YOUNG PERSONS TRANSFER OF CARE FRAMEWORK

Forward Thinking Birmingham (FTB)

& BSMHFT

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1. Summary and context

This framework relates to the transfer of young people with an ongoing mental health support need from secondary care services within Forward Thinking Birmingham (FTB) to Birmingham & Solihull Mental Health Foundation Trust (BSMHFT). The framework will particularly focus on transfers from FTB to Adult CMHT's (both Birmingham & Solihull) as the most commonly used transfer pathway. However, the principles outlined in this document are also applicable to transfers to other community-based services, such as AOT and CRHT. The framework aims to ensure transfers are planned and implemented consistently and safely and occur with as little disruption to the young adult's care as possible, and that the process supports the framework of the Care Programme Approach (CPA), and Dialog + in the future.

This framework is aimed at all FTB and BSMHFT staff members who may be involved in the transfer of young people's care. This framework should be read in conjunction with the Care Programme Approach (CPA) framework (and in the future Dialog+).

Promoting effective transfer should lead to reduced numbers of young people being at risk of dropping out of treatment in an unplanned manner, reduce periods of untreated episodes of illness and improve outcomes. From a service perspective, an effective transfer framework will promote flow and enable teams to maximise the use of their resources for the benefit of more young people. It will also enable the organisation and commissioners to identify and manage gaps in service leading to a more comprehensive provision to this group.

In Birmingham young people with Moderate / severe Learning Disability (LD) will be transferred from FTB to the Birmingham Community Healthcare (BCHC) Adult LD team according to the LD Transfer Policy.

This framework will support all transfer described above for young people who is eligible to receive services within the city of Birmingham.

As a minimum, young people transferring from FTB should have the following standards met:

- Young people and their carers and families should not expect services to assume that young people in FTB automatically need transfer to BSMHFT. For example, some young people may not meet the criteria for severe and enduring mental illness, and thus may not be eligible for BSMHFT. FTB commits to exploring other viable discharge pathways, including Primary Care Based Neighborhood Mental Health teams, before referring to BSMHFT. The young person should be offered additional and alternative support to BSMHFT including support from non-health settings, voluntary community faith social enterprise (VCFSE) sector services, primary health care (including GPs) and other universal services.

- A completed ToC referral form will be sent to BSMHFT by the FTB service in a timely manner, 6 months before the age of transfer. Where BSMHFT have alerted FTB to areas

where wait for transfer may exceed 6 months, for example Assertive Outreach Teams, FTB will work with the young person and BSMHFT to facilitate a referral at an earlier stage.

- There should be full involvement of the young person, family and carers where appropriate and with the young person's consent.

- The young person should expect planning to commence at least 6 months before transfer. This planning will be led by the lead FTB clinician, and, once a referral is made to BSMHFT, the identified BSMHFT clinician will also support planning towards a seamless handover of the young person's care. This will particularly be the case when the transfer of care involves multiple professionals from the MDT, i.e. care co-ordinator, medic.

- The potential likelihood of a change or reduction in frequency of contact should be broached / discussed so as not to give false expectation to the young person or their carer upon transfer, while noting that contact levels with the young person, irrespective of service provider, should be needs led. Both FTB and BSMHFT have a duty worker system, and services should explain to young people and their family/carers how they can access support via duty if required.

- Young people can expect to be referred to age-appropriate, accessible services where they exist; commissioners should be notified, by senior clinical and operational leads, where appropriate services do not exist.

- The young person (and where appropriate the family) should receive information about what to do if they become unwell again and how to access care in a crisis.

2. National policy and guidance

This framework will support the principles contained within the NHSE Model Service Specification for Transfers from Child and Adolescent Mental Health Services, January 2015, which state:

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

Where, following such a good practice timely referral, it becomes clear that the commissioned adult services are not equipped or/ 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 for action.

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.

Currently, many receive no such plan and are left to re-contact primary care services if further advice, treatment or care is required.

