



Policy for Transition out of Children and Families Health Services (Including Standard Operating Procedure for Ready Steady Go)

POLICY NUMBER	POL/001/011
DATE RATIFIED	3 rd October 2016
DATE IMPLEMENTED	4 th October 2016
NEXT REVIEW DATE	October 2019
ACCOUNTABLE DIRECTOR	Director of Quality and Nursing
POLICY AUTHOR	Quality & Safety Lead, Children's Specialist Network

PLEASE NOTE THAT THIS POLICY IS LINKED TO CPFT AGE APPROPRIATE ADMISSIONS POLICY WHICH IS OUT OF DATE AND AS IT IS A PAN-CUMBRIA POLICY IS IN THE PROCESS OF BEING REVISED

Important Note:

The Intranet version of this document is the only version that is maintained.

Any printed copies should therefore be viewed as “uncontrolled” and, as such, may not necessarily contain the latest updates and amendments



TABLE OF CONTENTS

1. SCOPE..... **Error! Bookmark not defined.**

2. INTRODUCTION.....3

3. STATEMENT OF INTENT..... **Error! Bookmark not defined.**

4. DEFINITIONS..... **Error! Bookmark not defined.**

5. DUTIES **Error! Bookmark not defined.**

6. DETAILS OF POLICY.....6

7. DISAGREEMENTS **Error! Bookmark not defined.**

8. TRAINING **Error! Bookmark not defined.**1

9. MONITORING COMPLIANCE WITH THIS POLICY.....12

10. REFERENCES/ BIBLIOGRAPHY **Error! Bookmark not defined.**

11. RELATED TRUST POLICY/PROCEDURES..... **Error! Bookmark not defined.**

12. EQUALITY IMPACT ASSESSMENT..... **Error! Bookmark not defined.**

APPENDIX 1 – TRANSITION MONITORING FORM 15

APPENDIX 2 – PROCESS SUMMARY.....18

1. SCOPE

This policy is aimed at all professionals working in Children and Families Care Group including CAMHS, Community and Specialist Care networks and Adult Health Services.

2. INTRODUCTION

This policy applies to all young people who are currently receiving input from children's health services and who have long term conditions that are likely to persist into adulthood. Young people with long term conditions may or may not need further intervention from adult services after their 19th birthday.

Transition is described as the purposeful, planned process that addresses the medical, psychosocial and educational/vocational needs of adolescents and young adults with chronic physical and medical conditions as they move from child-centred to adult orientated health care systems. (Society of Adolescent Medicine 2003) Transition should not be confused with transfer, which is a single event whereby the young person's care is transferred from one service to another.

Through consultation with children, young people and their families, it is recognised that young people require a process to prepare them for moving on from the relatively protective context of Children's health services in order to prepare them for taking responsibility for their own ongoing health care needs.

Transition plans are most frequently needed for young people with long term conditions whether or not they are likely to require support from adult health services either immediately or in the future. Where it is anticipated that a young person does not need to transfer immediately into adult health services, or in cases where an equivalent service does not exist within adult health, a transition plan is still required prior to discharge from children's services to identify the young person's ability to understand the implications and impact of their condition, and their knowledge and understanding of how to access further assistance from health services as and when required.

The following protocols should be followed for young people who are currently under the care of Children's Specialist Health Services and CAMHS and should be used in conjunction with the Cumbria Transition Protocol.

The transition process for Cumbria Partnership Foundation Trust utilises the **Ready Steady Go** programme which consists of an information leaflet for young people, a series of questionnaires, and a transition plan. On completion, the questionnaires provide information to enable the completion of the transition plan which is held by the young person with a copy kept within the patient record. This can be used to inform any future health, education or social care professionals of the young person's level of need and ability to take ownership for their own care. Also available is the **Hello** to adult services which can be introduced by Adult Health Services to give a clear overview of the young person's ongoing needs.

It is essential that the transition process is tailored for each young person's individual need and is introduced appropriately and in a timely manner. The transition process must be centred on the voice of the young person and clearly state their opinions and views.

Transitional arrangements for health needs should be considered alongside social and educational/vocational needs with particular reference to the Special Educational Needs and Disability reforms (SEND reforms). The **Ready Steady Go** programme is holistic and addresses physical, psychological and social elements of moving on from Children's Services.

