Pennine Care NHS
NHS Foundation Trust

Policy Document Control Page

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Transition of Patients from Healthy Young Minds Services Protocol

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- **Standards for Transfer Process update**
- **Appendix Update**

Originator

Originated By: Keith Walker and Anna Kushlick

Designation: Service Director and Trust HEALTHY YOUNG MINDS Lead Consultant

Equality Impact Assessment (EIA) Process

Equality Relevance Assessment Undertaken by: Dil Jauffur

ERA undertaken on: 03.01.2013

ERA approved by EIA Work group on: 31.01.2013

Where policy deemed relevant to equality-

EIA undertaken by: Dil Jauffur

EIA undertaken on: 03.01.2013

EIA approved by EIA work group on: 31.01.2013

Approval and Ratification

Referred for approval by: Angela Howarth – Governance Manager SSD

Date of Referral: 30th November 2017

Approved by: Specialist Services Governance Group

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Date Ratified by Executive Directors: 11th December 2017

Executive Director Lead: Director of Nursing

Circulation

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Circulated by: Information Department

Issued to: An e-copy of this policy is sent to all wards and departments

Policy to be uploaded to the Trust's External Website? YES

Review

Review Date: 30th November 2020

Responsibility of:

Designation: HYM Directorate Manager

This policy is to be disseminated to all relevant staff.

This policy must be posted on the Intranet.

Date posted: 18th December 2017

Pennine Care NHS
NHS Trust

HEALTHY YOUNG MINDS:

TRANSITION PROTOCOL

1.Introduction

1.1 The Trust Transition Protocol provides full guidance and benchmarks standards for the transfer of young people with ongoing mental health needs to ensure that they receive appropriate access to services with sound, safe processes in place. This is a requirement for CPA, for the Safeguarding of young people, and to meet core standards set out by the Care Quality Commission.

1.2 This protocol has been amended from the 2006 version to reflect the commissioned service developments since that time. Within Pennine Care the commissioning arrangements of community HEALTHY YOUNG MINDS (HYM) services are such that HYM provides fully up to 16th birthday, with specific enhancements to reach up to some 16 – 17/ 18 year olds, in a Needs Led Interface model with Adult Mental Health Services.

1.3 The 2004 National Service Framework for Children, Young People and Maternity Services set a key target that by 2014 there should be comprehensive specialist mental health services in place for young people up to 18th birthday. The blueprint or service configuration/ implementation is for local provider Trust and CCG solution.

1.4 The 2007 amendments to MHA, and the 1st April 2010 legislation for Age Appropriate inpatient mental health provision for young people up to 18th birthday,

have added further impetus for the re-configuration of community HYM.

2. Purpose of the Protocol

2.1 This protocol deals with the interface between the Child and Adolescent Mental Health Services (HYM) and other services, providing a current position statement on the relationship and responsibilities within HYM and these services for young people from age of 16 and 18 or 19 dependent on local commissioning arrangements.

2.2 HEALTHY YOUNG MINDS will have a wide range of partners it relates to in the course of its work with young people in preparing for transition discharge. This will include (non exhaustive list):

- Adult Mental Health Services
- Primary Care (including GP)
- IAPT/Healthy Minds
- 3rd Sector Providers (including voluntary services and training / employment services)
- Education Establishments
- Local authority services

For the purposes of this protocol, unless stipulated, the arrangements for transitions will refer to expectations for HYM to adhere to in respect of its relationship with patients.

2.3 In particular it draws a standardisation of response across all boroughs and of joint working arrangements between HYM including the Transition services, and all services. The principles of this are considered essential, despite any current small variation in the borough commissioning of “Transition 16–17 yrs” services / practitioner enhancements.

2.4 The protocol provides specific guidance concerning young people aged between

16 – 18/19th birthday in need of specialist mental health services, and the most appropriate service to which they should be referred or directed.

2.5 The protocol provides information on agreed transfer procedures for those young people who need to move from the care of HYM to other services. The protocol is intended to facilitate the transfer process ensuring that, when transfer does take place, it is in the light of full information and based on assessed need and should include young people's goals and aspirations.

2.6 This protocol has attached Appendix A - Transfer Checklist, plus Appendix B - an Audit Proforma, for the benchmarking and auditing of transfer processes, and to highlight any operational or service issues which may need addressing.

2.7 This protocol is underpinned by the service policies and principles of Child and Adolescent Mental Health Services, Adult Mental Health Services, National Service Frameworks and by the policies and procedures of the Care Programme Approach and Key CQC performance indicators.

