhood Experiences, constant uncertainty and perhaps have a perception that previous care systems have "let them down" is a complex therapeutic process to navigate and time consuming to achieve. Young people often need flexibility in how they start to engage with new services especially around timings of appointments and being able to rebook appointments if they do not attend appointments for various reasons.

Young people consistently say that they want:

- To be listened to, understood and taken seriously
- To experience well planned, smooth transition of care
- To receive flexible services, alongside continuity of care
- To have information and choice (CAMHS NAC 2010).

6.2 Alertness to Increasing Risk

As the period around transitioning of care can cause uncertainty and anxiety and therefore increased risk for the young person, the process should be transparent with a key focus on providing consistent Care Coordination.

6.3 The Role of Parents and Carers is Key:

Parents / Carers should be recognised as important sources of practical and emotional support and welcomed and included within the transition of care process where the young person has given consent. There should be active involvement and collaboration with young people and their families/carers and it should be remembered that parents/ carers may have been key to the young person's engagement and care to this point. The transition process should assist how young people start to develop a sense of responsibility and equip them with the necessary skills and knowledge to confidently manage their own physical and mental health care.

- Parents should be considered as a carer for the purposes of transition.
- Clinicians should be mindful to give parents and carers adequate information about how they can support the young person during this process.

6.4 Early Identification and Planning and Prompt Adult Team Response:

Timeliness is essential for young people who will need to transition to adult health services and enables effective planning and continuity of support. Once a young person is 17.5 years or older and has been identified as having continued physical or mental health needs beyond their 18th birthday, the transition of care pathway should commence. Transition may also begin sooner within some physical health pathways (as set out in the appendices 'Ready Steady Go' pathway), or if the needs of the young person are complex. Adults and children's teams should respond to each transition of care referral within defined timescales. There should be sufficient time for the young people/ families/ carers to ask questions and equip themselves with necessary information to feel prepared regarding transitioning their care to adult services, and time for plans to be reconsidered, adjusted and put in place.

6.5 Language that Cares

Language is a powerful tool for communication but sometimes the way that it is used within Health and Social Care can create stigma and barriers to understanding. We want young people to feel empowered through our use of professional language within their service experience. For young people, health-based language can feel complex, overwhelming and stigmatizing.

Using Language that Cares principles, GHC staff are encouraged to think about the language that the young person is using and how this reflects their experiences, before completing expected clinical record keeping or letters. Avoiding abbreviations and using Plain English and child orientated language can make a big difference. For

example, using alternatives to the word ‘foster carer’ is a good idea, because from our experience of the young people themselves, they often refer to them by their first name, or just say “my foster mum”. Language that Cares also helps us to avoid “labelling” young people.

6.6 Need for Transition of Care

Transition of care will be only be requested where there are ongoing health needs, if children’s services can discharge a young person safely they do. Options for support outside NHS health services should be explored and made clear to young people, alongside and where appropriate, instead of transition to adult NHS health services. As service thresholds and provision differs between child and adult teams, there should be transparent discussions regarding thresholds differences and what resources may or may not be available when the young person reaches their 18th birthday. Expectations of what adult health services can offer should be managed and flexibility offered in transfer arrangements where possible.

6.7 Working Together

Joined up working is key between children’s and adult’s teams to support assessment and planning processes across services. Effective transition of care involves significant preparation and planning as well as co-ordinated, documented and integrated support plans for young people and their parents/carers. Agreed pathways for transition out of children’s services will include timescales for assessments and decision making. Multiagency working may be required where there are other professionals supporting the young person. Where there is a multi-agency context to the current care pathway, key components of the process should include:

- A multiagency care plan referencing education, employment, housing, identification of support or carers if appropriate.
- A clear multiagency agreement regarding future provision of services.
- Multiagency meetings between the lead professionals as well as meeting with new care coordinators where the young person is supported by their existing network of professionals.

6.8 Vulnerable Groups:

Certain vulnerable groups of young people are placed at additional risk when facing transition of care to adult services. They have complex, multiple needs that tend to have poorer outcomes regarding transition of care. These groups include young people with Attention Deficit Hyperactivity Disorder (ADHD), Autistic Spectrum conditions, those with emerging personality disorder, teenage mothers, young offenders, those missing from home or care, children in care (CiC) as well as young people with learning disabilities (Williams & Hewson 2009). Adverse Childhood Experiences are also known to have lifelong impact on health outcomes.

6.9 Care Leavers and those who are Care Experienced:

All services should understand the additional complexities faced by care leavers and those who are care experienced and the roles and responsibilities of all professionals and agencies within this. These young people should be enabled to understand their health histories and have good access to provision for their full range of health needs

from primary care to specialist help and have timely and good quality pathway plans that reflect assessed strengths and needs and are co-produced and reviewed with them. Health passports should be available for all who require them.

6.10 Young People with Additional Needs:

Transition of care will be closely aligned to the Special Educational Needs and Disability (SEND) Code of Practice: 0-25 years. This is statutory guidance for organisations who work with and support children and young people with special educational needs and disabilities up to their 25th birthday (SEND 2014). For young people within LD CAMHS, planning timelines may have flexibility in order to accommodate issues of complexity and multiagency planning. The Transition of Care pathway typically includes an easy read Ready Steady Go Plan (RSG) and the RSG and Hello document should be available to all workers as a good practice document to be used for supporting transition. Care Education and Treatment Reviews should go alongside care planning where applicable. Health passports should be available for all those who require them.

Accessible information should be available, including information about preparing for adulthood for young people with special educational needs and disabilities (SEND) and their families (including information on the Mental Capacity Act and consent).

Key document: Transition from children to adults' services for young people using health or social care services, NICE guideline [NG43] Published date: February 2016.

6.11 Non-Attendance:

There is growing concern about the increasing Did Not Attend (DNA) rates for young people transitioning into adult services (NHS England 2016). Staff should be mindful that not attending appointments is an expected and typical transitional challenge. This transitional period is the start of how young people start to develop personal responsibility for their treatment and clinical care. An important part of the transition care plan is how all staff support vulnerable young people through this maturational stage to gradually acquire these necessary skills and knowledge base.

7. TRANSITION OF CARE PATHWAY: SERVICE CRITERIA

7.1 The transition of care process involves those young people who have reached the agreed age of transition for that area of care and have ongoing physical health, mental health or learning disability needs which are likely to warrant specialist input from adult teams beyond their 18th birthday. In the majority of cases, transition of care is aimed to be completed by their 18th birthday. For some areas of service intervention will continue while an 18 year old remains at school/ college.

The young person is registered with:

- A Gloucestershire GP and therefore the commissioning responsibility of Gloucestershire Clinical Commissioning Group (Glos CCG) and/or Gloucestershire County Council, including those with complex needs and/or care leavers.

- Meets the criteria for Early Intervention in Psychosis (GRIP) where the age of

transition is 14 years onwards.

Mental Health Transition of care discussions may start as early as aged 17 years for certain children involving a longer stay adolescent inpatient admission, LD or high risk/complexity/ vulnerability circumstances. Physical Health Transition as set out within the Ready Steady Go Pathways may start earlier. Early planning ensures there is sufficient time made available to assess and make provision for an individualised multiagency package of care as they approach their 18th birthday (or as an 18 year old leaves full time education in the relevant physical health pathway).