The following guidelines can be used to facilitate professionals, along with the child/young person and family, to make an informed clinical judgement and joint planning around the transition process.

This protocol is written with direct reference to the National Service Framework for Children, Young People and Maternity services (Standard 4) and should be used in conjunction with:

- the Special Educational Needs and Disability Reforms which have been put in place as a result of the *Children and Families Act 2014*.
- The Cumbria Transition Protocol

3.STATEMENT OF INTENT

This policy is based on the following principles:

- The focus of transition is on the young person's needs and desired outcomes.
- Young Service Users and their families/carers will have a smooth transition into Adult Health Services where this is applicable.
- Children's Health Services will have already provided relevant evidence-based interventions for the young person's health problems.
- Young Service Users and their families/carers will be actively empowered to identify their needs and be fully involved in the decision making process.
- During transition, Young Service Users and their families/carers will be able to work with Children's and Adult Health Services staff to develop a care plan that meets their individual needs and pace of ability to change. Care plans should be consistent with relevant approaches used in Children and Families Care Group.
- Clinical responsibility must be made explicit to all parties.
- Inter-agency arrangements will be made in ways which are consistent with the right to confidentiality.
- Delay in assessment or treatment is detrimental to a young person's mental or physical health and future engagement.
- Due to commissioning arrangements there are currently times when an individual may be leaving child services and there is not a commissioned adult equivalent i.e. there is a gap in commissioned services.
- Based on the joint multi agency principles:

- a. Clear aims, goals and outcomes for transition
- b. Multi-disciplinary working which begins with integrated commissioning
- c. Single most appropriate person has a coordinated role – nominated lead
- d. Planning for the future, not just the current – short, medium and long term targets
- e. Focus on keeping the child/young person safe
- f. Time to invest in individuals and families
- g. Young person should be at the center of transition (holistic): ‘it’s all about me’.

4. DEFINITIONS

CAMHS – Child and Adolescent Mental Health Services

AMHS –Adult Mental health Service

CMHART – Community Mental Health Assessment and Recovery Team

EIP – Early Intervention Psychosis Services

Children’s Services – Cumbria County Council Children’s Services

SEND –Special educational needs and disability

RiO –Electronic Patient Record

Transition - the purposeful, planned process that addresses the medical, psychosocial and educational/vocational needs of adolescents and young adults with chronic physical and medical conditions as they move from child-centred to adult orientated health care systems.

5. DUTIES

All clinicians and practitioners have a duty to collaborate to ensure seamless transfer from Children’s to Adult Health Services when this occurs.

Children and Young Peoples’ Physical Health Services’ Responsibilities

- The lead health professional will initiate and coordinate the **Ready Steady Go** process to ensure that contributions are made by all relevant members of the multi-disciplinary team.
- Members of the multi-disciplinary team will liaise with each other and with the child/young person and family to facilitate the transition process

Adult Physical Health Responsibilities

- Health professionals within the adult sector have the responsibility to liaise with colleagues in Children and Families Care group to attend joint appointments where appropriate and have an awareness of the **Ready Steady Go** documentation. Where necessary, adult health professionals should introduce the **Hello to Adult Services Documentation** in order to develop a client led health care plan.

Adult Mental Health Services Responsibilities

- The relevant AMHS manager will respond within 2 weeks of receipt of the transition request.
- A Care Co-ordinator will be identified who will arrange an initial meeting to discuss the requested transition and to identify those persons and agencies required to be involved in the Transition process.

CAMHS Responsibilities

- The CAMHS Care Co-ordinator is responsible for organising the transition and is ultimately responsible for its co-ordination until an agreed date for formal handover is reached and the young person is discharged from CAMHS.
- CAMHS must ensure that a young person transitioning to AMHS is well prepared, using the Ready Steady Go protocol and information sheets.
- The CAMHS Care Co-ordinator must ensure that the young person and, if appropriate, family or carers, are included in and consulted on any relevant transitional meeting and Care Planning. They must be consulted throughout the transition process and advised of the transfer date.
- The CAMHS Care Co-ordinator will have a responsibility to ensure that within the transitional process and care planning that any goals/objectives and timescales are met.