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 any other multi agency providers (e.g. education and social care) that constitute 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, to prepare for transfer(s) and to engage with adult mental health or other services, the transfer process between services needs to be underpinned by age, sensitive and developmentally appropriate care planning that is:

- *Supported by a named professional who can take a co-ordinating support role throughout the transfer process. It is recognised that whilst this professional may change over time, young people and their parents/carers should be able to name the professional undertaking this role at any point in the process.*

- *Supported by access to multi-media information resources that young people want to engage with 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.*

- *Delivered by staff who have specific training or experience in working with children, young people and young adults.*

- *Delivered by processes, systems and environments that promote safety, quality, effectiveness and are young people and young adult friendly. This will be evidenced by clinical outcomes, young people and parent/ carer 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 clinical records and reviewed at each key point in the transfer pathway.*

- *Inclusive of young people's physical health needs alongside their mental health needs.*

- *Written and shared and agreed with the young person. The care plan should agree the aims and goal of interventions during transfer with young person and where appropriate, parent and carer.*

- *Co- produced providing written information to the young person and if appropriate parent /carer about the care plan, how to access the services routinely and in a crisis.*

- *Using Think Family principles to consider support that may need to be provided to the family/caregivers.*
  https://www.birminghamchildrenstrust.co.uk/info/3/information_for_professionals/35/refer_a_family_to_think_family/

3. BSMHFT Referral Criteria

It is acknowledged that FTB may refer to an array of BSMHFT services, such as Assertive Outreach teams, and that these services may have their own specific referral criteria. However, for the purposes of this framework document, the referral criteria for Adult Community Mental Health Teams are included, as the vast majority of FTB young people who require transfer will transfer into Adult CMHT aged 25.

The Adult CMHT's will provide assessment and specialist support, care and treatment for people with:

- Severe and persistent mental disorders associated with significant disability, predominantly psychoses such as schizophrenia and bipolar disorder with complex needs.
- Any disorder where there is on-going significant risk of harm to self or others or where the level of support required exceeds that which primary care could offer.
- Mental disorders requiring complex intervention or intensive psychotherapy treatments.
- Disorders of personality which may benefit from available evidence-based specialist interventions. For more information regarding this please see document 'Personality Disorders no longer a diagnosis of exclusion' Department of Health 2003.

Individuals may also be referred to specialist services where shared care is thought to be necessary. This may include the following Trust services:

- Crisis Home Treatment Team
- Eating disorders service
- Psychotherapy service
- Perinatal service
- Neuropsychiatry service
- Deaf service
- Forensic service
- Assertive Outreach

People will not usually be considered who as their main presentation have:

- Bereavement reactions
- Relationship difficulties

- Adjustment disorders
- Mild depressive disorders
- Victim of sexual abuse (without an ongoing psychiatric need)
- A unitary drug and alcohol diagnosis
- Acute stress reactions without a significant risk to themselves or others

- Moderate/Severe Learning Disabilities
- ASD (without an ongoing psychiatric need)

- Chronic pain
- Psychosexual issues
- Gender Identity issues (without an ongoing psychiatric need)
- Psychological problems due to a physical health problem

In these cases, the young person should be signposted to alternative support, including support from non-health settings, VCSFE , primary health care (including GPs) and other universal services

4. Consent

The decision to transfer to BSMHFT must be made with the consent of the young adult concerned, following discussion, planning and the exploration of possible alternatives.

Where there is a lack of mental capacity to give formal consent, the transfer should be discussed with family members, nearest relative and/or carer with reference to the Mental Capacity Act (MCA) 2005 where appropriate.

Every effort should be made to involve the young adult and their family in the transfer process and inform them of whom they are being transferred to.

However, it must also be noted that a young person may be ambivalent about service transfer and may, on occasion, say they don't want to transfer and withdraw consent. In this scenario, BSMHFT will, in the first instance, discuss this with the young person's FTB named clinician, in order that withdrawal of consent can be further discussed with the young person. Withdrawal of consent in itself should not be a trigger for BSMHFT to automatically discharge a young person's referral from BSMHFT's care.

5. Lead Clinician responsibilities

- Coordinating all aspects of the care and treatment of the young person at all stages of their journey through the care pathway (for services that are not covered by the CPA (or Dialog +) these responsibilities are synonymous with the responsibilities of the lead professional). Key responsibilities are listed below.