7.2 Exceptions

There will be certain clinical circumstances where the young person should be considered for transition of care even though adult threshold criteria is not fully established. In these cases, all staff should demonstrate flexibility when considering transition of care referral and ensure there is due regard to the best interests and safety of the young person. Examples may include:

- A young person who will be 18 years old within 4-8 weeks but is referred in crisis with concerns around risk and mental illness.
- Where comorbid diagnosis appears highly likely but not fully understood at the time of transition.
- Where transition of care processes involve vulnerable young people with fluctuating but acute/continuing health needs. Such a young person may present as stable as they near their 18th birthday but have a well documented and known history of high vulnerability/acute health needs that would ordinarily meet adult health service criteria.
- In the best interests of these vulnerable young people, the Adult Teams must offer an assessment in the first instance. If adult service thresholds are not met, the young person must be advised about how to access services in the event of a future relapse.

7.3 There are likely to be occasions where it is not possible to flag young people up to adult services in a planned way, i.e. young people who were expected to have completed treatment prior to their 18th birthday but now require urgent transition due to treatment resistant issues or sudden changes in presentation just prior to becoming 18 years old.

8. THE CARE ACT (2014): TRANSITION FOR YOUNG PEOPLE TO ADULT SOCIAL CARE

There are two pieces of legislation that influence how young people transition into adulthood with care and support needs.

- Part 3 (2014) of the Children and Families Act focuses on Special Educational Needs and Disability (SEND)
- Part 1 of the Care Act (2015) focuses on the care and support of adults with care and support needs.

The Care Act (2015) gives young people and carers of children a legal right to request an assessment before they turn 18 years old. This supports them to plan for the adult care and support services they may need. The Act states that if a child, young carer or an adult caring for a disabled child (or 'child's carer') are likely to have needs when

they, or the child they care for, turns 18, the Local Authority can assess them if it considers there is 'significant benefit' in doing so. This is regardless of whether the young person currently receives children's services.

The Act states that the Local Authority must assess the needs of a young person's carer (where that child is already receiving support) and can provide services to them. Assessment for care and support needs can also take place alongside other assessments, to prevent the need for multiple assessments.

9. GLOUCESTERSHIRE CHILDREN IN CARE (CiC)

9.1 Prompt and flexible transition of care processes are particularly important for those young people who are designated "Children in Care" (CiC) by the Local Authority or who are care experienced and have identified mental health problems.

- "Children in Care" and those young people who are care leavers or care experienced require personalised, additional support to help to enable them to manage the transition into adulthood. These vulnerable young people need to experience responsive and timely services that do not have strict 'cut-off' points but are able to do "what is right for the young person" alongside good quality interagency communication. Their "voice" needs to be clearly heard throughout the transition of care process.
- These young people often have high level, complex needs which are not well serviced by constant change and being "bounced" between teams. It is important that they are able to experience a seamless transition of care process.
- There are statutory duties for supporting care leavers i.e. those young people who are over 18 years old and have been designated as CiC. The Local Authority has a duty to support all care leavers in planning and coordinating their care until they are 21 years old. If the young person remains in approved education and training, this can be extended until they are 25 years old.
- Under Section 20 of the Children's Act 1989, the Local Authority has a duty to provide accommodation in a community home for service users up to the age of 21 years old if they feel it is necessary to safeguard the young person or support their welfare.
- The "host" and "receiving" teams should be mindful that there can be clear challenges to effective transition due to the fact that foster/residential placement are often fluid. There is a high likelihood that accommodation status can change very quickly often as a result of a crisis and the young person is placed in a further placement which may be either within Gloucestershire or out of county.
- It is important that an Adult Care Coordinator is allocated as early as possible within transition and have Trust support to maintain Care Coordinator responsibilities to maintain consistency despite any future placement changes.

10. YOUNG PEOPLE KNOWN TO YOUTH JUSTICE

Health staff should ensure that the network of professionals around the young person are aware of any changes in the care offered to them at the earliest opportunity. This should include Youth Justice teams where appropriate and in line with usual confidentiality processes.

11. DESIGNATED CLINICAL OFFICER (DCO) FOR SPECIAL EDUCATIONAL NEEDS

AND DISABILITY (SEND)

- The purpose of the role is to co-ordinate and improve health SEND planning and practice within the local area. GHC have named DCO's in the trust. Supporting successful preparation for adulthood is key to the SEND agenda. It is expected that Local authorities, education providers and their partners should work together to help children and young people to realise their ambitions in relation to.
- Education Health and Care Plan (EHCP) s – it is the duty of the care coordinator to contribute to the health needs on a young person's EHCP. Children SEN can remain in education up to their 25 birthdays in accordance to the new children and families act 2014.

MENTAL HEALTH SERVICE TRANSITIONS:

12. TRANSITION OF CARE: ROLE OF THE CARE COORDINATOR KEY PRINCIPLES

12.1 The "host" CAMHS Care Coordinator (and team) will maintain clinical responsibility until the "receiving" Adult Team has identified a new Care Coordinator and the transition of care process has been completed. In the best interests of the young person there may be exceptional circumstances that while the referral will be open to adult services only, the host CAMHS clinician may remain in contact within a supportive capacity. Considerations around reasonable adjustments, transition of care principles and maintaining the "voice" of the young person at the heart of all decision making is key.

12.2 The CAMHS Care Coordinator (including where a medic is a Care Coordinator) should ensure that the electronic case record is fully updated including core assessment, care plan, risk assessment, clinical coding as well as crisis and contingency planning.

Key Performance Indicator (KPI):

For mental health related transitions of care, there is a commissioned GHC Key Performance Indicator (KPI) which sets out requirements around record keeping and process. All mental health care professionals should adhere to the requirements set out in this KPI. Please see separate information regarding KPI requirements.

12.3 Where the young person has an allocated Social Worker, their role is crucial and they should be involved in future planning and decision making. There can be extensive debate within and between agencies at this stage about which services will meet a young person's needs post 18. Where a young person has been within an inpatient unit or is a child in care there is frequently debate about which agencies should be involved and there is likely to be a change in Social Work team.

13. CAMHS INTERNAL PATHWAY FOR YOUNG PEOPLE REFERRED IN AT AGE 17.5 YEARS OR OVER

For young people newly referred into CAMHS there is a fast track clinic to ensure their needs are met in a timely way and transition commenced if necessary. This is detailed in the CAMHS Operational Handbook.

14. ADULT MENTAL HEALTH SERVICES (AMHS)

Young people may transition to the following secondary care community teams:

- Recovery Teams
- GRIP: Early Intervention in Psychosis Service
- Community Learning Disabilities Team

Details of the Transition of Care Process, how to make the referral and the responsibilities and expectations of staff involved are contained within service operational handbooks

The referral to adult mental health services will be made based on the locality of the current registered Gloucestershire GP. If relocation is anticipated, this will be discussed between CAMHS and the receiving Team Manager:

- If the registered GP is unknown, this should be escalated immediately as part of the transition of care process.
- Where uncertainty about current accommodation needs exist, a pragmatic approach should be taken and the referral should be assigned to the team most likely to be in the correct geographical area. For instance, if a young person is from the North Cotswolds but a placement is being progressed in Gloucester, then the case should transfer to the Gloucester team. Where there is uncertainty, then the team for the GP with whom the young person is currently registered should be the deciding factor.
- It should be noted that complex care packages will warrant Social Care involvement. Social care funding is not based on registered GP but on actual address prior to admission.

