

**2014/15 NHS STANDARD  
CONTRACT:  
Model Transfer of and  
Discharge from Care  
Protocol for young people  
with mental health  
problems in transition  
from CAMHS**



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<b>Description</b>	This model transfer of and discharge from care protocol for young people supports the commissioning of transition services for young people leaving Child and Adolescent Mental Health Services, and can be inserted into Section K of the NHS Standard Contract. This sample protocol is non-mandatory.
<b>Cross Reference</b>	Model Service Specification for Transitions from CAMHS
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### Document Status

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Model transfer of and discharge from care protocol for  
young people with mental health problems in transition  
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## 1 Guidance to Commissioners:

This aim of this sample 'Transfer of and Discharge from Care Protocol' is to support contract managers and commissioners who wish to improve the support given to adolescents (hereon referred to as young people) with mental health problems as they move from Child and Adolescent Mental Health Services (CAMHS) . This sample protocol is non-mandatory.

For those wishing to commission a transition service for young people with mental health problems there is a [specimen service specification](#) that commissioners can adapt to meet local needs.

Young people may move from Child and Adolescent Mental Health Services (CAMHS) into a specialist Adult Mental Health Service (AMHS) or return to community services in primary health or care systems. It is important to note that only a proportion of young people receiving mental health services from CAMHS need to transfer to secondary care AMHS teams.

As a consequence, commissioners may look to other services to support young people with persisting difficulties. This protocol can be used in contracts for AMHS, CAMHS or other services funded by health or social care commissioners for vulnerable adolescents with mental health and social care needs.

This protocol and the [sample service specification](#) are based on a range of quality standards and best practice. Further information can be found on the [CHIMAT website](#), the [SCIE website](#), [Youth Access](#), the [Mental Health Intelligence Network](#), [Right Here guidance](#) and from the Joint Commissioning Panel [Guidance for commissioners of mental health services for young people in transition](#). The National Institute for Clinical Excellence (NICE) is considering guidance around transition in 2014-15 but has not yet established specific Quality Standards. Any NICE Quality Standards developed for children and young people with mental health conditions or problems may well include information about what services should be provided through transition into early adulthood, and should also be consulted.

Commissioners should include young people and their parents / carers, as well as providers, in adapting this protocol to suit local circumstances and needs. Young people were however consulted in drawing up this sample protocol. Commissioners should be mindful of the needs of [inclusion health groups](#).

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it;

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- Given regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and in securing that services are provided in an integrated way where this might reduce health inequalities.”

The application of the protocol will need to be reviewed regularly (at least annually) and updated to reflect national and local strategic decisions and changes of resource by:

- Commissioners and providers, with active engagement from young people and parents/carers locally
- Local governance structures such as Health and Wellbeing Boards.

The protocol and specification are being piloted with Clinical Commissioning Groups (CCGs) that volunteered to be part of the pilot. An evaluation will take place to find out how useful CCGs have found the sample specification.

**The PDF version of this model protocol is the original full version published by NHS England. A Word version of the model protocol is also available for commissioners to use when developing their own for their local area – commissioners may amend and insert detail where appropriate. Once changes have been made, that protocol should be attributed to the specific commissioner/local area, not NHS England overall.**

## 2 Transfer of and Discharge from Care Protocols for insertion in National Contract Section K

This applies to service users transitioning from Child and Adolescent Mental Health Services (CAMHS) to other services and should be used in conjunction with the safer discharge policy for those service users leaving secondary care for primary care.

Transition arrangements should be framed by the following principles:

1. The mental and physical health of young people in transition should not decline during the process of transition.
2. Young people should be assisted to maximise their health and life opportunities.
3. Young people should be treated as far as possible within their own community and close to home
4. Commissioners will need to ensure that appropriate plans are in place for young people in crisis
5. Services should work together in integrated and coordinated ways in the best interests of young people
6. It is essential that young people and families are involved in commissioning and service design (as well as providing feedback to services). Young service users and their families, as well as those who have yet to access services can help commissioners prioritise and identify any gaps and blocks to access, and assist providers in improving services and evaluating change.
7. Commissioners should consider the diversity of the populations they are responsible for, not only in terms of cultural and ethnic diversity, but all of the factors that may both influence the risk of developing mental health problems, as well as those that need to be taken into account in the design and delivery of services.