Responsible Consultant Status (Mental health)

Responsible Consultant status will transfer from the CAMHS Consultant, should they be involved, to the AMHS Consultant and both parties must be invited to attend any relevant CPA or Transition Meeting

6. DETAILS OF THE POLICY

6.1 Ready Steady Go Programme

The Ready Steady Go programme should be considered initially as the programme of choice when transition from Children and Young People's Physical or Mental Services is being considered (See sections 6.1 and 6.2 for guidance on age). This is a holistic programme which is designed to improve a young person's knowledge about their condition and confidence to take ownership and responsibility for their own well-being once adulthood is reached. Documentation for the Ready Steady Go programme is

available on sharepoint and the Standard Operating Procedure can be found in Appendix 2 of this document.

<http://cptportal.cumbria.nhs.uk/SiteDirectory/ChildrensServices/Shared%20Documents/Fo rms/AllItems.aspx?RootFolder=%2fSiteDirectory%2fChildrensServices%2fShared%20Doc uments%2fready%20Steady%20Go%2dTransition&FolderCTID=&View=%7b14EBCFBF %2dE7C8%2d42BF%2d9FB1%2dE791EC41716C%7d>

Each service is required to follow their standard operational procedure to ensure appropriate risk assessment and discharge/transition planning prior to discharge.

The **Hello to Adult Services** documentation is available for use by adult services and should be approached in the same way as the **Ready Steady Go** Programme. The **Hello** questionnaire gives an overview of the service users understanding of their condition and will facilitate in the development of a client led health care plan.

6.2 Initiation of Transition Process

The **Ready Steady Go** plan should be initiated at an appropriate time for each individual child. For those with physical health problems, the recommended age to initiate the transition process is at age 11 years. This is in line with the transition process within education that is recommended for children and young people with special educational needs and disability.

In circumstances where the young person has begun to use services after their 14th Birthday, (e.g. having moved into the area, acquired brain injury etc.), transitional arrangements need to be considered depending on the nature of the young person's condition and reasons for referral into children's physical health services.

Good practice indicates that when a young person is to transition from CAMHS to AMHS preparation should be initiated at least one year in advance. (Hascas (Health and Social Care Advisory Service) Tools for Transition (DoH 2002)). However, where appropriate this transition process can commence six months before the planned move. All young people receiving Child and Adolescent Mental Health Services will be screened at an appropriate time with regard to them requiring ongoing treatment from AMHS.

The decision to proceed with the transition programme should be made in collaboration with the young person and their family and a named transition worker should be identified in collaboration with the young person's wishes. Where multiple professionals are involved, the named transition workers should act as the point of contact and should initiate and coordinate the transition process. Where appropriate, health transition should be introduced and discussed at multidisciplinary meetings such as a Team around the Child

meeting. In the case of young people accessing CAMHS, the process is facilitated by the CAMHS care coordinator.

Throughout the process, consideration will need to be given to adult services that the young person may need to transfer to as part of the process. Within Mental Health services this may include social care, LD team, 3rd Sector, Adult Mental Health etc. In the cases of both mental and physical health, there may not be equivalent services into which a child can transfer. However, in these cases, transition planning is important to ensure that the young person has a full understanding of their condition and how to access support if necessary. The **Ready Steady Go** programme continues to be relevant even if the young person is transitioning back into the care of their G.P. In these cases, the involvement of the G.P in multidisciplinary meetings and EHCP/ transition planning meetings is crucial. G.Ps must receive feedback from the meetings in all cases, regardless of the availability of equivalent adult services.

This document also applies when a young person is an inpatient in a CAMHS Unit and requires a Transition to an adult mental health bed in accordance with the Age Appropriate Admissions Policy (2010)

6.3 Transferring to Adult Services as part of Transition Process

Throughout the course of the transition process, it will become apparent which adult services, if any, the young person needs to be introduced to.

As appropriate for each service, children and families care group should work jointly with colleagues in adult services using the **Ready Steady Go** documentation and guidelines as outlined in this document

At this point, the appropriate health professional(s) should contact any relevant adult services in order to enable proactive caseload planning. Each health professional should take on responsibility for transition arrangements into the equivalent adult service for their own profession. The named transition workers should maintain oversight of this process.