15. TRANSITION OF CARE PATHWAY: ESCALATION PROCESS

In the rare instances where there is a difference in clinical opinion whether young people are either not accepted for assessment or not accepted for ongoing treatment this should be managed at a Team Manager level in the first instance. Where this does not resolve the uncertainty a young person's needs are taken to the Interface meeting by the adult team manager who has received the referral for discussion.

16. PROCEDURE WHERE YOUNG PEOPLE ARE NOT ACCEPTED BY ADULT TEAMS

In cases where adult teams do not accept a young person for assessment or treatment following a CAMHS transition of care referral, the Adult Team Manager should:

- Ensure the clinical rationale for "non-acceptance" is clearly documented on electronic record progress notes and headed "Transition of Care".
- The Adult Team must notify CAMHS and the young person/parent/carer in writing regarding the reasons why the service threshold has not been met at this time. The Adult Team is likely to be in the best position to explain what other resources/options of support may be available to them beyond their 18th birthday and should also make any recommendations for appropriate ongoing support options. For example; details of useful organisations, non-NHS support such as local youth counselling, charities or college programmes. crisis teams and helplines. This information is very useful to the young person, their family/ carers, the care co-ordinator and any professional network around them. Letters that are

strengths based and emphasise a positive array of support as opposed to a narrow and abrupt 'decline' are most valuable.

- The young person should be offered the opportunity to raise any concerns or questions via the care co-ordinator in order that they feel equipped with necessary information and what they should do if they require services in the future.
- Clinical correspondence from the Adult Team should be routinely sent to the young person and copied to the CAMHS referring clinician as well as the GP.

17. NON-ATTENDANCE

17.1 In cases where the young person does not attend one or more of the transition of care CPA meetings, a discussion should take place between the Adult "receiving" Care Coordinator and CAMHS Care Coordinator to agree a clinically appropriate response.

17.2 If a young person does not attend appointments following the Second CPA Review meeting when the Adult Team has taken over care, the following should be considered: -

- It is important that reasonable adjustments are considered for young people, ensuring all considerations and decision making are made within a developmental framework and age appropriate culture of care. Young people should not be routinely discharged if they don't attend initial appointments with the new service. The Adult Team should consider the best way forward, which may include more assertive follow up
- The Adult Team may wish to include the previous CAMHS clinician in this discussion.
- Decisions should be based on the young person's current clinical presentation, known clinical risk to self and others as well as other vulnerability issues.

TRANSITION OF CARE PATHWAY WITHIN PARTICULAR ADDITIONAL CIRCUMSTANCES:

18. YOUNG PEOPLE WITHIN INPATIENT UNITS

18.1 Where a young person approaching transition age is under the care of CAMHS and is in a CAMHS Tier 4 inpatient adolescent unit, the responsibility to ensure smooth transfer will remain with CAMHS. The majority of young people who remain as an inpatient by their 18th birthday are highly likely to have combined continuing mental health and social care needs.

18.2 Transition of care discussions may start as early as age 17 years for some young people where there is existing longer stay adolescent inpatient admission or high risk/complexity/vulnerability circumstances.

18.3 In very exceptional circumstances where the young person is receiving care from Wotton Lawn Hospital or an out of county Tier 4 Unit and transition of care to adult services is deemed part of the overall discharge plan, it is the responsibility of the unit/ward to initiate discussions with the "receiving" Adult Team. Where there is a CAMHS Care Coordinator, they should be invited to the first CPA Review Meeting.

18.4 Where the young person's home location is not yet clear the team attached to the most

recent in county GP should allocate a Care Co-ordinator even if this is in the short term.

18.5 In all cases, the CAMHS Care Coordinator should commence exploring transition of care arrangements as soon as is practically possible.

18.6 The role of an identified Social Worker is crucial in ensuring there is effective transition of care planning for those young people requiring complex Social Care placements beyond their 18th birthday. In cases where a multiagency package of support is indicated post their 18th birthday, the CAMHS Care Coordinator should identify/make a referral to a Social Worker from Children's Services to undertake a formal social care assessment.

Alongside Social Care, it is important to clearly identify and document ongoing therapeutic, mental health and social needs so an outcome focussed placement/support package options can be agreed in conjunction with the young person and their family and appropriately commissioned.

18.7 The Complex Commissioning Team based at Wotton Lawn Hospital (WLH) should be notified directly by the CAMHS Care Coordinator where there is a potential transition of care issue post their 18th birthday.

18.8 Where the transition of care process involves a young person who has either had a lengthy CAMHS Tier 4 adolescent inpatient admission or there are prevailing high risk/complexity/vulnerability circumstances, there should be an identified and allocated Social Worker involved in the process. The allocated Social Worker should have a key role in ensuring there is effective transition of care planning for those cases involving complex social care placements beyond their 18th birthday. The role involves maintaining legal oversight of the inpatient placement, undertaking necessary Social Care assessments, accessing funding streams as well as liaising with relevant agencies as part of developing a multiagency package of care.

18.9 The CAMHS Care Coordinator should note that if a young person is placed in a CAMHS Tier 4 low secure adolescent inpatient unit, thresholds for low secure services for adults differ significantly and are not comparable. Early transition planning is essential to explore least restrictive options including supported accommodation with associated packages of care. CPA requirements continue to apply for all transitions from CAMHS Tier 4 inpatient units.

18.10 The CAMHS Care Coordinator and the allocated clinician from the "receiving" Adult Mental Health Team should attend all the discharge planning meetings as well as the final/discharge CPA Review meeting at the inpatient unit.

18.11 A young person detained under section 3 or section 37 will be subject to section 117 after care and there is a judgement as to which Local Authority is liable for any fees, access to legal advice will likely be required to clarify arrangements under the "who pays guidance" DoH'.

19. YOUNG PEOPLE WHO REQUIRE URGENT MENTAL HEALTH ASSESSMENT AND ARE APPROACHING THEIR 18TH BIRTHDAY

19.1 CAMHS will offer an assessment for the majority of Under 18's excluding crisis referrals

up to the age of 17 years 10 months unless there is clear indication that this is not in the young person's best interest. CAMHS and AMHS should collaboratively explore the best outcome for young people referred to CAMHS after 17 years 10 months.

19.2 Where young people age 17 years 10 months and above have been referred to CAMHS and received an assessment and have been identified as having mild-moderate depression and anxiety issues, a referral to Let's Talk/MHICT could be made for Cognitive Behavioural Therapy (CBT) interventions once a clinician has discussed suitability with Let's Talk/ MHICT.

19.3 The referral to an Adult Team will be made based on the locality of the current or most recent registered Gloucestershire GP. If relocation is anticipated, this will be discussed between CAMHS and the receiving Team Manager:

20. VULNERABLE YOUNG PEOPLE WITH FLUCTUATING BUT ACUTE / CONTINUING MENTAL HEALTH NEEDS

20.1 Where the proposed transition of care involves a highly vulnerable young person presenting with ongoing but intermittent high clinical risk and vulnerability (i.e. takes overdoses as an entrenched stress related coping mechanism), the overarching principles of taking a person centred, collaborative approach to decision making and formation should be adhered to. All decision making should be formally documented on the electronic record and headed Transition of Care".

