Northamptonshire Healthcare
NHS Foundation Trust

Guidance for the Transition of Young People between services

1. Preamble

The aim of this document is to provide clear guidance for clinicians and managers for the transition of young people from Children's Services within Northamptonshire Healthcare NHS Foundation Trust and local partners. Its purpose is to ensure that the needs of young people and/or their parents are met in a comprehensive, cohesive and clinically appropriate way.

The guidance is based on the good practice set out in the NSF for Children (DH 2004); NICE Guidance (NG43); A joint paper on good practice and guidance from the interfaculty working group of the Child and Adolescent Faculty and the General and Community Faculty of the Royal College of Psychiatrists (Lamb, et al 2008), National and Regional Pathway guidance, Local Authority (NCC) guidance and clinical policies of other NHS Trusts.

2. Introduction

This Policy recognises that there are a number of significant transition points for Children and Young People between health, social and education services. In particular the transition from adolescence is a crucial stage of social, personal and emotional development when the need for careful and person-centred management of often complex disorders and difficulties is high.

Service configurations are sometimes unhelpful to achieving continuity of care between child and adult services because they frequently involve different care plans, care teams and funding arrangements.

Furthermore, an arbitrary age point assumes that chronological age alone indicates readiness for transfer, discounting the complexity of adolescent development. Similarly, school-attendance is an outmoded cut-off criterion for access to services.

Flexibility about the age at which transfer takes place should be determined by clinical need. In some cases, completion of an intervention beyond the young person's 18th birthday may preclude the need for transition. Alternatively, a young person presenting with complex difficulties in the six months prior to their 18th birthday, and who is likely to require longer term provision for their needs, may be more appropriately seen within Adult Services.

Regardless of which service the young person is being transferred to, that service should get to know them before the transition and a plan should be in place to ensure the transition happens as seamlessly as possible.

The age to start transition will depend on the service Children and Young People are accessing but for Children and Young People with an Education Health Care Plan (EHCP) this must happen from school year 9 (aged 14) and for Young People leaving Care transitions must start from at least aged 15 and a half.

All Transition Plans should be:

- In the best interests of the client and involve shared decision making
- Undertaken collaboratively and in partnership with the client
- Planned, structured and timely
- Embedded in the involvement of all agencies and staff involved in the client's care
- Take into consideration the needs of carers.

The needs of young people who present in an emergency situation should be managed in accordance with local guidelines and agreements.

3. Terminology

Transition:
The process of moving between services. It refers to the full process including initial planning, the actual transfer, and support throughout.

Transfer:
The actual point at which the responsibility for providing care and support to a person moves from one provider to another provider.

4. Overarching Principles: (Adapted from NICE Guidance NG43)

Managing the transition of young people to adult services should take full account of the overarching principles which have been adapted from NICE guidance. These include:

1. Involvement of young people and their carers in the co-production of service design, delivery and evaluation.

2. Ensure that transition support is timely and developmentally appropriate, taking account of:

    a) Maturity
    b) cognitive ability
    c) psychological status
    d) needs in respect of long term conditions
    e) social and personal circumstances
    f) caring responsibilities
    g) communication needs

3. Ensure that transition support:

a) Is strengths based (not predetermined by set transition options) and identifies sources of support to develop a positive transition plan
b) Identifies the support available to the young person (which includes support from family or carers, but is not limited to this support alone). Carers and those supporting young people may need support to promote their active involvement.
c) Comprehensively planned to minimise risks, reduce stress and allow for the provision of joint care where appropriate.

4. Uses a person-centred approach to ensure transition support:
    a) Treats the young person as an equal partner in the process and takes full account of their views and needs.
    b) Young people should be able to exercise informed choice in the treatment they receive, within the constraints of what is available. The approach to meeting the needs of young people should be characterised by personalisation, flexibility, co-operation and empowerment.
    c) Involves the young person and their family or carers, primary care practitioners and colleagues in education as appropriate. Approaches should be young person friendly and welcoming of parents as carers.
    d) Supports the young person to make decisions and builds their confidence to direct their own care and support over time
    e) Fully involves the young person in terms of the way it is planned, implemented and reviewed
    f) Addresses all relevant outcomes, including those related to:

        i. Education and employment
        ii. Community inclusion
        iii. Health and wellbeing
        iv. Independent living and housing options

    g) Involves agreeing goals with the young person
    h) Includes regular reviews of the transition plan with the young person

5. Multi-agency Service Manager involvement in proactive identification and planning for young people in their locality with transition support needs.

6. Potential inequalities are identified in a non-stigmatising way to ensure that inequalities are narrowed and young people are not further disadvantaged through the transition process. Providers should be particularly vigilant of potential inequalities in relation to young people who are:

    - from different cultural or ethnic background
    - looked after by the local authority
    - disabled
    - from ‘traveller’ families
    - seeking refugee or asylum status

- homeless.

7. Where there is disagreement between services about the most appropriate service provision, this should be resolved by Service Managers, taking account of the client's needs and clinical recommendations.