3.Commissioning Arrangements for under 18 years age group

3.1 Children below 16 years

Within the Pennine Care footprint, generic HYM services are commissioned to provide full range of specialist mental health services for children and adolescents up to 16th birthday at the time of referral.

Psychosis EIT in most boroughs are also commissioned to reach down to children / young people from age 14 years onwards.

The Community Eating Disorder Service (CEDS) is in place to support young people from the age of 14 with a diagnosed eating disorder requiring intensive community based treatment.

3.2 **Young people 16 – 17 / 18 years**

The Transition HYM services/ enhancements are commissioned to provide a targeted service for those young people 16 – 18/19 years with mental health problems which are beyond the care offered by Primary Care Mental Health Services but which do not meet eligibility for adult mental health services. This may be either by virtue of their age, service availability, threshold criteria or a combination of these factors.

Boroughs will have differing configuration, criteria and capacity dependent on local commissioning arrangements. The different capacity is described in Appendix 1.

For 16 – 17 age group, HYM therefore reach up in Needs Led Interface model with Adult services. This is a result of differing commissioning arrangements within the boroughs.

The Adult Mental Health Services - CMHT's, CRHT's, A/E Liaison – remain commissioned to provide services for young people aged 16 years onwards, who meet the service eligibility criteria.

Changing mental health service needs of older young people

3.3 The nature and presentation of mental health difficulties in this age group reflects significantly higher incidence of:

- Formal mental illness
- Alcohol and Substance Misuse, and dual diagnosis
- Multiple pathology /mental health disorders
- Self harm and suicidal behaviours
- Crisis and emergency presentations
- Mental health disorders in young offenders

3.4 Changing social and developmental context also means:

- Increased independent living, with financial responsibility, isolation from parents/ carer networks, potentially homelessness.
- Social Care support less easily or willingly accessed by this age group.
- Likelihood of mental health crises which are not buffered by family/ carer support, therefore requiring “wrap around” services and intensive mental health support.
- Increased maturity and decision-making capacity
- More likely to be sexually active, and may be parents themselves.
- Increased vulnerability of transitions age range young people.
- Risk of “being lost” in fact of multiple transition points
- Continued challenge of cross border arrangements for all young people but especially looked after children, young people subject of other (youth justice) statutory orders.

3.5 Safeguarding Children principles apply to young people to 19th birthday. Appropriate carer/ family links should also remain integral to mental health care planning and provision for older young people.

3.6 A driving principle is therefore to ensure young people access services most able to meet their specific mental health needs.

4. GUIDANCE FOR REFERRING YOUNG PEOPLE AGE 16 – 17 YEARS, WHO REQUIRE A SPECIALIST MENTAL HEALTH SERVICE

4.1 When a young person age 16 – 17 years may continue to use Generic HEALTHY YOUNG MINDS service

- The young person age 16 is already well engaged in Generic HYM since before 16th birthday, and it is anticipated that their existing mental health treatment can be concluded within approximately six months or on finishing high school year 11 or with flexibility according to developmental needs.

- Or a clear local service specification exists with the individual borough commissioning CCG or MBC, **and** the young person meets those service cohort criteria: ie specifically

- HEALTHY YOUNG MINDS Looked After Children service
- HEALTHY YOUNG MINDS Learning Disability service
- Neuro developmental Disorder service

4.2 Criteria for referral young people 16 – 17 years to Transition services

- Emotional adjustment disorders and early emergent PD difficulty – is a significant though not exclusive focus

- Other mental health disorders – e.g. anxiety/ mood disorder etc… where a systemic or family focus is felt to be most appropriate emphasis – e.g. living at home and in full time education.

- The incumbent mental health needs and clinical risks are viewed as manageable within the limited capacity of Transition service/ practitioners, and do not require intensive CRHT response or high level crisis support

- Transition teams/ senior practitioners may by per case agreement, offer consultation or contribute to joint work, CPA and planning for older young people with more complex needs.

4.3**When an older young person 16 – 17 yrs should be considered for referral or transfer to Adult Mental Health Services**

- Diagnosis or persistent features of psychosis or equivalent severe and enduring mental illness. (Early contact and joint assessment with the Early Psychosis Team is advisable)

- Other serious mental health disorders – e.g. depression/ anxiety/ PTSD/ OCD/ BDD/ eating disorders - which are likely to continue into adulthood and to require the expertise and resources of specialist adult mental health services

- Mental health disorders, including emerging personality disorders, which are associated with high risk and persistent suicidal behaviours or risk to others, and which require enhanced service response e.g. intensive home treatment, CRHT, EIT, or Forensic mental health oversight

It is by local borough agreement, capacity and on per case basis, on which basis the Transition Services may offer a joint/ contributory role in clinical care prior to definitive transfer to Adult Services.