If the young person has been receiving treatment from Tier 3 CAMHS, the initial referral to AMHS will be made through the CAMHS Care Co-ordinator via the CMHART Single Point of Access Service referral form. Where the young person has not been fully assessed by CAMHS prior to Transition, the referral should be made to the CMHART Single Point of Access Service

Following the transfer, the named transition worker should be available to support the young person as necessary for 6 months. Practitioners should follow their local standard operating procedures for ending an episode of care/discharging.

6.4 Transitional Process

The principles of the transitional process remain consistent across the Trust regardless of the services involved. The information leaflet should be made available to the young person and their family and a description of the process should be made. The **Ready Steady Go** process is gradual and the questionnaires are not designed to be completed at one sitting. Rather, they should be used as a guide and a prompt to discuss aspects of a child/young person's understanding of their condition and potential challenges to daily life. Details of the process are recorded in the Process Summary in Appendix 2. However, there are operational differences as described in the following section:

6.4.1 Mental Health Services

Once there is an identified care co-ordinator from the relevant AMHS, an initial meeting will be held between the CAMHS Care-co-ordinator and AMHS Care Co-ordinator in order to identify any relevant professionals/agencies who will need to be included in the formal transition meeting.

The **Ready Steady Go** documentation should be introduced by the CAMHS care co-ordinator at a Review of Care Plan meeting. Flexibility and clinical judgement should be applied when considering the appropriateness for using all 3 questionnaires when young people have entered the CAMH services in the latter stages of their teenage years. Some young people may need to progress rapidly to the GO stage as appropriate to the young person's needs. Any young person who has begun to engage with the ready Steady Go programme should have this denoted on the Electronic Patient Record (RiO)

The transition meeting will be arranged and chaired by the CAMHS Care Co-ordinator. This transitional meeting will include:

- (i) Involvement of the young person and if relevant the family or carer and other relevant parties.
- (ii) An agreed care plan for transition which sets out the goals and timescales. This will be drawn up jointly by the CAMHS care co-ordinator and the young person. The timing of the care plan should reflect the needs of the young person.
- (iii) The devised care plan needs to be followed according to agreed goals, activities and timescales.
- (iv) An agreed date set for a Review Meeting for the formal handover of care from CAMHS to AMHS. At this meeting all relevant parties will ensure that the package of care has been successfully transferred to the Adult Mental Health Services.
- (v) The CAMHS Care Co-ordinator will remain as care-co-ordinator until the care of the young person is fully transferred to the relevant Adult Mental Health Service Care Co-ordinator and the young person is discharged from the CAMHS Service.
- (vi) After 6 months the CAMHS Care Co-ordinator will contact the relevant services and/ or young person to follow-up that the transition process has been successful (Added from Tier 3 Specification for Child and Adolescent Mental Health Services Section 3.9.2 on page 32)

(vii) Transition will only be completed when all relevant documentation has been completed to the satisfaction of the Adult Care co-ordinator and CAMHS Care Co-ordinator and information databases amended appropriately. This includes transfer of the care records with the client to the appropriate AMHS.

6.4.2 Physical Health Services

The **Ready Steady Go** documentation should be introduced by the named transition worker, ideally at a Team around the Family meeting. All professionals involved in the care of the young person should be aware of the initiation of the process and this should be denoted on the Electronic Patient Record (RiO).

6.5 Advocacy

Where the young person has severe or profound learning difficulties or communication difficulties, or lacks mental capacity, it is appropriate to use advocacy. This can be arranged on an individual basis, according to need, and the questionnaires can be completed on the young person's behalf by the parent or carer. It is important for young people who are dependent on their carers for all their daily needs that their carers have a full understanding of all the issues that are discussed throughout the **Ready Steady Go** programme. If questions are not applicable, they can be omitted but should be used as a platform to open conversations on related subjects that have not been previously addressed.

6.6 If ongoing care is not necessary

If it is appropriate to discharge the young person from health services, the **Ready Steady Go** process should be followed to ensure that the young person is aware of how to access services if the need arises. In CAMHS this would involve a relapse prevention/sustainability plan.