8. Every service involved in supporting a young person should take responsibility for sharing confidential or safeguarding information with other organisations, in line with local information-sharing and confidentiality policies. Decisions on primary clinical responsibility should be decided on a case by case basis.

9. Ensure that the young person is registered with a GP/has a named GP.

10. All decisions are clearly documented in electronic client records.

11. Regular audits should be undertaken to identify good practice, shortcomings and actions for service improvement where shortcomings are identified.

Transitions for 0-19 Universal Public Health Services

- Transitions within the 0-19 service occur at key points of development in the family and child's life and the 0-19 service is delivered in stages which match natural transitions, designed to support children and families to navigate these changes and achieve their best possible outcomes:
  - Becoming a parent is supported through the mandated Health Visiting contacts: antenatally, at 10-14 days and at 6-8 weeks;
  - Baby to toddlerhood is supported through the 8-12m development review with the Health Visitor;
  - Toddlerhood to pre-schooler is supported through the 2-2.5y review with the Health Visitor, this is also a key preparation contact for school readiness;
  - School readiness is assessed and supported with an holistic health needs assessment and universal screening contact with children in their reception year at school by the School Nursing Team;
  - Puberty and preparation for adolescence are supported through health education in school and parents are invited to contact their school nursing team through the year 6 parent health questionnaire, this is also a key part of preparation for transition to secondary school as it is a key introduction to the school nursing service;
  - Preparation for secondary school is supported through an holistic health needs assessment in year 6, at which point children who have additional vulnerabilities are identified so that additional support can be put in place to support the transition to secondary school;
  - Secondary school entry is a particularly vulnerable time for young people and young people in year 7 are offered a face to face health interview with their school nurse which enables health promotion and introduction to the service;

- Teenagers and young people from 11y and upwards are offered direct access to their school nursing service through drop-in clinics and via text to ChatHealth, this enables preparation for transition to adulthood by enabling young people to gain independence and autonomy in accessing health services to maintain their wellbeing;
- Preparation for adulthood is supported through the provision of health education around sexual health; emotional wellbeing; healthy relationships and substance misuse. Young People are supported to access any specialist services that they need and are supported to develop risk assessment skills and confidence in asserting their own desires and preferences, including managing peer pressure.

- All Young People leaving school at 18years are discharged annually (or sooner if they move out of Northamptonshire). Where children have specific health requirements and adult services are available, appropriate referrals are made and transition planning is undertaken.
- Children who do not have specialist health needs at the time of their transition are discharged back to their GP.

5. CAMHS to AMHS - Practice guidelines for the transition of 16-17 year olds:

The standards listed below provide practice guidance for the transition of young people to Adult Services and should be followed for all young people to be transitioned.

Standard 1:
The point at which Adult Services provide services for young people should be based primarily on clinical presentation and their treatment needs. (A flexible approach to meeting the needs of a small number of young people with different circumstances may be required)

Standard 2:
No less than 6 months before a young person reaches the age of 18 years, the responsible Children's Services clinician will formally review and document the appropriateness of the client remaining within the Children's Service or the need to implement a planned transition.

Standard 3:
Where transition is considered clinically appropriate, Children's and Adults' Services will actively co-operate to ensure a smooth transition, and appropriate service documentation and processes (e.g. CPA in CAMHS) will be used as a vehicle for the transition.

Standard 4:

A brief clinical summary (including a risk assessment) is completed by the Children's Services Clinician and forwarded as a referral to the appropriate Adult Service with an invitation to attend a clinical discussion (e.g. the next CPA in the case of CAMHS)

Standard 5:
A named clinician must be identified in the Adult Service to respond to the referral within 4 weeks of its receipt. Where a referral is accepted, the named clinician from the Adult Service and the referring Children's Services clinician will collaborate to plan and facilitate the transition (see also Standards 8 and 9).

Where a referral is not accepted, both clinicians will collaborate to identify an appropriate alternative service or course of action and this will be recorded in the appropriate electronic clinical record. See Standard 9 for situations in which a service cannot be offered.

Standard 6:
When a Local Authority has parental responsibility for a young person, the Local Authority should be notified of the transfer to Adult Services

Standard 7:
The young person and family/carers are involved in organising and planning services to ensure that services address the issues and needs of the young people sing the service through transition. This will include ensuring that the young person and their family is given advice on how to access appropriate information leaflets or websites on the new (Adult) provision to which they will be transitioned.

Standard 8:
Within 8 weeks of the referral the Adult Services clinician, the Children's Services Clinician, the young person and their family/carer will convene a joint meeting with the Adult Service (CPA in the case of CAMHS). At this initial meeting the Children's Services Clinician, young person and family/carer will share appropriate information with the Adult Services provider of care, including:

- A history of the care provided by Children's Services
- Presenting difficulties, current concerns and diagnosis
- Details of any support that the young person or their family/carers expect from the Adult Service
- Details of any risk issues or assessments
- Information which the Adult Service will need to know to manage the young adult's condition
- Details of other support given to the young adult and their family/carers, e.g. educational provision, Children and Young People's (Social) Services, Individual Funding Plans, Health, Education and Care Plans etc.

