NHS SCOTLAND

Transition Pathway

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Transition Pathway

Existing Case-Holder identifies young person approaching end of input with their service but requiring ongoing treatment. Discuss transition process with patient and family/carer. **This should be done 3-6 months before transition.**

If the young person decides to finish treatment: Discharge back to GP with letter to Young Person highlighting keep well strategies and signposting to how to seek help in future. The young person will then have 4 weeks where they can change their mind and be picked up without having to be re-referred.

The Existing Case-Holder should send full written case summary and any review minutes/formulations/letters to Receiving Service for consideration. The case review should include what has worked well in CAMHS including carer's views, young person's views and services views. The young person and family/carers should receive a copy of the summary.

Receiving Service should then meet to discuss appropriateness of referral. The outcome of this meeting should be shared with the Referring Service within 14 days.

'Transition Care Plan Guidance Document' should be shared with young person and family/carers. 'Transition Care Plan' document should be completed to identify concerns prospectively. **They should be given the name of their New Case-holder.**

Transition meeting to be held in two parts:

1) Existing Case-holder and New Case-holder; other relevant professionals where appropriate.
2) Service user, family/carers, Existing Case-holder and New Case-holder

At these meetings, young person and family/carers concerns about the transition process should be addressed and a transition plan should be agreed with all relevant parties. **The final handover date should be agreed and documented at this meeting.**

At final handover, the Existing Case-holder is responsible for informing the GP and all relevant professionals that the handover has been completed, and provide contact details for the New Case-holder. They are also responsible for ensuring that the case notes have been sent to the Receiving Service.

Receiving service should invite the patient and family/carers to complete the 'Transition Care Plan Evaluation Form'.
If the patient does not attend their first appointment, they should be contacted by the Receiving Service and given further opportunities to engage.

Where there are disagreements between services around the suitability of referrals, the senior operational/strategic manager should be informed and involved in supporting services to work effectively to deliver best care for the young person.

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

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