4.4**De Novo Acute/ Emergency New Presentations of 16 – 17 year olds**

For the present time, these will continue to require rapid response coordinated through working age adult services. (HYM is not yet commissioned or resourced to offer a comprehensive 16 – 17 year olds emergency service – either within office hours or out of hours.)

HEALTHY YOUNG MINDS can be contacted to give per case consultation to adult colleagues.

Following clinical discussions, young people may then if clinically appropriate be transferred to Transition services for follow up. Transfer of clinical information should use same benchmark standards as those used when transferring from HYM to Adult services.

These arrangements will be subject to revised service provision and an evolving Crisis Care Pathway for Children and Young People.

5.STANDARDS FOR TRANSFER PROCESS

(This includes either the transfer to Transition Services, OR transfer to Adult Mental Health Services)

Level of Transition

Following an audit of the protocol in 2013 it was agreed that complex cases meeting the requirement for CPA will require an enhanced level of transition with additional standards.

As outlined in the CPA policy, key determining factors will be:

- severe mental health disorder with either significant risk and/ or functional impairment

- plus need to ensure close communication / co-ordination with young person, cares, other professionals and agencies

Appendix 1A (Transition Template) summarises the standards required for all cases and additional standards required for complex/CPA cases.

6.1 Planning for Transition

Young people aged 16 and over who may need transfer from generic HEALTHY YOUNG MINDS will be prospectively identified by HYM. Consideration should be given to establish whether Transition or Adult Services are most appropriate.

Good practice dictates that transfer is a staged process and planning should start up to 6 months before the planned handover.

The young person and family/ carer should be fully involved in the transfer decision, with documented evidence of informed discussion in the clinical case notes.

Case note records management

The default position is for HEALTHY YOUNG MINDS case notes (or the latest volume if more than one exists) to be transferred to the receiving (PCFT) Adult service when the care coordination role has been formally handed over. The young person and their carers should be advised of this.

Where the young person or carer raise objections to notes being handed over, this must be discussed with the HYM operational manager and the objections further explored. A full summary of care should still be handed over to adult services, and current Safeguarding concerns must be shared. Any final decision to withhold HYM case notes must only be done with the full agreement of the Information Governance lead, HYM Directorate manager and HYM trust clinical lead.

HYM case note records are archived/ retained after closure, by HYM until the person's 25th Birthday, or 26th birthday if referred to HYM at age 17yrs.

When HYM patient transfers to Adult services, or when a previous HYM patient re-presents in adulthood, the HYM case notes should be requested by adult services**.**

6.1 Initial Contact with Adult Services/ Transition Services

For complex/CPA cases initial contact should be made either directly or by telephone between the HYM case holder/ Transition Service case holder and the appropriate Adult Mental Health Services; the HYM / Transition worker should initiate this. Any verbal discussion and outcome should be documented in case notes.

6.2 Transfer /Referral

A formal transfer /referral will be made by letter to the Transition or Adult Mental Health Professional identified in point 3. (Transfer information should include the information outlined in Appendix 1B)

From receipt of the written information the receiving Transition or Adult mental health professional will make contact with the referrer within two weeks of the referral and if the case is appropriate for transfer agree a review date.

A review meeting must take place within 3 months of receipt of the referral, or clearly documented reason why this was not required.

6.3 Transfer Planning

Transition of any cases to any other services is a full and comprehensive transfer letter copied to the young person, cares, GP and other professionals involved as appropriate. This can be supported optionally by telephone discussion or a joint appointment with the relevant Adult Mental Health Service. This should be driven by the expressed wishes and needs of the young person.

For all complex/ CPA cases, a jointly attended CPA transfer meeting is additionally mandatory.

From the joint meeting or robust alternative a formal plan and time table for the transfer of care should be agreed and include:

- Transition process, including planned date
- Any joint working needed
- Agreement on roles and responsibilities
- Clear explanation and involvement of young person

Where it is agreed that it is not appropriate for a service to continue to be provided, then advice will be given about any alternative sources of help and support the

young person can access.

Written notes of the meeting/ alternative, and a revised care plan will be produced by the HYM / Transition worker and distributed to all involved, including the young person/ family and the GP.

Some young people may be subject to other statutory care planning processes (CAF, CiN, LAC). In these cases, processes should aim to complement, integrate and support planning rather than operating a dual duplicating process.