Standard 9:
The receiving Adult Services team agrees the suitability of the referral with the Children's Services Clinician, the young person and their family/carers at the joint initial meeting.

Where it is not possible to offer the services requested, the reasons for this must be fully explained to the young person and their family/carers and be clearly documented in the electronic clinical record. In such cases, the Children's Services Clinician, young person and their parent/carers then agree an appropriate referral route to another service and start the process again, following the procedure from Standard 2. Alternatively, an exit strategy from Children's Services is discussed, agreed and documented and the young person is discharged.

Standard 10:
Children's Services Commissioners will be informed by Care Co-ordinators (or case responsible clinicians) within Children's Services of all young people whose care packages include specialist funding and for whom transition is initiated. Examples of specialist funding include: continuing health care funding; in-patient funding; multi-agency funding; complex care funding; independent organisation funding or looked after children funding.

The Transition Plan is implemented and reviewed as agreed, at regular interval until the young person's transfer has been completed and the Children's Service withdraws.

Completion includes ensuring that Children's Services Commissioners have completed any funding agreements with Adult Services Commissioners.

Standard 11:
Any transfer of care should allow for the seamless continuation of any specific services individually commissioned for the young person during the transition, for a period after the transition or until the intervention/therapy has been completed.

Such provision must be signed off by managers in Children's and Adults' Services on a case by case basis.

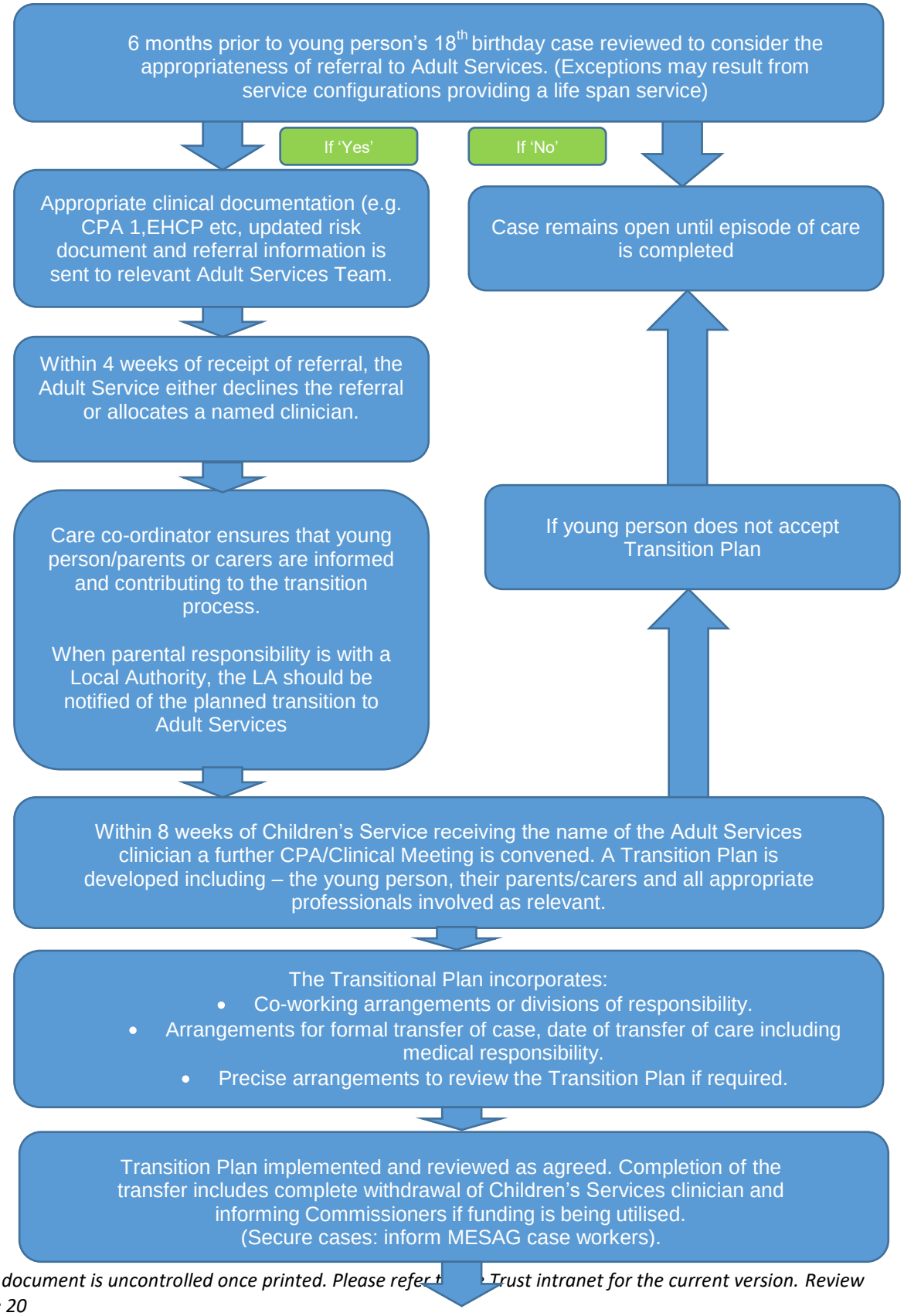
Standard 12:
Transfer of care will ideally take place when a young person is not acutely unwell. Exceptions may arise, (particularly in CAMHS) if the young person is in in-patient care, home treatment or where a specific provision is identified within Adult Services.