6.7 Children Looked After (CLA) Out of Area

Where Cumbrian children are residing in placements out of county and there is no input from health professionals other than the CLA team, it is the responsibility of the placing authority to initiate the transition process. Transition planning should take place in accordance with NICE Guidelines (PH28) Looked-after children and young people and The Children Act 1989: transition to adulthood for care leavers.

6.8 End of Episode of Care

When a young person, accessing Children's Therapy Services or Learning Disability services, has ended an episode of care but it is anticipated that he/she will require adult services in the future, the referral route must be made explicit to the young person and/or their family and relevant adult services must be made aware.

6.9 Non-engagement with Adult Services

If, following transfer to adult services, the young person does not engage with health services and regularly does not attend meetings and appointments, the relevant adult service should work within safeguarding protocols to:

- Attempt to contact the young person and their family
- Follow up with the young person
- Involve other relevant professionals, including the G.P.

Re-referral to services should be undertaken where appropriate and the care should be reviewed to support the young person to access services according to need and to work with the young person to explore alternative ways to meet their ongoing needs.,

In the interest of consistency, the same healthcare practitioner should undertake the first two appointments with the young person following transfer.

6.10 Equipment

Where young people leave children's specialist services but still require the use of medical equipment that has been provided by the Trust, the arrangements for maintenance, replacement and review must be made explicit to the young person and/or their family and the appropriate documentation completed. Details of the equipment the young person requires should be clear in the transition plan. Adult services must be made aware of any arrangements agreed with the young person and/or their family including arrangements for maintenance and clinical review.

7. Disagreements

The aim of this protocol is to ensure the needs of the young person are met at a time of transition out of children's health services. All people employed in the Trust have a responsibility for ensuring the needs of the young person are met by the most appropriate services. This process relies on the exercise of clinical judgement and good relationships between teams and agencies to ensure that the young person receives the best service possible. Even so, there may be instances where agreement cannot be reached and there is a difference in opinion as to the best way to meet the young person's needs. Where this is the case:

- The clinician should inform the service manager for their service when it appears there is a disagreement on how best to meet the young person's needs. At all times the views and needs of the young person must be actively taken into consideration.
- The relevant service manager and clinicians must attempt to resolve the dispute and involve the clinicians in the resolution process.
- Disputes should be resolved quickly but if no resolution is agreed, the Children's services manager must consult with the appropriate Adult Health service manager and a plan agreed to resolve the disagreement.

- In the case of unresolved Cross Trust/Agency disagreements advice should be sought from senior Trust managers.
- The young person and carers will be given timely information and their views will be taken into account. The young person has the right to make their views known and should be assisted to do so by an independent advocate e.g. PALS Officer, advocacy services, should they wish. Where appropriate the young person must be given advice on how to make a formal complaint and assistance must be provided by an independent advocate

8. TRAINING

All clinicians should have an awareness of the **Ready Steady Go** programme and **Hello to Adult Services** programme. The Ready Steady Go programme is included in the Children and Families Induction for new staff. Awareness of the transition policy in adult and children’s teams is required as is annual audit and review of the audit findings

9. MONITORING COMPLIANCE WITH THIS POLICY

The table below outlines the Trusts’ monitoring arrangements for this policy/document. The Trust reserves the right to commission additional work or change the monitoring arrangements to meet organisational needs.

Aspect of compliance or effectiveness being monitored	Monitoring method	Individual responsible for the monitoring	Frequency of the monitoring activity	Group / committee which will receive the findings / monitoring report	Group / committee / individual responsible for ensuring that the actions are completed
<p>One audit of following standards:</p> <p>Evidence of referral letter from Children’s to Adult Services where input from Adult services is necessary</p> <p>Evidence of transition beginning at appropriate time for the young person i.e. before 14th birthday for young people with long term conditions. Where young person has entered the service</p>	<p>Audit of standards</p> <p>10% sample of all people undergoing transitions in a 12 month period.</p>	<p>Clinical services Managers CAMHS/Children’s services</p>	<p>Annually</p>	<p>Children and Families NICE/Clinical Audit sub-group which will feed into Children and Families Clinical Governance</p>	<p>Children and Families Director of Operations</p>