- Monitoring the delivery of care, convening CPA (or Dialog +) reviews, maintaining contact with the young person and/or their relative/carer(s), ensuring effective communication with and between all relevant others involved in the care, treatment and support of the young person, and reassessing the young person's needs and current situation as required. Ensuring that all relevant and required information is available including but not limited to the information listed in section 7.

- Where known, alerting relevant other services and practitioners about any issues related to safeguarding adults/children or multi-agency public protection arrangements (MAPPA), particularly those that may impact on safe and effective transfer planning.

- Ensuring that any identified relative/carer(s) are well informed with regards to issues related to the transfer process and care options, including interim or intermediate placements. Ensure that all practitioners and agencies, including non-statutory agencies, involved in the planning and preparation of the young person's transfer are aware of the care plan and transfer arrangements.

- Ensuring that appropriate follow up arrangements are made within the required timescales in line with this framework.

6. When will FTB make a referral to BSMHFT

Transfer arrangements to the appropriate Adult Community Mental Health Team should begin once the young person has reached 24 years 6 months old within FTB. At this point, FTB will make a referral to BSMHFT. FTB will retain responsibility until the young person's 25th birthday or, if cared for on the Early intervention Psychosis (EIP) pathway, then 2 years and 6 months from their start of care with EIP (if aged from 24.5 years to 35 years).

FTB may make a referral prior to these points if BSMHFT waiting times for transfer exceeds six months. In these circumstances, it will be expected that BSMHFT will proactively communicate transfer wait times to FTB, via local interface meetings and other identified means, i.e. when responding to the list of FTB's Delayed Transfers of Care list. In the absence of such communication FTB will plan on the expectation that the young person will transfer within 6 months.

There is an expectation that there should be a period of preparation and engagement between BSMHFT and FTB, particularly for joint working with the young adult and their significant carers, prior to transfer at age 25 (or after three years with EI).

All FTB staff should be familiar with the referral criteria for services, such as BSMHFT CMHT's, as well as the referral criteria for Neighbourhood Mental Health teams, before making a referral. FTB

should call and speak to staff from BSMHFT's Single Point of Access (SPOA) should they wish to discuss eligibility criteria prior to referral.

If liaison with BSMHFT, either via a conversation with the Single Point of Access or in a planning meeting concludes there is no requirement for transfer to Adult Services, the FTB worker will continue to support the young person until the case can be closed or transferred to Primary Care or other appropriate services.

7. Referrals from FTB to BSMHFT

Referrals from FTB to BSMHFT will be made via FTB's Transfer of Care (ToC) referral form on RIO by the lead FTB clinician and sent electronically via the Single Point of Access (SPOA).

All BSMHFT managers and clinical leads should ensure, via BSMHFT's clinical systems department, that they can access the ToC form on RIO.

The information that should be contained with the referral is as follows:

- A completed ToC form
- Honos Cluster
- Most recent risk assessment
- Most recent care plan
- Most recent medical review summary letter (must be within the last 6 months)
- List of current medication
- Evidence of Physical Health check within the last 12 months, if receiving prescribed medication
- Current safeguarding concerns
- CTO (if required)

This is the agreed standard regarding information transfer to facilitate a referral. BSMHFT receiving teams will have access to further clinical information on RIO.

BSMHFT teams will not delay the management of a referral for transfer via asking for more clinical information, in addition to the list above.

BSMHFT can request that a clinician attend an MDT to discuss the young person prior to transfer and, where FTB believe that this is warranted to facilitate the transfer and ensure good, ongoing clinical care, a clinician will attend. However, this will be agreed on a case-by-case basis and it is not envisaged that FTB will need to attend MDTs to discuss transferring young people in the majority of cases. Attendance at MDT's will need to add demonstrable value to the young person's transfer, with a clearly articulated rationale for attendance agreed beforehand. Other forms of communication, other than MDT attendance, may support equally effective information sharing methods

Once a referral has been received by BSMHFT SPOA, this should be acknowledged as received within 48 hours alongside an update of which BSMHFT team the referral has been allocated to. The subsequent receiving team within BSMHFT should contact the relevant FTB team within two weeks to confirm outcome of referral screening. Feedback should be sent directly to the referring clinician.