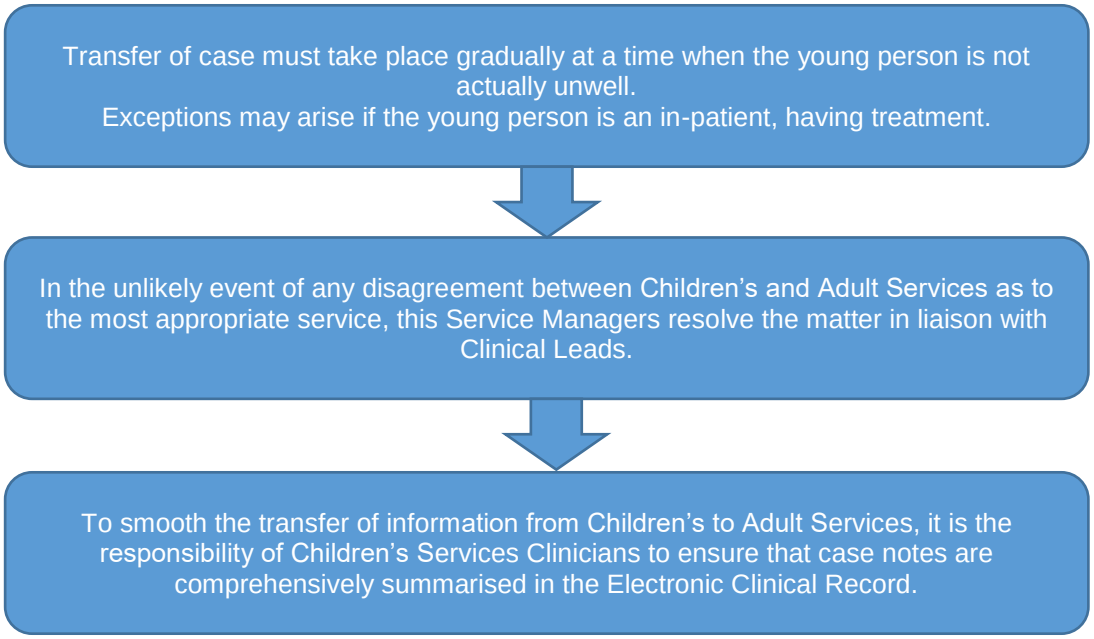
Standard 13:
Where there is disagreement between Children's Services and Adult Services about the most appropriate service provision, attempts will be made to resolve this between managers of the respective services.

Standard 14:
Children's Services clinicians are responsible for comprehensively summarising case notes to facilitate the smooth transfer of information to Adult Services and remain clinically responsible until the transfer is finalised.

(The Transition Standards Flow Diagram overleaf provides a generic overview of the process. A CAMHS to AMHS Flow Diagram is appended)

Transition Standards Flow Chart CAMHS




Transfer of case must take place gradually at a time when the young person is not actually unwell.
Exceptions may arise if the young person is an in-patient, having treatment.
In the unlikely event of any disagreement between Children's and Adult Services as to the most appropriate service, this Service Managers resolve the matter in liaison with Clinical Leads.
To smooth the transfer of information from Children's to Adult Services, it is the responsibility of Children's Services Clinicians to ensure that case notes are comprehensively summarised in the Electronic Clinical Record.

6. Special/additional considerations for different client groups:

All transitions within Northamptonshire Healthcare NHS Foundation Trust will follow the general guidance outlined above. Additional special considerations are set out below: ***A flexible approach, on a case by case basis, based on clinical need, should characterise discussions between providers where there is any deviation from this guidance.***

6.1 *Young People transitioning from CAMHS to Adult Mental Health*

- For all Young People transitioning from CAMHS to AMHS, the Care Programme Approach (CPA) will be followed.
- Plans should be negotiated and agreed between CAMHS and AMHS on the basis of informed consent and in line with the CPA Policy (CLP010)
- Young People who present for the first time and are aged 17years 6 months and over, and who are likely need ongoing treatment will be picked up by the appropriate Adult Services team.
- Staff in both CAMHS and AMHS should be familiar with a psychosocial approach and the complexity of young people's lives, and the assessment, treatment and management of severe mental illness and the recovery model of care management.
- Young People being seen in CAMHS, approaching the age of 18, whose episode of care is likely to be completed by the age of 18years 6 months, will continue to be seen in CAMHS until discharge.
- The exception to the above is for Looked After Children, who will be seen by the CAMHS LAC Team if they are under the age of 18 years, irrespective of first presentation.