20.2 **GRIP:** Where the proposed transition of care involves a young person over 14 years of age who is presenting with psychosis, the following guidance should be considered:

- If there is a suspected psychosis then a referral should be made to GRIP for assessment. If they meet the at risk mental state criteria then GRIP will hold care coordination but if they do not meet the criteria then CAMHS should hold care coordination.
- In some cases, GRIP may provide a "watchful wait" supportive role.
- GRIP have a referral to treatment target of 14 days. Please refer to GRIP as soon as possible either for a first episode or suspected first episode.
- GRIP also offer advice/consultation via telephone.

Young people should not be referred solely for consideration of use of antipsychotics, although this may be an opportunity for joint working between GRIP and CAMHS.

21. ASD / ADHD SERVICES

Adult ASD/ADHD services are assessment only and there may be rare instances where this assessment is indicated beyond a young person's 18th birthday.

Young people with ASD/ADHD should be considered for transition to adult mental health services where there are identified significant, comorbid mental health problems. Where comorbid mental health problems have been identified, decision making concerning appropriateness for transition of care should be noted on the electronic record. Decision making should clearly demonstrate that a person centred and collaborative approach has been taken to establish a shared understanding of the young person's difficulties and next steps.

Where there are no comorbid mental health difficulties, young people should be signposted to locally commissioned support i.e. Independence Trust. Following the Winterbourne Review report, there is a requirement to identify all people with ASD who are residing within locked facilities/services to the Transforming Care Team within Glos CCG.

22. YOUNG PEOPLE PRESENTING WITH COMORBID MENTAL HEALTH PROBLEMS ALONGSIDE AN EATING DISORDERS DIAGNOSIS

22.1 Care pathway for new routine referrals with co-morbid eating disorders:

- All new referrals for young people aged 17.5 years and over where the primary presenting problem is eating disorder and there are no significant concurrent mental health needs will be forwarded directly to the Eating Disorder team by the CAMHS Front Door team
- Where the primary presenting problem is a mental health need then young people will receive a triage phone call from the CAMHS Front Door team. Next steps will be determined by the outcome of this triage call.
- If it is considered that the young person would benefit from the Eating Disorder team then the referral will be sent on to them with a copy of the triage. If CAMHS intervention was being recommended alongside consideration from the Eating Disorder team then this will be specified in the triage plan.

Care pathway for new urgent referrals with comorbid eating disorders:

- Referrals for a priority mental health assessment of young people aged 17.5 who have high clinical risk alongside likely comorbid eating disorders will be managed by CAMHS in the first instance via an urgent initial assessment. The Eating Disorder team would be alerted when the referral was received.
- If it is considered that the young person would benefit from the eating disorder team then the referral will be sent on to them with a copy of the triage. If CAMHS intervention was being recommended alongside consideration from the eating disorder team then this will be specified in the triage plan.

Care pathway when Eating Disorder intervention is continuing past 18 but CAMHS involvement will be ending:

- Regardless of who is care coordinating both CAMHS and the Eating Disorder team should be involved in the decision making and planning alongside the young person regarding onward mental health and eating disorder care.
- Where a young person's mental health needs will continue to be met by an Adult Mental health team e.g. recovery, then care co-ordination will be transferred to that Adult Mental health Team.
- Where a young person's mental health needs have been met by CAMHS and there is no indication for ongoing mental health need but Eating Disorder needs continue then care co-ordination will be transferred to the Eating Disorder team
- There should be a joint CPA review to handover care coordination prior to CAMHS closing.

23. MEDICATION OVERVIEW FROM CAMHS TO ADULT TEAMS

Referrals solely for this will only take place in instances where:

- There are presenting complex pharmacological issues.
- Specialist advice is being sought from adult medical colleagues.
- Where the transition is complicated by the young person being with a placement that has been commissioned by outside of Gloucestershire.

24. MENTAL HEALTH ACT (MHA) STATUS

- In complex care cases where the young person is likely to continue to be detained under the MHA or requiring to continue with an inpatient admission, the transition of care plan should focus upon returning the young person to Gloucestershire as a key priority.
- Where the young person is likely to continue to be detained under the Mental Health Act (MHA) following their 18th birthday, the CAMHS Consultant will need to also identify an Adult Team worker to hold a key role regarding ongoing Social Care assessments.
- The role of an identified Social Worker is crucial in leading this process to ensure there is effective transition of care planning for these cases. The Mental Health Individual Case Management Service based at Wotton Lawn Hospital can provide a limited advisory role.

There are a range of existing duties on the Local Authority and Health bodies requiring them to work together. The Health and Social Care Act 2012 and the NHS Mandate both make clear that NHS England, CCGs and Health and Wellbeing Boards must promote the integration of services if this will improve services and/or reduce inequality, and they should consider arrangements under section 75 of the National Health Service Act 2006, including the use of pooled budgets. The Children Act 2004 also places a duty on Local Authorities to make arrangements to promote cooperation with its partners (including the police, health service providers, youth offending teams and the probation services) in promoting the wellbeing of children and young people under 18 which includes safeguarding.

25. YOUNG PEOPLE REQUIRING ACCOMMODATION AS PART OF THE TRANSITION OF CARE PROCESS

- Some young people (i.e. care leavers, those within inpatient units) will require identified accommodation as part of their transition of care plan.
- where uncertainty about current accommodation needs exist, a pragmatic approach should be taken and the referral sent to the Adult Team considered most likely to be in the correct geographical area. An example is where a young person is from the North Cotswolds but a placement is being progressed in Gloucester, then the case should transfer to the Gloucester team. Where there is uncertainty, then the team for the GP with whom the young person is currently registered should be the deciding factor.

LEARNING DISABILITY SERVICE TRANSITIONS

26. TRANSITION PATHWAY: CAMHS LEARNING DISABILITIES (LD)

Children are identified aged 17 who are likely to require a transition to adult services.

A monitoring list is reviewed via team meetings monthly to ensure a timely plan is in progress. There are four locality community learning disability teams. Each team has a transition champion.

- East County – covering the Cotswolds, Cheltenham and Tewkesbury
- Stroud/ Cirencester
- Forest of Dean
- Gloucester.

The team has a transition pack which is given to children and families aged 16 plus. The easy ready steady go can be begun at this point preparing the young person and their family for adulthood. To include conversations around consent, mental capacity act and diagnosis.

A referral can be made at 17.5 years to the CLDT via their referral form or a letter and a joint review will take place, if the child is open to psychiatry we aim to do this as a joint review with sending and receiving services and their families.

Once the new service has met the family the LD CAMHS service will provide a discharge summary and discharge care coordination will transfer to the CLDT allocated clinician.

There is a monthly complex transition meeting with representatives from children and adult social care and CAMHS and CLDT's, LDISS and inpatient services. There is also a quarterly GHC transition meeting to ensure processes are reviewed to increase opportunities to ensure a smooth transition by preparing adult services of transitions in a timely manner and updating of resources.

Some children will be in out of county residential placements, some placement continue until the young person is 19. These children are referred to LDISS by CAMHS LD to support with transition back to a placement in Gloucestershire. CAMHS will retain care coordination for these people until they are placed back in county and can be referred to their receiving CLDT

See pathway in Appendix 8.

PHYSICAL HEALTH TRANSITIONS

27. GHC has adopted the Ready Steady Go Transition Model to support the transition process. (See Ready Steady Go Transition Pathway flow chart appendix 1. Adolescence in particular is a difficult time for young people especially for those who have on going health needs and so it is essential that young people and their families under the care of the GHC are confident and have a clear understanding about how the transfer of health care will take place from Children's Services to Adult's Services.