Transition is a process undertaken over time. It may include, but is more than, a planned transfer to an adult service. Primary care services must be included to achieve streamlined, efficient and effective transition for all patients. This is, particularly true for those patients needing a range of health and social care services during their transition and beyond.

Transfers from CAMHS whether to Adult Mental Health Services (AMHS) or to other services including discharge back to primary care, are single point events in the entire transition process. Young people may be subject to serial and sequential transfers within and across different health care organisations / specialist teams over time. CAMHS should follow Care Programme Approach (CPA) guidance and make a referral 6 months before the transition time, where possible, so that the young person and their family and both CAMHS and the receiving service(s) have good time to communicate the needs and provide continuity of care at this vulnerable time.

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Where, following such a good practice timely referral, it becomes clear that the commissioned adult services are not equipped / appropriate to provide NICE evidence based care, for example, if Attention Deficit Hyperactivity Disorder (ADHD) or Autistic Spectrum Disorder (ASD) specialists are not available, this should be brought to the attention of the commissioners of services.

Young people who do not meet the threshold for adult mental health services may be best supported by primary care, other agencies such as Youth Counselling services, or may be discharged with a clear plan which tells them and their families what to do if they become unwell.

Transfers require co-ordinated, documented and integrated support plans for young people and their parents/carers from all health services involved in their care and in partnership with other multi agency providers (e.g. education and social care) constituting the changing team around the young person at this time.

In order to enable young people (and their parents / carers) to become and remain active partners in their care, prepare for transfer(s) and engage with adult mental health or other services; the transition process between services needs to be underpinned by age sensitive and developmentally appropriate care planning that is:

- Supported by access to multi-media resources with which all service users including young people want to engage and have been involved in developing.
- Supported by access to peer support which may be offered individually or in groups, face to face or through social media.
- Supported by a named professional who can take a co-ordinating support role throughout the transition process. It is recognised that whilst this professional may change over time, young people and their parents/carers, where appropriate should be able to name the professional undertaking this role at any point in the process.
- Delivered by staff who have specific training or experience in working with young people.
- Delivered by processes, systems and environments that promote safety, quality, effectiveness and are young people friendly. This will be evidenced by clinical outcomes, young people and parent/ carer, where appropriate reported experience measures and by the involvement of young people and their parent/ carers in service design and evaluation.
- Documented in the young person's medical records and reviewed at each key point in the transition pathway.



## 2.1 The provider shall:

- Co design and review the transition care pathways with CAMHS, the receiving service (insert name of service here), young people and families to ensure timely referral needed for a safe and smooth transition
- Work with all relevant agencies to ensure the services for young people with mental health problems are coordinated during transition and address their individual needs, providing a holistic approach
- Include GPs in the pathway development to ensure GPs have the relevant information to support young people (and their parents/ carers) during and after transition.
- Ensure that young people and their families are treated with compassion, respect and dignity, without stigma or judgment
- Ensure that young people's physical health needs are considered alongside their mental health needs
- Ensure that young people who require services during and post transition are seen in a timely manner
- Ensure that if appropriate to the provider, services are provided in an emergency or crisis, including out of hours. If not appropriate to the provider, that the, multiagency coordinated plan includes information about crisis and out of hours care
- Provide an agreed care plan that is written and shared with the young person. Where appropriate this should also be agreed and shared with the parent and carer
- Seek and use feedback in a range of settings including the use of routine outcome monitoring of medications, therapy and social and vocational outcomes, active feedback regarding service delivery and complaints
- Ensure young people and their families are offered a choice of interventions appropriate to their needs delivered by trained and appropriate staff
- Agree the aim and goal of interventions during transition with young person and where appropriate, parent and carer. Monitor the changes to agreed and shared goals and to symptoms, amending therapeutic interactions as a result to deliver the best possible outcome
- Provide information at all stages of the pathway about interventions or treatment options to enable and/or families to make informed decisions about their care appropriate to their competence and capacity.
- Co-produce the care plan and provide that written information to the young person and where appropriate parent /carer about the care plan, how to access the services routinely and in a crisis