8. Common Barriers within the referral and transfer process and how these will be managed

FTB and BSMHFT have identified several issues that can have a negative impact on the effectiveness and timeliness of the transfer process for young people. Transferring care between clinicians and teams can be a vulnerable time for young people and every care must be taken to ensure that the transfer process, in itself, is neither detrimental for the young person's care nor runs the risk of the young person disengaging with either service, as both have the potential to increase clinical risk.

In addition, delayed transfers of care have an adverse impact on FTB's service capacity, which in turn can increase the waiting times other young people experience. The provision of effective support and treatment for young people at the earliest possible stage is a significant factor in achieving positive outcomes, and in turn reducing the amount of young people who will need to transfer to BSMHFT.

FTB and BSMHFT will work together to address the following issues:

- **Young Persons with No Fixed Abode or insecure accommodation**-If FTB are aware that the young person being referred is homeless then FTB will refer to the BSMHFT homeless team at 24 ½ years old. To ensure no young person is disadvantaged, if a young person becomes homeless during the transfer period it will be expected that the BSMHFT team who originally accepted the referral will take over the young person's care, once they have attended their agreed transfer appointment within the agreed six-month transfer period. This team will then internally transfer the young person's care to the BSMHFT Homeless team as required. It is also acknowledged that some young people may have insecure accommodation, i.e. moving between family members and friends, in this case FTB will decide, based on their knowledge of their young person and associated risks, which is the most appropriate team to refer to within BSMHFT. This rationale will be outlined in the referral documentation and subsequent communications and the position will be accepted by BSMHFT. Both organisations will support the young person in registering with the Health Exchange for primary care should they be homeless.
- **Young people who move address within Birmingham during the transfer period**-It is acknowledged that young people will occasionally move within Birmingham during the transfer period. To both maintain a positive experience and to promote flow within the system, the BSMHFT team who originally accepted the referral, will continue to transfer the young person and will then facilitate an internal transfer within BSMHFT once the FTB young person has transferred. The only exception to this will be when two BSMHFT teams can demonstrate that the young person can be transferred from one team's waiting list to another, without experiencing any disadvantage or delay with regard to their transfer waiting time.
- **BSMHFT Inter team transfer**-Occasionally, during the transfer period, BSMHFT may identify that a different type of service provision is more appropriate, i.e. AOT instead of CMHT. In these circumstances, such a decision needs to be made at the earliest possible opportunity, and again the FTB young person should not be disadvantaged by having to join the bottom of a new services waiting list and the time waiting to date should be taken into consideration. If the wait for the newly identified service exceeds the six months transfer period, then the FTB young person should still transfer to the originally identified service, i.e. CMHT, and then they will manage the onward transfer to subsequent BSMHFT services, such as AOT.
- **New referrals to FTB**- All new referrals received by FTB for young people aged over 24 ½ and over will be triaged and if the envisaged waiting time and/or care needed is likely to exceed their 25th birthday, the referral will be sent to the appropriate team within BSMHFT. This does not include First Episode Psychosis, Eating Disorders or young people who require urgent crisis or home treatment intervention. FTB will provide appropriate support and signposting, aligned to 4 week wait to help standards, alongside explaining to the young person that their referral for ongoing treatment has been passed on to BSMHFT.

- **FTB Patient is currently an inpatient**-BSMHFT will manage referrals for young people who are currently inpatients based on their home address and GP and will not transfer referrals to other CMHT's based on the address of the inpatient unit that they are currently residing in (if within Birmingham). Please see section 10 for more information

9. The Transfer Date

BSMHFT will provide the relevant FTB lead clinician with a clear transfer date. The transfer date will be when the young person has been seen by their allocated BSMHFT clinician who will hold clinical responsibility for their care. This may be a medic or a care co-ordinator. It is not appropriate for a young person to be seen by one member of the BSMHFT team, only to be told that their care will not transfer until they see a subsequent member of the same multi-disciplinary team. This causes confusion for both the young person and services during the transfer period, a clear handover of care if required and this should be when BSMHFT engage with the young person at their first appointment.

In addition to appointment information being available to FTB via RIO, BSMHFT will copy the FTB lead clinician into all appointment correspondence, in respect of transfer, so the FTB Lead Clinician can support the young person in attending. This, on occasion, may involve a joint appointment with the FTB clinician in attendance.