All Children services (consistent with clinical guidelines) are available for children and young people up to the age of 18 years old (and 19 if in full time education) with arrangements in place for smooth handover of complex cases.
In addition, the young person may choose to access adult services in these instances as this may be to best service to meet the needs of the young person.

- Physiotherapy
  Young people from the age 16 presenting with a musculoskeletal condition, in the absence of a long-term complex childhood condition may choose to access adult Physiotherapy services.

- Speech and Language Therapy
  Children and Young people from the age of 16 presenting with speech and language pathologies such as voice, stammering and swallowing difficulties may choose to transition to the adult services to access support.

Children and Young people with learning disabilities leaving a full-time education placement may choose to transfer to the adult learning disabilities team.

Arrangements are in place for the effective transfer of young people's care to adult services (including transfers of care to other organisations) and that these arrangements are monitored including for those with long-term mental health conditions, learning disabilities, chronic disorders, children and young people with palliative care needs.

A key worker should be designated or lead professional to work with the young person, their family and relevant services to plan the transition.
Arrangements are in place to identify, young people relocating into or out of the county and that appropriate action is taken for the smooth transition of their care.

- Informed consent will be gained and documented to allow sharing of information across organisations.
- The services should provide specific pathways or flowcharts outlining the process through to adult services and these flowcharts should highlight at which point the child moves through the transitional process by identifying the school year at each stage. Please see appendices 2 to 7.

28. DEFINITIONS

- ACE: Adverse Childhood Experiences
- ADHD: Attention Deficit Hyperactivity Disorder
- AOT: Assertive Outreach Team
- ASD: Autistic Spectrum Disorder
- CAMHS: Child and Adolescent Mental Health Service
- CBT: Cognitive Behavioural Therapy
- CHTT: Crisis and Home Treatment Team
- CiC: Child in Care
- CLDT: Community Learning Disability Teams
- CPA: Care Programme Approach
- CYPS: Children and Young People Service
- DNA: Did Not Attend
- EDT: Eating Disorders Team
- GRIP: Gloucestershire Recovery in Psychosis Team
- LD: CAMHS Learning Disabilities Team

- LDISS; Learning Disability Intensive Support Service
- KPI: Key Performance Indicator
- MHICT: Mental Health Intermediate Care Team
- MDT: Multi-Disciplinary Team
- OT: Occupational Therapy
- SALT: Speech and Language Therapy
- SEND: Special Educational Needs and Disability (SEND)
- Tier 4: CAMHS inpatient provision (out of county)

29. PROCESS FOR MONITORING COMPLIANCE

29.1 There will be Management oversight for the monitoring of compliance for this guidance/policy.

30. TRAINING

30.1 Training in transition for new staff in transition of care will be provided as part of the local induction process and any updates in processes and practices will be communicated to all staff at team meetings

31. REFERENCES

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5. *Department of Health. (2010). Achieving equity and excellence for children – How liberating the NHS will help us meet the needs of children and young people. Department of Health London: HMSO.*

6. *Department of Health. (2011). Guidance for commissioners of mental health services for young people making the transition from child and adolescent to adult services. Joint Commissioning Panel for Mental Health.*

7. *Department of Health. (2011). No health without mental health, Delivering better mental health outcomes for people of all ages. London: HMSO.*

8. *Department of Health. (2012). Guidance for commissioners of mental health services for young people making the transition from child and adolescent to adult services: Joint Commissioning Panel for Mental Health London: HMSO.*

9. *Department of Education and the Department of Health. (2014). SEND code of practice: 0 to 25 years: Guidance on the special educational needs and disability (SEND) system for children and young people aged 0 to 25, from 1 September 2014.*

10. *NHS England. (2016). Moving transition of adult services forward in the South West. Prepared by the SW Maternity and Children's Strategic Clinical Network.*

11. *NMHDU. (2011). Planning mental health services for young people – improving transition. London: HMSO.*

12. *Williams, J. & Hewson, L. (2009). Improving the transition from CAMHS to adult services Jo Williams and Lesley Hewson, CAMHS National Advisory Council, YOUNGMINDS Magazine Issue 103 December/January 2009/10.*

13. NICE guideline [NG43], (2016). Transition from children's to adults' services for young people using health or social care services

APPENDIX 1 – Ready Steady Go Transition Pathway:

Young person identified with:

- EHCP
- Predicted to have ongoing specialist medical needs post 18

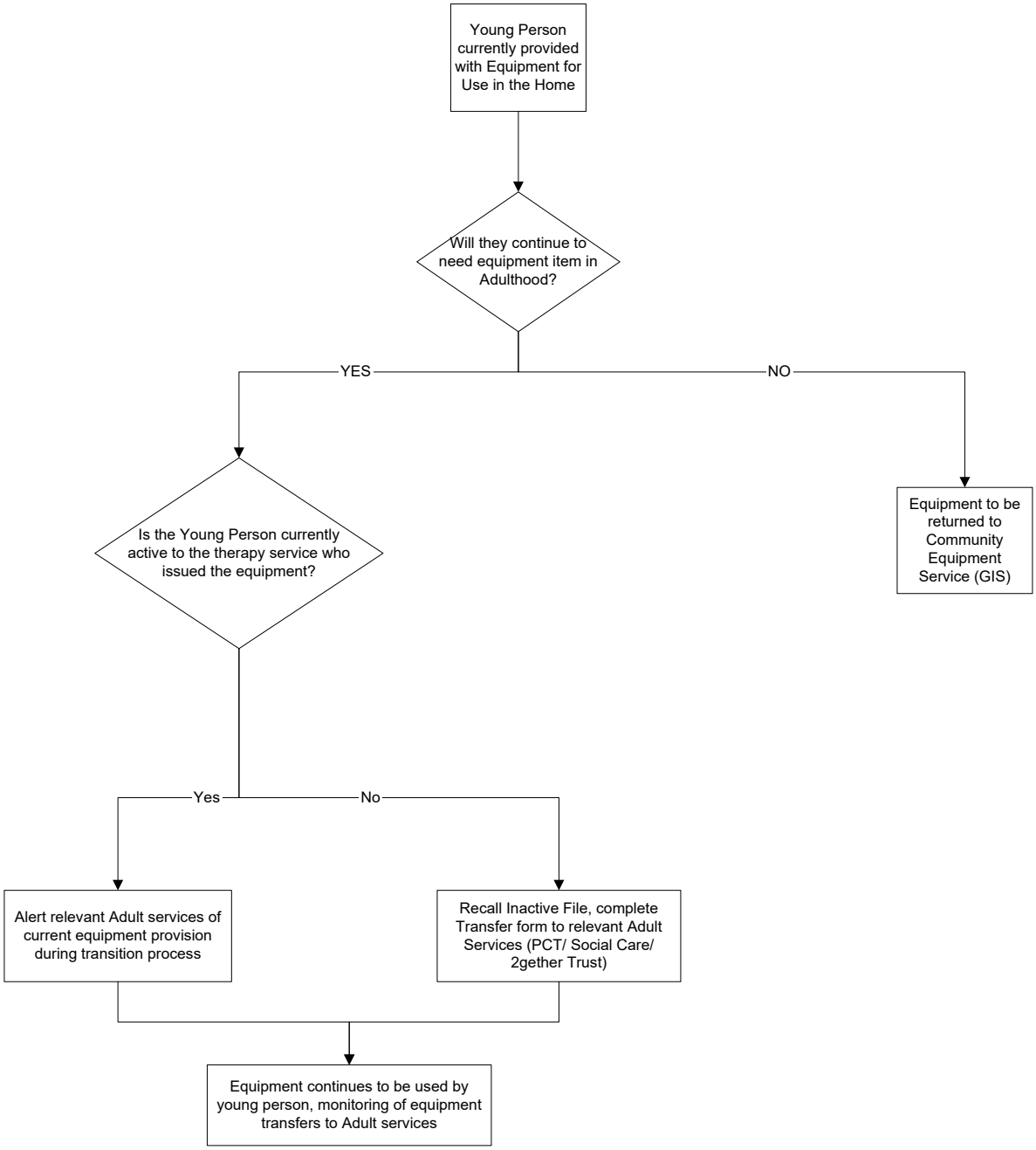
For all ages specified also consider developmental appropriateness