<p>after the age of 14 years, a clinical judgement is made as to the timeliness of the commencement of transition planning. (In CAMHS, this should be at least 6 months prior to discharge and Holistic assessment of need template must be completed</p> <p>Evidence of population of ready, steady and go questionnaires plus Final transition Plan</p> <p>Evidence in patient record of young person being actively involved in transition arrangements</p> <p>Evidence of period of joint working with adult services where appropriate.</p> <p>Evidence of a Care co-ordination review carried out within 6 weeks after transition followed up after six months to check that the transition has proceeded smoothly (CAMHS only)</p>					
---	--	--	--	--	--

10. REFERENCES/ BIBLIOGRAPHY

http://www.hascas.org.uk/pdf_files/HASCAS%20tools%20for%20transition%20Lit%20Review.pdf

http://www.rcpsych.ac.uk/pdf/Transition_2008.pdf

<http://www.uhs.nhs.uk/OurServices/Childhealth/TransitiontoadultcareReadySteadyGo/Transitiontoadultcare.aspx>

<http://www.uhs.nhs.uk/OurServices/Childhealth/TransitiontoadultcareReadySteadyGo/Hello-to-adult-services.aspx>)

11. RELATED TRUST POLICY/PROCEDURES

Mental Health Act and Young Person's Admission Policy

APPENDIX 1 – TRANSITION MONITORING FORM
To be completed by CAMHS

Name of Service User:	
Date of Birth:	Age:
Address:	
GP Name and Address:	
CAMHS Consultant:	
Adult Mental Health Consultant:	
Diagnosis / Mental Health Difficulties:	
Current CAMHS Worker/s:	
Other Professionals Involved:	
Reason for Transfer of Care:	
Date Notice Received by CMHT:	
Care Co-Ordinator Allocated:	
Date CAMHS Worker Informed:	
Agreed Care Co-Ordination Date and Venue:	
Date Transition Completed:	
Date of 6 month follow up:	

Appendix 2 - Process Summary

A link can be added to the Clinical Portal of a Patient Record to notify health care professionals that the Ready Steady Go programme has been initiated. Please refer to RiO guidelines for details of how these can be added.

At each stage, the Ready Steady Go documentation is completed electronically on RiO. Identical information is recorded on the Ready Steady Go Questionnaire which is held by the child/young person or advocate/family.

What should happen?	When?	Who should do it?	Why?
Identification that young person is ready to start transition process	From age 11 years (Physical Health) or When care plan indicates (CAMHS)	Team around the Child/Paediatrician/ CAMHS Care Co-ordinator	To begin the process which will help the child start to develop an understanding of his/her condition
Named transition worker identified to initiate RSG process with the young person's view taken into consideration.	From age 11 years (Physical Health) or When care plan indicates (CAMHS)	Team around the Child/CAMHS Care Co-ordinator	To coordinate and maintain the ongoing RSG process
Patient Information leaflet introduced at next appointment with verbal explanation of transition	From age 11 years (Physical Health) or When care plan indicates (CAMHS)	Named transition worker/ CAMHS Care Co-ordinator	To explain the transition process
Denote process has commenced on RiO Demographic page	When agreement for the commencement of RSG has been made	Named transition worker/CAMHS care coordinator	To ensure all Health Care Professionals are aware and able to contribute to the process.
Arrange appointment to introduce "Ready" Questionnaire and Parents Questionnaire	From age 11 years (Physical Health) or When care plan indicates (CAMHS)	Named transition worker/ CAMHS Care Co-ordinator	To initiate the transition process for both CYP and parent /carer
Continue to work through the Ready Questionnaire with the young person. The issues are not addressed in a single consultation but over the following 1- 2 years in 'bite sized pieces' at a pace	At age 11-13 years and at each appointment that the young person attends.	All health professionals involved with the young person can address questions appropriate to their own field of expertise.	To assess their knowledge of their condition, treatments and that they know who does what in their healthcare team. To support the development of self-advocacy.