Upon transfer, FTB will communicate to all relevant professionals and network members, that the young person's care has transferred to BSMHFT within 2 weeks.

In exceptional circumstances cases may arise where transfer of care should take place prior to the young adults 25th birthday due to the needs of the young person being better met by adult services. These cases should be discussed on case-by-case basis between BSMHFT and FTB.

10. Transfer of Care during an Acute Episode

It is preferable to transfer a young person between services when they are stable in the community, however this is not always possible. Both FTB and BSMHFT acknowledge that transferring the care of an inpatient needs to be handled compassionately and sensitively, with clear communication to the young person, their family or carers and other agencies contributing to the MDT.

Our objective is to minimise the number of young people that require transfer between services whilst they are an inpatient. BWC and BSMHFT will work together as a collaborative to provide flexibility over a one-year transition window, between ages 24 ½ and 25 ½. The following table is expected to act as a guide for clinician's that will serve most young people , however minor exceptions can be agreed collaboratively where clinicians agree that an exception is in the benefit of the young person

Expected lead provider based on age of inpatient.		
Age	**Existing admission**	**New admission**
Under 24 1/2	BWC	BWC

24 ½ - 25	BWC	BSMHFT if the EDD is likely to be beyond the 25th birthday & BWC if the EDD is likely to be before the 25th birthday. Exceptions to be agreed between Head of Pt Flow (BWC) and Head of Nursing for UC (BSMHFT) & on call managers out of hours.
25 – 25 1/2	EDD before 25 ½ BWC EDD beyond 25 ½ - BSMHFT	BSMHFT
Older than 25 1/2	BSMHFT	BSMHFT

With this approach BSMHFT will accept bed management responsibilities for new inpatients from 24 years and 6 months who are likely to have a LOS beyond their 25th birthday. In reciprocation, BWC will continue to manage inpatients beyond their 25th Birthday where a discharge to the community is anticipated before they are 25 ½, recognising that, due to the young person being over 25, this discharge will be directly into the care of BSMHFT community services. FTB will still support the required discharge planning, i.e. attendance at meetings, information sharing, to aid the young person's s discharge into the care of BSMHFT community services. Cases will not be closed by FTB until transfer has been confirmed by the receiving BSMHFT team

An accurate EDD is not always known on admission, and if there is any disagreement between providers the admission will default to BWC for 24 ½ to 25 and BSMHFT beyond 25.

10.1 Process for managing the transfer of bed management responsibilities during an admission

EDD's are generally not agreed preadmission. FTB will first become aware of the EDD via FTB Discharge Co-ordinators attending ward rounds within the first 1-2 weeks of a young person's admission. In addition, contracted bed providers furnish FTB with the EDD via daily bed state reports.

Once FTB Bed Management become aware that the EDD will run past 25 years of age, particularly for a new admission, FTB's Patient Flow Lead (or equivalent) will liaise with their counterpart in BSMHFT to initiate the transfer of bed management responsibilities. Once agreed, the FTB Patient Flow Lead will then liaise with the FTB Community Team who are currently delivering community care, and request that they initiate transfer and send clinical documentation and referral (as outlined in this SOP) to be sent to BSMHFT. BSMHFT will then allocate the CYP to the respective community team so they can support discharge planning back into BSMHFT community services.

Please see section 13 with regard to the management of disputes

Acquired Brain Injury

Young people who present with an acquired brain injury e.g. stroke, tumours removal, traumatic brain injury etc. will be referred to the Neuropsychology/ psychiatry Service.

11. Young adults with learning disabilities and a mental health problem

Young adults with a moderate-profound learning disability will be referred to the appropriate Adult Learning Disabilities Service from the age of 18yrs 6 months, and no later than six weeks before the CYP's 19th birthday, and will not be referred to BSMHFT as the lead provider of care.

Young adults with a borderline (mild) learning disability and a mental health problem as their primary need should be referred to BSMHFT. Those that do not meet the criteria for services provided by BSMHFT and from whom appropriate services cannot be identified should be flagged up via the unmet needs process described earlier.