AGE	DOCUMENTS
By 13	Young Person: Ready Steady Go: Ready questionnaire (ghc.nhs.uk) Ready Steady Go: Transition plan (ghc.nhs.uk) Transition: moving into adult care - patient information (ghc.nhs.uk) Ready-Steady-Go-Ask_3_questions_v2.pdf (ghc.nhs.uk)
	Carer: Ready Steady Go: Parent plan (ghc.nhs.uk)
By 14	Young person: Ready Steady Go: Steady questionnaire (ghc.nhs.uk) Ready-Steady-Go-Ask_3_questions_v2.pdf (ghc.nhs.uk)
By 16+	Young Person: Ready Steady Go: Go questionnaire (ghc.nhs.uk) Ready-Steady-Go-Ask_3_questions_v2.pdf (ghc.nhs.uk)

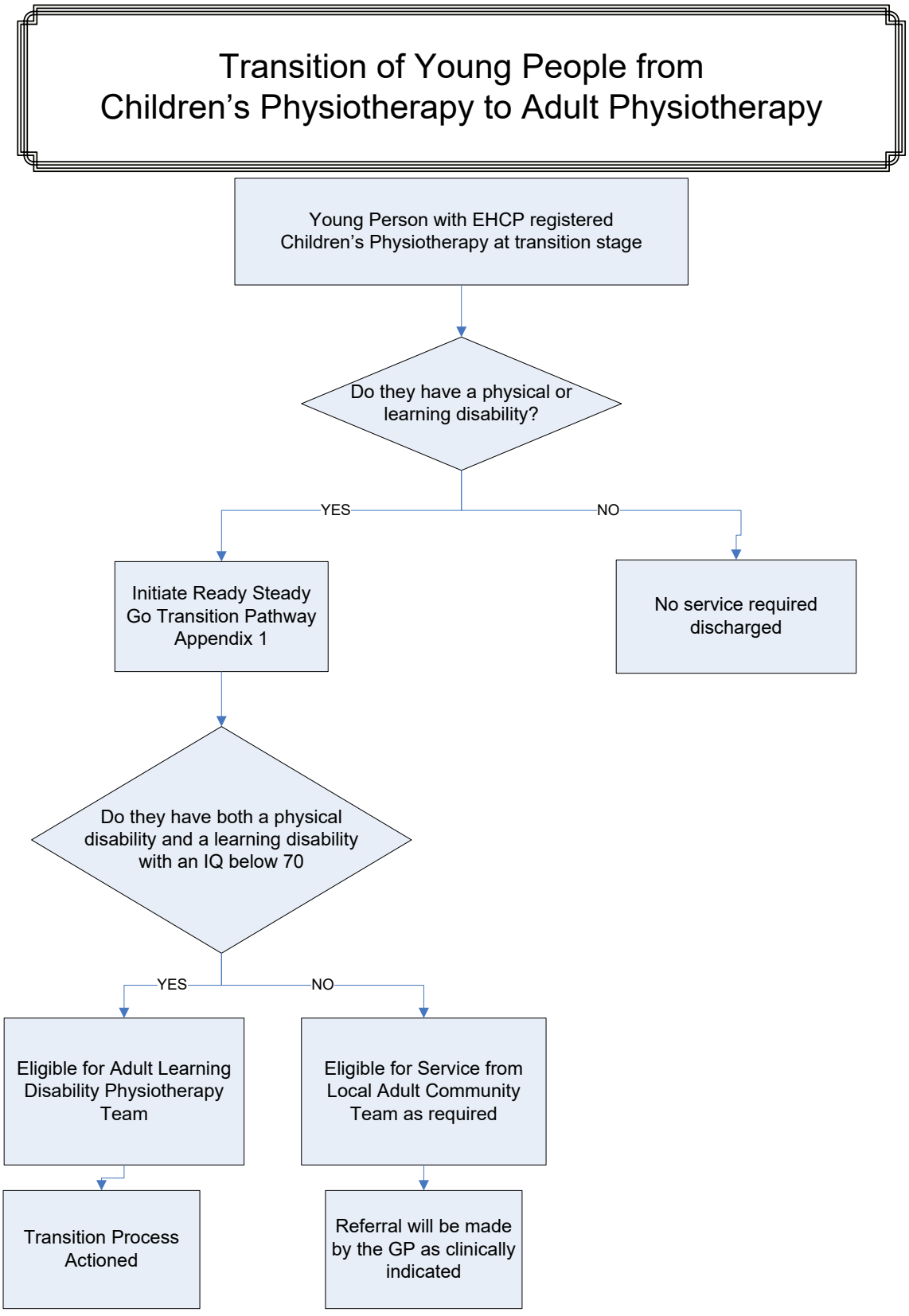
By 18	Young Person: Hello to adult services - Hello (print ready) (ghc.nhs.uk) Hello to adult services - parent plan (print ready) (ghc.nhs.uk) Hello to adult services - programme (print ready) (ghc.nhs.uk) Ready-Steady-Go-Ask_3_questions_v2.pdf (ghc.nhs.uk)