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- Provide written assessments, care plans etc. that are jargon free (where any technical terms are defined)
- Ensure that young people leaving the service have a written and agreed discharge plan that supports self-management where possible and explains how to access help if this becomes necessary.
- Where a young person is moving to another service, whether to adult mental health services or to a different service, the provider will ensure that the agreed transition protocol is followed with, as a minimum, a joint meeting between the provider and new service that includes the service user and/or family member, a written discharge summary, followed up after six months to check the transition has proceeded smoothly. The sending service will agree with the young person what information will be provided to receiving service to minimise the need for the young person to repeat information
- Ensure that the service is accessible and provided in an appropriate setting that creates a safe physical environment
- Ensure that the service provides Continuing Professional Development (CPD), appropriate supervision and appraisal and has a clear workforce plan that takes account of the changing needs of the local population
- Ensure that appropriate clinical information, structural governance and audit arrangements are in place, including protocols around information sharing and confidentiality.
- Maintain an accurate data set and provide accurate and timely reporting to commissioners (local, regional and national) and national organisations when requested
- Have clear reporting processes and standards, for example [Youth Wellbeing Directory](#) and [Child Outcomes Research Consortium \(CORC\)](#)
- Ensure that care plans (following Care Programme Approach, or CPA, where applicable) are in place for people receiving support for mental health problems. These plans may be (where more than one professional group is involved in delivering care) and multi-agency developed in collaboration with service users and carers. A copy should be given to service user, parent or carer (if appropriate) and GP.
- Ensure that the care plan includes risk management and crisis planning
- Review the care plan with the service user, including the goals of treatment, and revise the care plan at agreed intervals of no more than one year.
- Select treatment options in consideration of NICE HTAs. NICE guidelines and NICE Quality standards :
  - Age-appropriate best practice/evidence based psychological intervention
  - Pharmacological and psychosocial interventions

- Environmental and occupational/educational interventions or provision
- Multimedia prevention package whilst on waiting list – best practice
- Engagement, flexibility and choice
- Ensure that systems are in place to coordinate effectively with other services when service users are in treatment, when they move between other services both for their physical and mental health and that there are processes in place to plan the ending of treatment or services.

## **2.2 Groups needing particularly robust transition processes**

### **include:**

- Young people transferring from child and adolescent to other emotional wellbeing and mental health services
- People transferring from Early Intervention Psychosis services to another service
- Vulnerable children and young people's groups including
  - Looked after children
  - Care leavers – moving to independent living
  - Young people entering or leaving inpatient care
  - Young people entering or leaving prison
  - Youth offending
  - Young people with learning disabilities
  - Young people with ADHD and ASD and Asperger's syndrome
  - Any planning for children and young people with severe educational needs should take account of and be part of the child or young person's statement
  - Unaccompanied asylum seeking minors
  - Young people with caring responsibilities
  - Young people with chronic illnesses and/or lifelong health conditions
  - Young people who have suffered significant harm such as sexual abuse, neglect, physical and emotional abuse and or who have post traumatic stress disorder

Any planning for children and young people with severe educational needs should take account of and be part of the child or young person's statement or Education Health plan.

### **2.3 Interdependence with other services/providers**

Providers should ensure they have excellent links with:

- General Practice
- Schools and academies FE colleges and other education providers including links to apprenticeship providers , and employment advisers
- CAMHS
- Adult mental health services (adult, specialist, forensic)
- Drug and alcohol services
- Voluntary sector providers
- Independent providers
- Housing services
- Inpatient or other highly specialist services
- Youth services
- School counselling services
- Safeguarding – children and adults (Local Safeguarding Children's Board)
- Local authorities
- Acute sector hospitals
- Emergency departments
- specialist practitioners for looked after child and care leavers
- Criminal justice system – including young offenders services
- Addiction services
- Local independent providers

Providers should have a formal route to refer service users to highly specialist mental health services for example, 24/7 intensive case management, assertive outreach teams and Early Intervention Teams or - for example, if a transfer of inpatient service is required i.e. young people turning 18 who will continue to require inpatient care.