12. Young Person Refusing Care

If a young person loses contact with the services or the young person does not attend a meeting designed to facilitate the transfer of care, BSMHFT and FTB care coordinator/lead professional should work together to support the lead FTB clinician to:

- Attempt to contact the young person and determine whether they still have ongoing care needs.
- Consult with people involved in the young person's care to consider the outcome of attempts to contact the client and any further care needs
- If a young person has moved to another area, inform the local services that care was being offered and how to get more information
- If a young person does not attend a transfer appointment, or cannot be contacted, BSMHFT must discuss the case with FTB, in terms of clinical risk and engagement, before any decision is made to close the referral. BSMHFT should offer two appointments before any decision is made to close the referral.
- If young person is thought to be a safeguarding risk and/or missing, then Police should be alerted
- All actions to be summarised in the CPA care plan and recorded in the young person's case notes in accordance with the organisations Records Management Framework and Standard Operating Procedures.

It is worth remembering that people should be offered care related to their assessed needs and can rightfully refuse care that is not indicated by any assessed need. However, such decisions could have seriously negative consequences for the young person and such a refusal must be assessed and responded to with this in mind with consideration of capacity and the Mental Capacity Act (MCA) 2005.

If a young person fails to keep an appointment for treatment, for example 'DNAs, this may well indicate an increased need for help and a different response than would ordinarily be applied.

FTB may , following risk assessment and MDT discussion, discharge a young person back into the care of their GP, with a direction to refer the young person back to BSMHFT, should they re-present with an ongoing mental health need that meets the criteria for secondary care

13. Disputes

In the event of a dispute between FTB and BSMHFT regarding transfer arrangements, attempts should be made to find a resolution at a local level.

Examples of disputes could be:

- An A&E / LP referral where the young person is nearly 25 years old
- An out of area admission within a month of 25th birthday who is begin referred in area for follow up
- A known young person re-referred into FTB weeks short of being 24 and a half who we anticipate requiring a lengthy clinical intervention
- A student just outside of the age range, already in OOA services and requires continuation of care
- A young person who has nearly completed transfer and is clinically deteriorating

Where a dispute remains unresolved, it should be referred to FTB/BSMHFT clinical management. Within FTB this will be the Clinical Team Manager, in BSMHFT this will be the Hub Manager. This process will be supported by FTB Head of Nursing/General Manager and BSMHFT Clinical Service Managers.

Management will arbitrate between the services to ensure the young adult receives the treatment they require.

In all disputes, the young adults' needs will be paramount.

In the event this still cannot be resolved, it should be escalated to the Senior Clinical leads in both organisations (FTB-Medical Director and Associate Director of Nursing, BSMHFT-Clinical Director) to arbitrate. Senior Operational Leads, i.e. Director of Operations or Chief Operating Officer, may become involved in escalations that relate to bed management responsibilities.

Disputes will be resolved within 2 weeks. If the dispute is not resolved within this timeframe the FTB clinician should complete an incident report on datix.

14. Appendices

1. BSMHFT Transfer of Care (ToC) Referral Form
2. Learning Disability Team Transfer Pathway
3. FTB Community Hub contact details
4. BSMHFT Adult Community Mental Health Team contact details

Appendix 1 – BSMHFT referral form

SPOA%20Referral%20Template%20v0.1.dc

Appendix 2 - Learning Disability Team Transfer Pathway

Introduction:

The intention of this document is to provide an overview of the FTB Learning Disability Transfer Pathway.

Legislation:

Support for disabled young people preparing for or making Transfers has been guided by policy and strategy papers such as:

- Valuing People (2001)
- National Service Framework: Children, Young People and Maternity Services (2004)
- Improving the Life Chances of Disabled People (2005)
- Transfer: Getting it Right for Young People (2006)
- Learning for Living and Work (2006)
- Aiming High for Disabled Children: Better Support for Families (2007)
- Progression Through Partnership (2007)
- A Transfer Guide for all Services (2007)
- Transfer: Moving on Well (2008)
- Valuing People Now (2009)
- Pathways to Getting a Life: Transfer Planning for Full Lives (2011) and Fulfilling Potential: Making It Happen, (2013)

This wide range of legislation and guidance provides a comprehensive guide of the requirements, expectations and good practice on Transfer planning at local level.

