NHS SCOTLAND

Responsibilities of Services to Ensure Good Transition

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Best Practice Statement
To ensure the smooth transition allowing a continuous episode of care of young people from their existing service to their next service.

Responsibilities for Referring Service to lead on

Responsibility	Date completed
Prospectively identify and discuss young people who are likely to need ongoing treatment from another service. If the current episode of care can be completed in one service by being flexible about age boundaries, then that should be considered preferable to transition.	
Introduce the topic of transition and provide 'Transition Care Plan Guidance Document' to the young person and their family/carers/friends. Ask if they would like to be transitioned.	
Identify Receiving service and organise referral to this service.	
Ensure Receiving team receives full written case summary and any review minutes/formulations/letters with the referral.	
Ask young person and carers to complete 'Transition Care Plan' document – this informs planning of the transition and identifies concerns prospectively.	
Arrange a transition meeting to which Existing Case-holder, New Case-holder and other relevant professionals are invited.	
Arrange a transition meeting to which Existing Case-holder, New Case-holder, young person and family/carers/friends are invited. At this meeting a final handover date should be agreed and documented. Notify GP of the plan and timing for transition.	

Give the family/carers/friends written information describing the Receiving Service and the process of transition including specific information on accessing help in and out of hours and the date that this new process begins.	
Make the young person and family/carers/friends aware of any differences in the management of their care between the Referring and Receiving Service.	
Where appropriate, ensure that the young person is aware of the medication that they take, when they take it, and why they take it. Give information about where to seek help if there are any difficulties.	
Where appropriate, offer visits to the centre of the Receiving Service and/or joint home visits with New Case-holder.	
Ensure clear documentation in case notes that all of the above has been discussed, when and by whom.	
Ensure final handover is made and that the young person's case notes have been received by the Receiving Service. Ensure that the GP is notified of the transition and has contact information for the New Case-holder.	
Identify early any further transitions (e.g. leaving home to attend further/higher education in an area outwith locality) and ensure clear communications of all clinical information with the extended team. This can be a task for both teams depending on the timing and situation.	
Invite the young person and family/carer to complete the 'Transition Care Plan Evaluation Form.'	

Transition Care Plan Documents

The Transition Care Plan Guidance; Transition Care Plan and the Transition Care Plan Evaluation Form can all be found at:
https://www.nhsinform.scot/care-support-and-rights/health-rights/young-people/transition-care-plans-moving-from-camhs-to-adult-mental-health-services

Responsibilities for Receiving Service to Lead On

Responsibility	Date Completed
Communicate with Referring Service as to the appropriateness of the referral within 14 days following receipt of the referral.	
Ensure that the information leaflet describing the service is available to the Receiving service, up-to-date and accessible for service-users.	
Identify New Case-holder and ensure link is made with Referring Service. Where possible, it helps if the same professionals from the Receiving Service see the young person through the transition process.	
Where appropriate, facilitate informal visits to the centre by young person and carers	
Liaise closely with the Referring Service to ensure smooth advance planning of formal handover.	
Identify early any further transitions (e.g. leaving home to attend further/higher education in an area outwith locality) and ensure clear communications of all clinical information with the extended team. This can be a task for both teams depending on the timing and situation.	
Make the young person and family/carers/friends aware of the ethos of care that the Receiving Service has and make them aware of any differences in management of their care, which should not be perceived as negative in respect of either service.	
Invite the young person and family/carer to complete the 'Transition Care Plan Evaluation Form.'	
If the young person does not attend the 1st appointment after transition the Receiving Service is responsible for contacting the young person and giving them further opportunities to engage.	

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