6.2 *Looked After Children (LAC)*

- Children who are looked after by the Local Authority are particularly vulnerable to falling between services, particularly at times of transition and specific attention should be paid to ensuring that their needs are met during transition.
- It is essential that there is multi-agency engagement in any care planning processes
- Inviting Adult Services to Statutory Reviews of LAC may form an integral part of the transition process.
- Advocacy to ensure that the young person's views are expressed and that they support any decisions made about provision for their needs.
- For Young People in Secure Children's Homes on welfare grounds, Children's Commissioners will need to be informed

6.3 *Children with Attention Deficit Hyperactivity Disorder, Autistic Spectrum Disorders, Tourette's Syndrome and other Neuro-developmental Disorders*

- The ADHD/AS team within NHFT is a lifespan based service
- Where young people have a co-morbid psychiatric disorder, concurrent referral to Adult Mental Health Services is required, with associated use of the CPA process and documentation as appropriate.

6.4 *Young people in CAMHS in-patient provision*

- The CAMHS Care Co-ordinator responsible for the management of a young person's episode of in-patient care follows the transitional model outlined in this guidance, requiring referral to AMHS and to Adult in-patient provisions prior to the young person reaching their 18th birthday.
- AMHS should be made aware of any young person aged 17 years and above being admitted to in-patient care, by the assessing key worker.
- Under Section 85 of the Children's Act (1989) hospitals are required to inform a young person's Local Authority Children's Services if they have been an in-patient for more than 3 months. The Local Authority may then assess if additional facilities and support are needed to help meet the young person's needs (See Appendix 1), thereby becoming involved in the transition process.
- When a young person not previously known to CAMHS is admitted to in-patient care shortly before their eighteenth birthday their inpatient Care Co-ordinator will invite AMHS to a CPA meeting to ensure that the transition process is initiated and the young person's transition needs assessed.

6.5 *Young People with Eating Disorders*

- The model and guidance provided in this guidance, (including following the standards and arranging a joint meeting) should be followed for young people with an eating disorder.
- Where a young person presents with a co-morbid psychiatric condition, referral to both the Specialist Eating Disorder Service and AMHS is made
- The guidance outlined under the section on 'Young people in CAMHS in-patient provision' must be adhered to as appropriate when the young person has an in-patient episode.
- Where young people have a co-morbid physical condition e.g. diabetes, dual transition to adult medical provision should be undertaken
- Extension of therapeutic provision (as outlined in Standard 12) may apply, or there may be a longer period of joint working between CAMHS and the Adult Eating Disorder Service.

6.6 *Young People with a mental disorder who are in Forensic Services*

- Clinicians should be alert to the complex Issues for treatment and transition of care of young people with a mental disorder who pose a risk to others or have a forensic history, and eligibility criteria potentially resulting in gaps in service provision, resulting in unmet developmental needs.
- It is essential that a non-stigmatising approach is adopted throughout the transition process and that young people and their families/carers remain involved in the process.
- Where specific packages of care are funded by Children's Commissioners it is essential that both the Commissioners and AMH Forensic Services are made aware of the transition when a young person is aged 17 years 6 months.

- The direct transitional model is used, with some adaptation of the standards where appropriate.
- Multi-agency involvement is essential and may involve Education; Children and Young People's (Social) Services; Youth Offending and Youth Justice services and the Police.

6.7 Young people in Youth Offending Services

- Work with children in secure settings is a strategic priority for improving outcomes for vulnerable children as set out in Every Child Matters: Change for Children programme. This includes:

    - an early response to difficulties
    - partnership work (including pooled budgets) with service agencies and families
    - A duty of co-operation which extends to all agencies, including Youth Offending Teams
    - A specific duty is placed on prisons and other secure establishments to safeguard and promote the welfare of the children in their care

- The practice guidelines outlined for 16 – 17 year olds in this document must be followed for young people with mental health problems who are seen in the Youth Offending Service.
- It is the responsibility of the `youth Offending Care Co-ordinator to transition such young people into Adult Services
- Where a young person in a secure establishment is receiving a service from CAMHS via a mental health 'in-reach team' the transition will occur as the young person moves into an adult secure establishment
- Children's Commissioners must be informed when the transition process begins for young people who are resident in a Secure Children's Home on welfare grounds to ensure that appropriate accommodation is sought alongside the Adult Services Commissioner.

6.8 *Young People in Drug and Alcohol Services*

- Where young people with mental health difficulties are being seen by CAMHS and the above services, the Care Co-ordinator must ensure that transition to the appropriate service is undertaken at the appropriate time, following the guidance in this document.

6.9 *Young People requiring Psychiatrist Only services*

- In cases where medication only reviews are provided by CAMHS, the CAMHS Consultant Psychiatrist is required to liaise with the Adult Consultant Psychiatrist, following the guidance in this document.

6.10 *Young People transitioning from Community Paediatric provision*

- Where young people are open to Community Paediatricians and are expected to require ongoing support for a long term condition transitions should start at school year 9.

- Where there is no equivalent adult team to transition to the young person will be transitioned to the GP.