The Transfer between child and adult services actually occurs between sixteen and nineteen. During these years young disabled people will leave school and:

Some will move from children's services to adult health and/or social care.

Some will go into further education/day services.

Some will get a job.

Improving the Life Chances of Disabled People declared the government's ten-year goal:23
By 2015, all disabled young people and their families will experience continuity and co-ordination in the services that they receive, as both children and adults.

Unless there is substantial health or social care involvement with a child approaching Transfer, then education is usually the lead agency for the Transfer process whilst education generally has the lead responsibility, government guidance has always emphasised that Transfer planning must always be a multi-agency process.

EHCP Plans:

The EHC plan is a legal document describing a young person's needs, what should happen to meet those needs from birth to twenty-five. The SEN Code of Practice requires that, once finalised, the EHC plan is reviewed by the local authority every twelve months as a minimum. For children and young people with EHC plans, discussions about post-16 options will be part of the 'preparing for adulthood' focus of EHC plans reviews.

Social Services:

Local authorities have a clear obligation under the Disabled Persons (Services, Consultation and Representation) Act 198679, the Children Acts80 and accompanying statutory guidance to make sure that their children's services and adult services departments engage effectively to anticipate the Transfer of young disabled people.

Health Services:

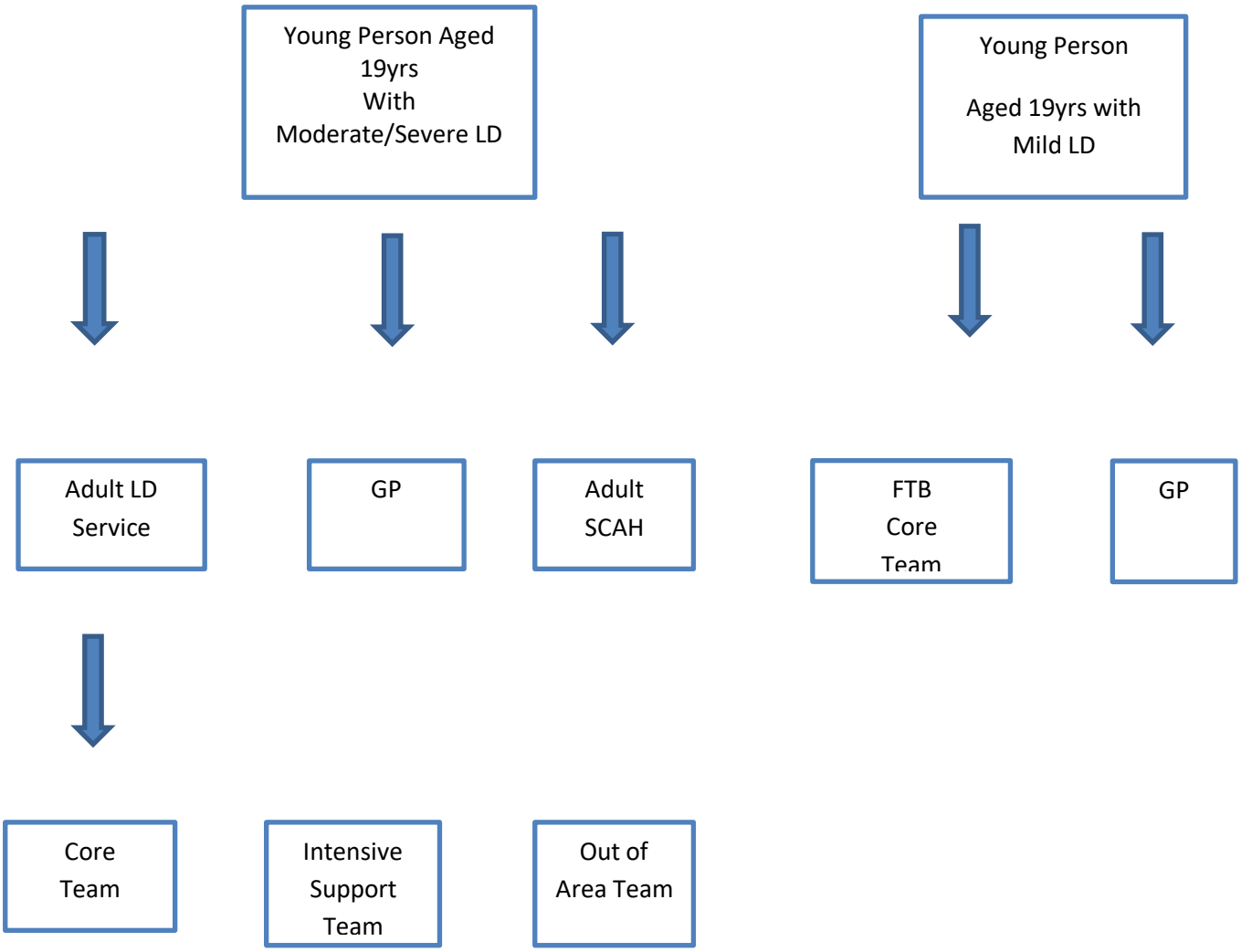
Since 2004, the *National Service Framework for Children, Young People and Maternity Services* has required that health services develop appropriate young persons' services to enable smooth Transfer to comprehensive adult multi-disciplinary care. Standard 8 sets out expectations in relation to the establishment of a multi-agency 'Transfer Group' which will assume responsibility for overseeing Transferal arrangements at both strategic and operational level and for agreeing inter-agency protocols.