6.5 Discharges from HEALTHY YOUNG MINDS/Transition Services (Transition to Primary Care)

A detailed discharge letter should be completed, for every young person transferred/ discharged from HYM / Transition Services. The discharge/ transfer letter should meet HYM Directorate operational standards for written communication, be sent to the GP/ Care coordinator/ other agencies/ young person and family, and a copy held on file.

Notification of Discharge or Transfer from HYM Transition Service, should be completed within 10 working days as directed within current performance objectives and recognized as good approved practice and should be documented on the HYM Casenote Chronology.

6.6 Discharges from HEALTHY YOUNG MINDS/Transition Services (Transition to 3rd Sector Providers

A detailed discharge letter should be completed for every young person transferred/ discharged from HYM / Transition Services. The discharge/ transfer letter should meet HYM Directorate operational standards for written communication, be sent to the GP/ Care coordinator/ other agencies/ young person and family, and a copy held on file.

The young person should be fully involved in the transfer decision and transfer planning. Transfer planning should include what is identified in points 6.3 and 6.4 in this protocol.

Notification of Discharge or Transfer from H Y M Transition Service, should be completed within 10 working days as directed within current performance objectives and recognized as good approved practice and should be documented on the HYM Casenote Chronology.

6.4 Cases coming into unplanned contact with Adult Mental Health Services, when HEALTHY YOUNG MINDS have previously had involvement

Adult Mental Health services should as part of their assessment and screening process, ascertain if a young person was previously known to HYM. If so, cross referencing of clinical information is essential. A request should be made for the HYM file (with the patient's knowledge) and where appropriate direct contact made with HYM professionals to gather information.

6.5 Auditing of transfer cases

The HEALTHY YOUNG MINDS Directorate will audit transfer of cases against the above standards, and ensure that findings are fed into appropriate work streams for continued service improvement.

6.6 Service Development

Issues of unmet need and areas of difficulty, which arise in transition process, will be communicated to Operational managers within H Y M and Adult Mental Health Services.

Appendix 1A:

Transition Practice for all Transitioned Cases

* applies to complex/CPA cases

Mandated Practice

Planning of Transfer

Transition planning should start 6 months prior to transfer
The young person and family should be involved in the transfer process

Transfer/ Referral

*Initial contact should be made between HEALTHY YOUNG MINDS case holder and appropriate Adult Mental Health Service
A formal transfer / referral letter should be made (See Appendix 1b)

Transfer Planning

* A joint meeting/CPA review should occur between services
For standard cases a robust alternative (detailed letter/ telephone conversation) should occur between services

A transfer plan should be written and the young person should receive a copy of this with clear and jointly agreed understanding of the young person's needs and a timescale for discharge form HYM

Where it is not appropriate for a service to be continued then advice about alternatives should be given

Discharge

A detailed discharge letter should be completed and meet the standards outlined in appendix 1b

Consent

Documented consent from the young person regarding their acknowledgement and agreement with regard to both transition planning and the casenote transfer (where applicable to other PCFT services)

Case note Management

HEALTHY YOUNG MINDS case notes should be transferred to the receiving adult service when the care co-ordinator role has formally been handed over
The young person should be advised of this.

Good Practice (and capacity allowing)

Case note Management

HEALTHY YOUNG MINDS case notes should be transferred to the receiving adult service when the care co-ordinator role has formally been handed over
The young person should be advised of this

Transition Process

Accompany young people to first appointment to new service as necessary and appropriate.

Transitions Documentation

Transition letter should be young person focused in style, accessible with no jargon and acronyms.

Appendix 1B : Information required in transfer letter

Identification data:

Name, Address

Date of Birth

NHS Number and GP details

Clear Rationale for Transfer:

Clinical Formulation (including multi-axial diagnosis where appropriate)

Present mental health symptomatology

Medication – name and dose regime

Risk Assessment:

Suicide and Self Harm

Violence/Aggression

Self Neglect

Safeguarding Issues

Initial Presentation to HEALTHY YOUNG MINDS /

Transition including: Referral source

Initial formulation

Family/Carers including:

Family/Carers structure, plus relevant dynamics

Family history of mental health problems

Salient Developmental History

Current Circumstances including:

Social functioning

Accommodation

School/ Education/ Employment (attendance, any special needs or Learning Disability)

Offending behaviour/history

Substance or Alcohol misuse

Spiritual and Cultural needs

Independent living skills

Care Plan and Progress including:

Details of current care plan/ CPA documentation if subject

Summary of treatment interventions, and their effectiveness

Names and contact details of professionals involved

Appendix 2 Audit Proforma tool for Transition Cases

This can be found on the following link

https://www.surveymonkey.co.uk/r/5T2XDWH