appropriate for the young person and carer. Goals should be set with the young person where necessary and recorded on the transition plan. The Ready Questionnaire is added to on RiO.			<p>To develop an understanding of the issues around a healthy lifestyle, sexual health and where relevant pregnancy.</p> <p>To review educational and vocational issues to ensure the YP has high but also realistic expectations and has a plan to achieve their potential,</p> <p>To identify and address any psychosocial issues</p> <p>To develop an understanding of the concept of transition</p>
Progress and goals are documented in the transition plan by the healthcare professional which remains in the patient record.	Throughout the RSG process	The healthcare professionals involved in the young person's care/ CAMHS Care Co-ordinator	To monitor progress.
Completion of Ready questionnaire	Age 13 (Physical Health) or When care plan indicates (CAMHS)	Healthcare professionals with the young person/ CAMHS Care Co-ordinator	To give clarity around progress and future goals.
Initiate and progress through the "Steady" questionnaire	Age 13-14 years (Physical Health) or When care plan indicates (CAMHS)	Named Transition worker in liaison with the Team around the Child/ CAMHS Care Co-ordinator	To monitor progress on existing issues and ensure that any new issues that may arise are also identified and tackled at an appropriate pace over the following two years, again with agreed targets and goal setting.
Completion of Parental Questionnaire again (optional)	Age 13-14 years	Parents/Carers	To ensure issues are addressed.

Initiate the “Go” questionnaire. Any issues are highlighted and, once again, goals are agreed and actioned over the next couple of years in preparation for the move from children’s services.	Age 15-16 years (Physical Health) or When care plan indicates Go questionnaire should be implemented for transition to other services. If transfer is to adult services, this should be at age 17 (CAMHS)	Named Transition Worker in liaison with the Team around the Child/ CAMHS Care Co-ordinator	To ensure that they have all the skills and knowledge in place to take ownership of their condition and access adult services confidently where necessary.
If it is necessary to access Adult services, the young person is introduced to the adult team.	Age 15-16 years, at least a year prior to transfer. Ideally this should happen earlier in the programme if resources permit. The actual timing of the move to adult services is one that is mutually agreed by the young person, parents or carers and medical professionals. Where children are looked after (CLA) the plan and transition date will need to be included in their annual CLA review medical assessment for Young People (BAAF YP).	Appropriate health professional(s)/ CAMHS Care Co-ordinator	To prepare the young person and his/her parents/carers for the change in health professionals. To introduce the adult team and ways of working which are unfamiliar to the young person. To allow the adult team to develop an understanding of the young person’s needs. To highlight ongoing issues to the adult team.
Transition plan is completed and a copy is given to the young person	Age 18-19 years	Lead health professional/ CAMHS Care Co-ordinator	To inform future health professionals of any ongoing needs
Hello questionnaire is provided to the young person	On entry to Adult services	Named Transition Worker in adult services	To update and inform on young person’s ongoing needs

Version Control

Version	Amendment	Requested by	Undertaken by	Date
0.1	Original Document	n/a	HW	21.01.15
0.2	Amendments to section 6. Rearrangement and rewording of information Bullet points added.		HW	02.02.15
0.3	Amendments to wording in CAMHS section. ASddition of links	Una Parker	HW	02.02.15
0.4	Additions to table 2.1	Una Parker	UP	02.02.15
0.5	Amendments to section2. Removal of table 2.1.	UP,HW, AS	HW	10.06.15
0.6	Removal of superfluous text in section 6 with view to inclusion in SOP. Change of layout of information	EA, UP, HW, AS	HW	15.06.15
0.7	Minor text change to section 6	HW	HW	25.06.15
0.8	Text amendment section 6.2	Elaine Audini	HW	17.07.15
0.9	Transferred to new template. Amendments to CAMHS. Rearrangemtn of document to improve clarity and integrated approach across physical and mental health	LW, HW,UP	HW	17.11.15
1.0	Addition of SOP	HW, LW,RD	HW	10.03.16
1.1	Repair of links. Updating of definitions. Headings changes.	Dr Wendy Rankin	HW	01.06.16
Final version	Additional Text –section 6.7 and 6.9. Cover and title changes	NICE guidelines	HW	07.07.16

UP, Una Parker, Lead Psychologist
 HW, Helen Walker, Quality and Safety Lead, Children’s Specialist
 EA, Elaine Audini, Quality and Safety Lead, CAMHS
 LW,Lindsay Wright, Interim Quality and Safety Lead, CAMHS
 RD, Rachel Doherty, Occupational Therapist