APPENDIX 2

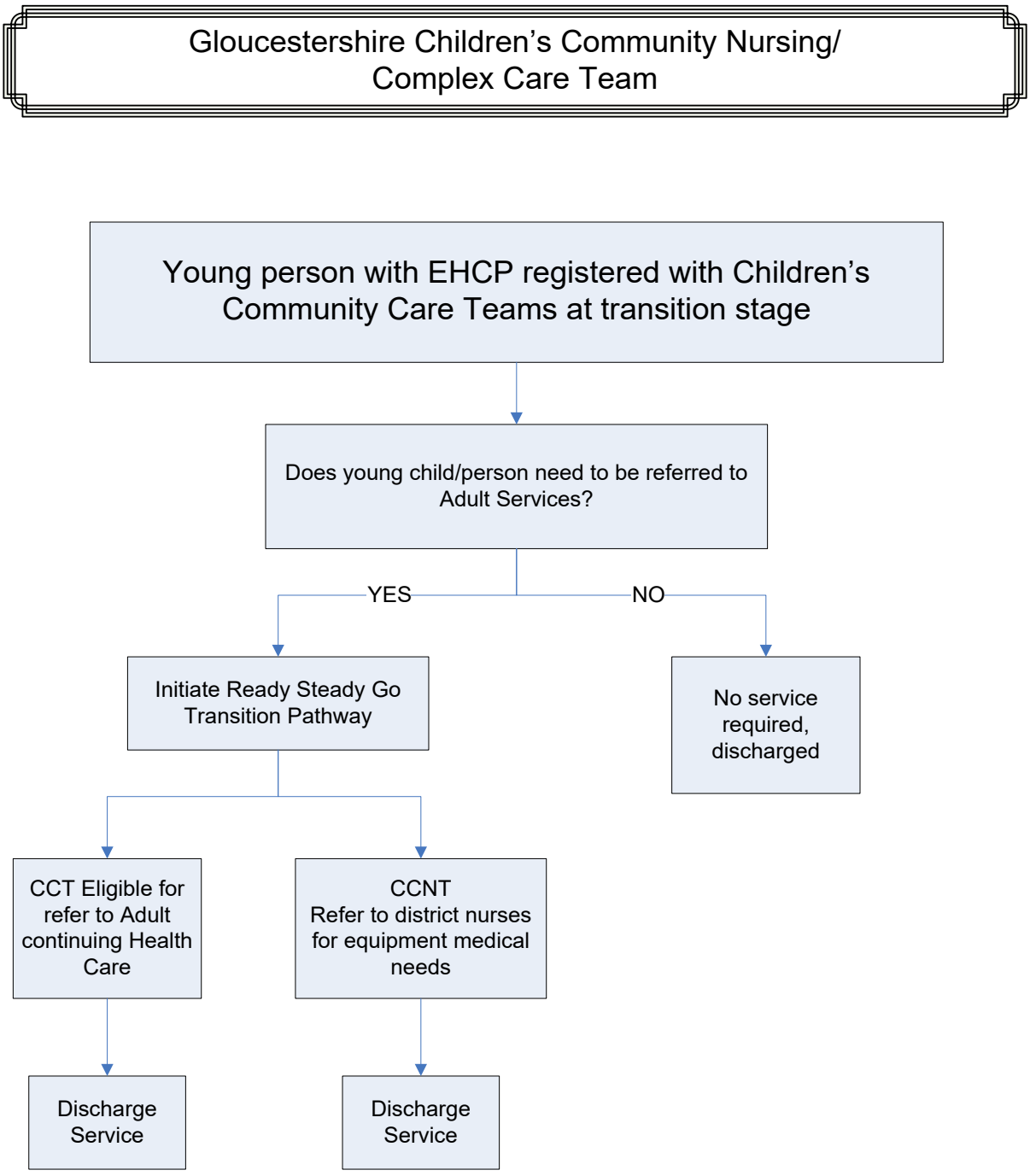
Specialised Equipment Transition Pathway for Young People