6.11 *Young People transitioning from Children's Therapies Services (Occupational Therapy, Speech and Language Therapy and Physiotherapy)*

- Where Young People Are open to therapy services transitions to adult services will be initiated at school year 9.
- Where there is no equivalent adult team to transition to the young person will be transitioned to the GP.

6.12 *Young people with Long Term Conditions*

- National and Regional pathways exist for some Long-Term Conditions (ie Cystic Fibrosis & Oncology) – pre-planning will take place and the transition point will be agreed with Young Person, Family, and appropriate care teams including local acute providers
- Where National and regional pathways do not exist more local arrangements for both medical and nursing cover will be arranged. Intermediate Care Team or Community Nursing Teams may be involved and a period of handover (approx 3-6 months) will be undertaken to ensure care planning, supply of equipment, consumables and competency assessment can be undertaken. This allows a period of discussion and familiarisation to take place for the Young Person, families and the receiving team.
- Medical handover is the responsibility of the GP, Acute and/or Tertiary Centre.

Young People whose needs are overseen by Specialist School Nursing provision

- All Young People leaving school are discharged annually (or sooner if school placement is terminated). Where children have specific (health) requirements and adult services are available, appropriate referrals are made and transition planning is undertaken.
- As Young People progress through older teenage years, where appropriate, the CTPLD Children's Team will commonly be involved in providing a service for them, and transition arrangements as delineated in section 6.15 are followed.
- Children who do not have specialist health needs at the time of their transition (often to college placements) are discharged back to their GP.
- Where feeding management and equipment is required a Dietetic Pathway is in place and should be followed.
- Where there is an ongoing requirement for other equipment (e.g. suction machine etc) a referral will be made by the SSN to Community Nursing and a period of joint working will be undertaken to ensure smooth transition, before the young person is discharged from the service.

6.14 *Young people in receipt of Short Breaks*

- Short Breaks is commissioned and placement-managed by NCC. From the age of 17 discussion will be held with Young Person, Families, Short Breaks Service, Education and NCC to identify what provision may be required post 18. (The age is determined by NCC guidance.)

- Alternative Short breaks or full time provision is sought from age 17.5 and is the responsibility of the designated Social Worker.
- Short Break provision can advise and aid the transition by providing staff for transition visits, care planning and support to Young Person, Family and receiving Unit.

6.15 *Young people with a Learning Disability being seen in the CTPLD Children's Team*

- The CTPLD Children's Team (Community Nursing and Psychology) will continue to provide a service for Young People with a Learning Disability if required, until the age of 19 years.
- Any referrals received for Young People aged 18 at the point of referral will be forwarded to the CTPLD Adult Team.
- If an active case remains open at 18yrs and 6mths the responsible clinician will need to plan a transition to the Adult Team and have a clinical meeting with the appropriate Clinical Lead from the CTPLD Adult Team to agree a Transition Plan and date.
- Any referrals on the waiting list that reach the age of 18 should be transferred to the CTPLD Adult Team waiting list. They will not be prejudiced by the length of time for which they have been waiting, and will be incorporated into the CTPLD Adult Team waiting list with the original date of referral being used to determine the point of entry.
- The CTPLD Children's Team aim will make decisions about transitions based on the best interests of the young person and the application of common sense, (e.g. where a long-term therapeutic provision for a young person with attachment difficulties is due to end just beyond the age typically seen by the CTPLD Children's Team, they will remain in the team until the intervention is concluded. Similarly such a case presenting just before the age at which transition is appropriate, would be redirected to the CLPLD Adult Team.
- Complete and up to date information on all cases transitioned from the CTPLD Children's Team must be recorded on SystmOne prior to transition.

6.16 *Young people with Continence problems*

- Young people with on-going continence issues requiring product provision will be identified from age 17. Twice yearly transition meetings between Children's and Adults' Continence Services take place in a timely fashion for individual Young People to ensure the seamless supply of products.
- Adult services will undertake an assessment following twice yearly 'transition meetings' meetings to determine service provision during adulthood.

6.17 *Early Intervention in Psychosis (NSTEP)*

- *All young people in NSTEP have a CAMHS responsible medical officer they therefore follow the CAMHS transition*

6.18 *Young people with emerging personality difficulties/disorder.*

- Young people will also be open to CAMHS and should therefore follow the CAMHS transition pathway

6.19 Family Nurse Partnership

- Please see appendix three for the transition pathway.