APPENDIX 3

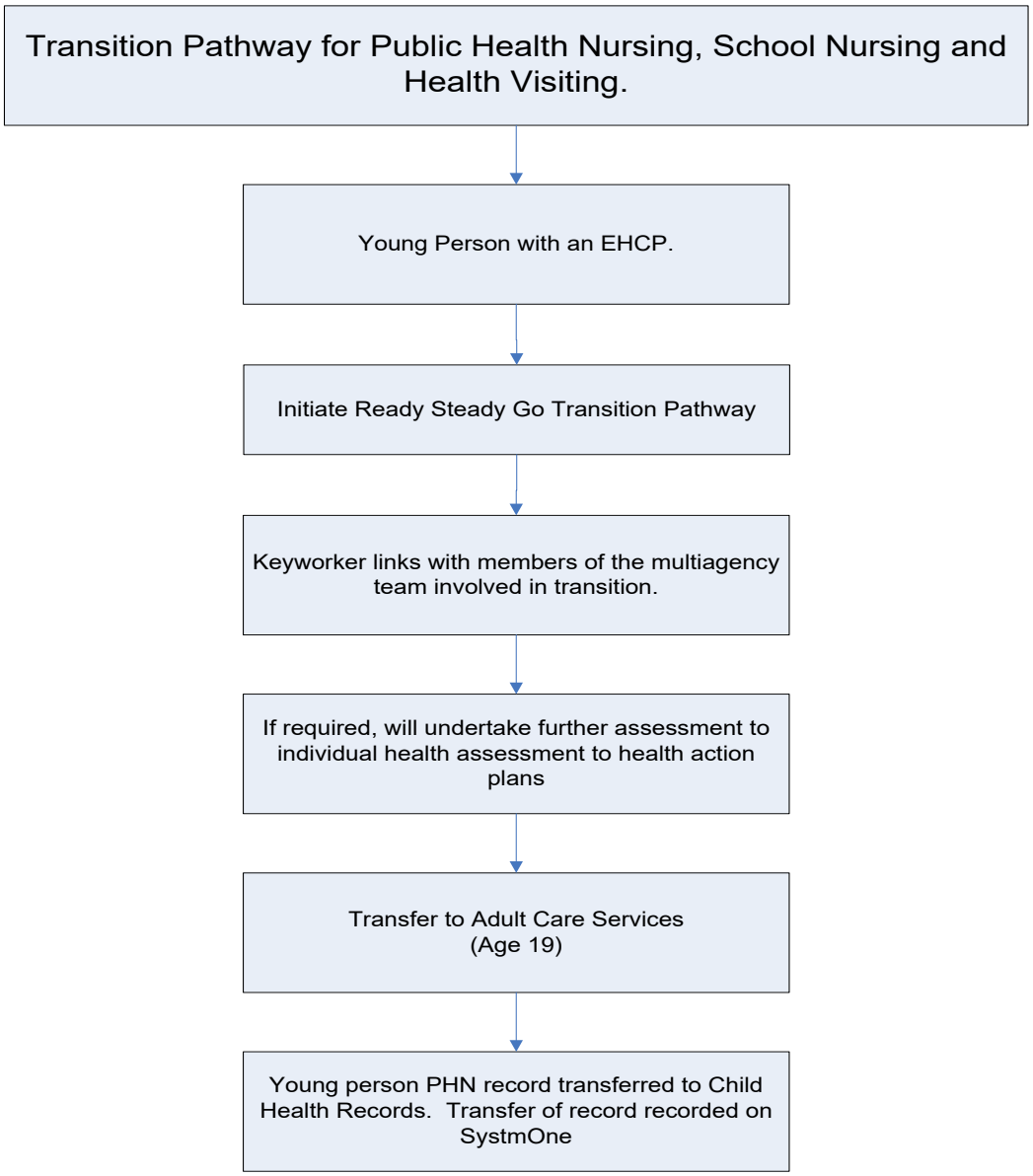


APPENDIX 4



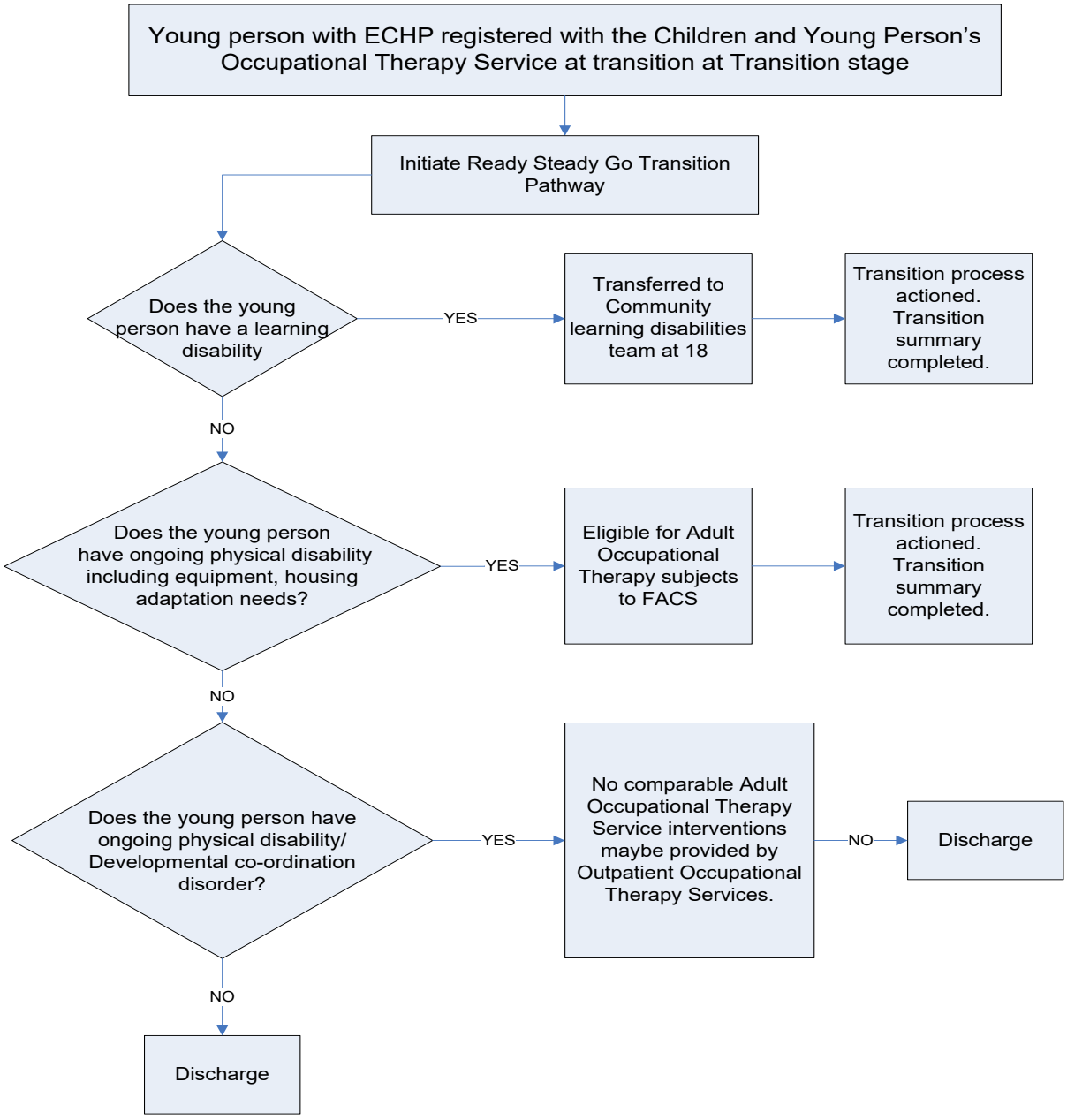
Appendix 5

Children's Health Visiting and School Nursing Pathway



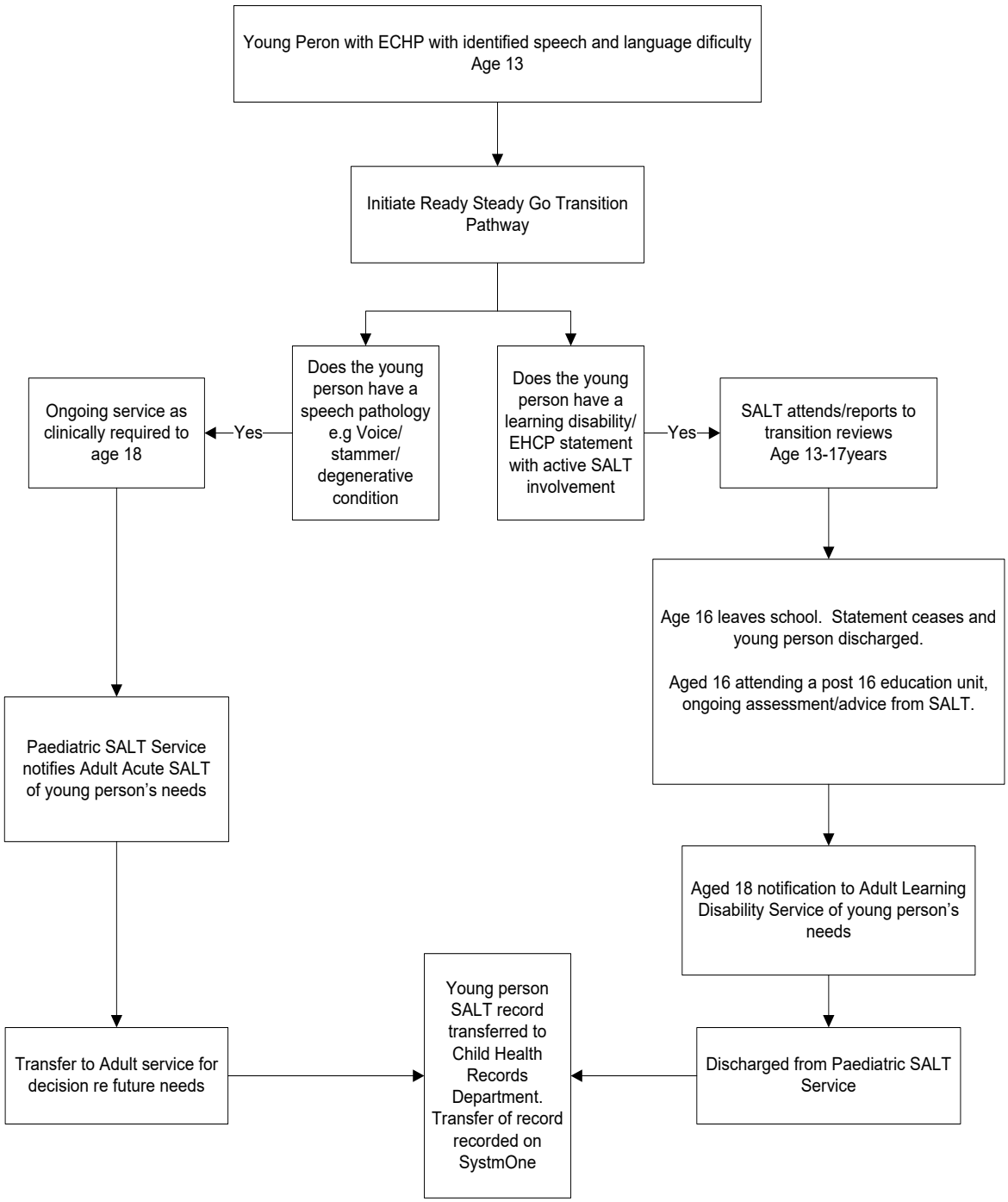
Appendix 6

Children's Occupational Therapy



APPENDIX 7:

Transition of Young People from Speech and Language Therapy to Adult Services



APPENDIX 8: Transitions from child services to CLDT