6.20 Young People with Gender Dysmorphia

- Young people will also be open to CAMHS and should therefore follow the CAMHS transition pathway

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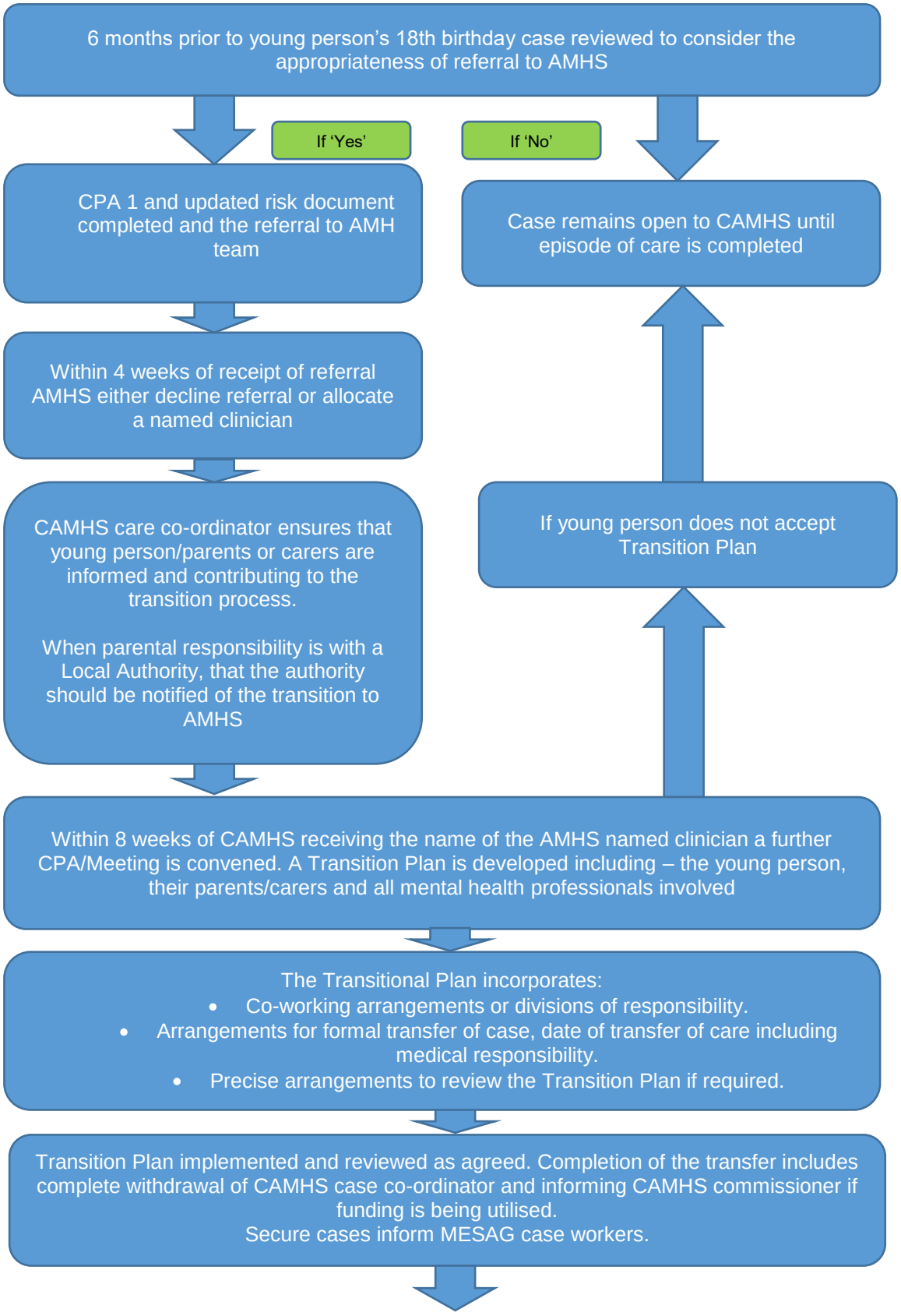
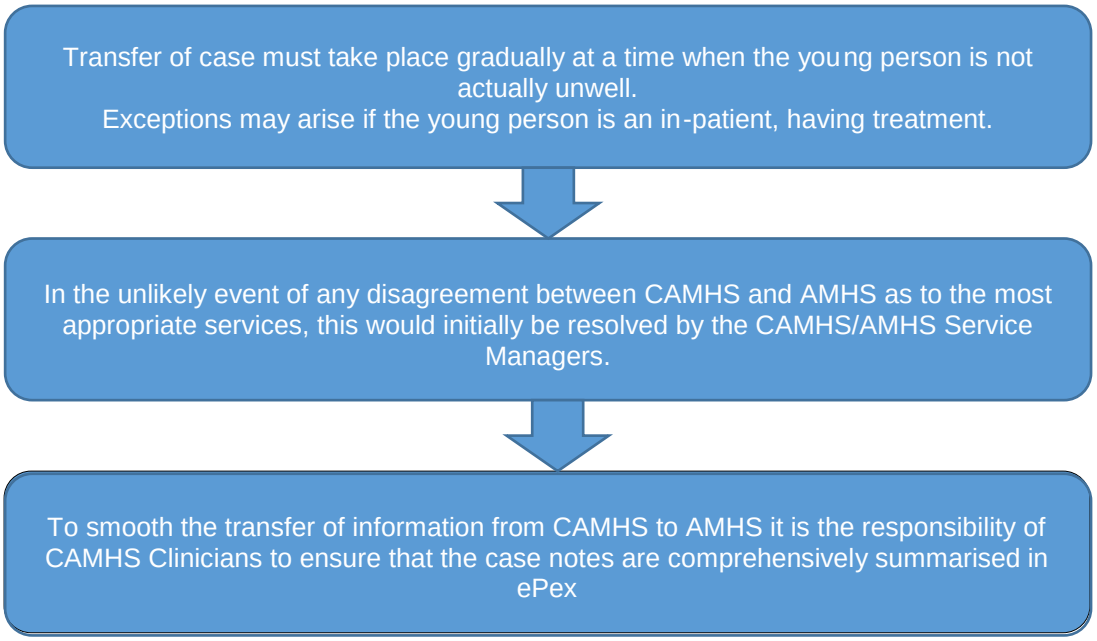
APPENDICES:

Appendix 1: CAMHS to AMHS Flow Chart

CAMHS Transition Standards Flow Chart




Transfer of case must take place gradually at a time when the young person is not actually unwell.
Exceptions may arise if the young person is an in-patient, having treatment.
In the unlikely event of any disagreement between CAMHS and AMHS as to the most appropriate services, this would initially be resolved by the CAMHS/AMHS Service Managers.
To smooth the transfer of information from CAMHS to AMHS it is the responsibility of CAMHS Clinicians to ensure that the case notes are comprehensively summarised in ePex

Appendix 2(a):

Dear Intake & Assessment Team Manager

Re: Notifications to Children and Young Peoples Services under Section 85 Of the Children Act 1989

Name/DoB/Address/Date of Admission/Contact Details (Parents/Carers)
Ward/Department/Residential Establishment

Under Section 85 of Children Act 1989 I would like to inform you that the above child is likely to be accommodated for a period of three months/has been accommodated in a residential establishment for a period of three months/has now been discharged from the residential establishment.

Date of Discharge ……to (address)……

This is a routine notification.

An assessment of the child and family's needs are required because ……

His/her parents/carers are/are not aware of this notification.

Yours sincerely

Named Nurse Child Protection
cc.
Child's Notes
Parents/carers

Appendix 2(b) **TRANSITION TEMPLATE** **CPA 1** Date:…….

Age:…… Age in 6 months
……. ……

Name NHS No
…… ……

Patient I.D. No
.....
.

Address
……
.....
.
……

Parents/Carers
……
……
…….....
..

Care Coordinators
……..
…….....
..

Legal Status or Young Person

……

……..

Mental Health Act …… Children's Act ……..

Section……. Section…….

From……. To …… From……. To ……

Who Has Parental Responsibility

……...

Young Person and Parents/Carers Informed of Transition

Process

By Whom

…… ……

When

……

Service User Signature Parents/Carers Signature

…… ……...

Referral to Adult Mental Health

Services

By Whom…….

When……..

Who Referred

……

Acknowledgement from Adult Mental Health Services

Date

……

Accepted

……

Declined

……

Adult Services invited to CPA

By Whom …….

When ……

Informing Others of Transition Process

			Date
Mental Health Act Office	☐	☐	……
Local Authority	☐	☐	……
Commissioners	☐	☐	……
Others	☐	☐	…….

2nd Transitional CPA

Date ……..

Name of Adult Mental Health Case Coordinator

……

Transition Plan Developed

Date

……

Is a Discharge CPA Being

Convened? Date

……

Formal Handover to Adult Mental Health Service

Date ……

	Yes	No	Date
GP Informed	☐	☐	……
Local Authority Informed	☐	☐	
Mental Health Office Informed	☐	☐	
Commissioners Informed	☐	☐	
Others Informed	☐	☐	

Appendix 3:

FNP GRADUATION PATHWAY.docx

Equality considerations

The Trust has a duty under the Equality Act and the Public Sector Equality Duty to assess the impact of Policy changes for different groups within the community. In particular, the Trust is required to assess the impact (both positive and negative) for a number of 'protected characteristics' including:

- Age;
- Disability;
- Gender reassignment;
- Marriage and civil partnership;
- Race;
- Religion or belief;
- Sexual orientation;
- Sex;
- Pregnancy and maternity; and
- Other excluded groups and/or those with multiple and social deprivation (for example carers, transient communities, ex-offenders, asylum seekers, sex-workers and homeless people).

The author has considered the impact on these groups of the adoption of this Policy This document is for young people aged between 16-18 and will affect commissioner clinicians and carers in the CAMHS (Child , Adolescent Mental Health Service), Adult Mental Health services in Northamptonshire and al specialist and universal children's services.

It is intended to ensure that young people and/or their parents/carers mental health and/or physical health needs in terms of transition to other services are met in a clinically appropriate and timely way. This Policy may mean that transitions for Children and Young People with protected characteristics are a feature would benefit from a joined up approach to transitions.

(a) Line Managers should ensure that staff returning from maternity or paternity leave are given time to update themselves on any changes made to the policy.
(b) Equality Considerations - Should the reader of this policy or any other group believe they are disadvantaged by anything contained in this policy, please contact the Equality & Inclusion Manager, who will then actively respond to the enquiry.