In 2008, the Department of Health published further guidance on health care Transfer planning. *Transfer: Moving On Well* states that:

The process of Transfer should start while the child is being cared for by children's services and may, subject to the needs of the young person, continue for a number of years after the transfer to adult services.

Health professionals working with a young person with complex health needs, or a disability can prepare them for adulthood by developing a health Transfer plan, which takes an approach that is much broader than the medical diagnosis and helps the young person to address other lifestyle issues that may be concerning them. This needs to form an integral part of the broader Transfer plan, linking closely with education and social care.

Learning Disability Transfer Pathway



Learning Disability Team Current Process:

1. When a young person becomes 18.5 years the Allocated Core Worker will commence the Transfer process.
2. Allocated Core Worker will discuss with young person and family/carer how and where the health care will be transferred.
3. Commence "My Transfer Booklet" with young person.
4. If the young person has a complex presentation (Orange Rag Rating) pathway lead will notify adult services.
5. If the young person does have a complex presentation joint working will commence as soon as possible.
6. Most young people are transferred around their 19th birthday.
7. Both FTB and Adult LD Services endeavour to complete a joint appointment to ensure Transfer is smooth for the young person.

The Pathway Lead meets with Health Transfer MDT Team on a quarterly basis – (*Current MDT is made up of Adult LD Clinicians, Health Facilitation Clinicians, School Nursing and Out of Area Adult Clinician)*

Aims of Health Transfer MDT Meeting:

To ensure smooth Transfer for young people.
To ensure physical/mental health care needs of young people with Learning Disabilities are met.
To ensure adult services are aware of those young people out of area.
To ensure adult services are aware of those young people currently in hospital/detained under the MHA

Appendix 3

Forward Thinking Birmingham Hub contact details

South Birmingham Hub (Oaklands):

- Telephone: 0121 333 8342
- Email: Oaklands (admin) bwc.oaklandshubadmin@nhs.net
- Email: Oaklands (duty): bwc.ftboaklandsduty@nhs.net

West & North Birmingham Hubs (Finch Rd):

- Telephone: 0121 333 8383
- Email: Bwc.ftbfinchroad@nhs.net

East Birmingham Hub (Blakesley):

- Telephone: 0121 333 8396,
- Email: bwc.ftbblakesley@nhs.net

Appendix 5

BSMHFT Community Mental Health Team contact details

Name of CMHT	Address	Telephone number
Aston CMHT	Orsborn House, 55 Terrace Road, Handsworth, Birmingham, B19 1BP	0121 301 1710
Erdington & Kingstanding CMHT	Northcroft, 190 Reservoir Road, Erdington, Birmingham. B23 6DW	0121 301 5263
Ladywood & Handsworth CMHT	Orsborn House, 55 Terrace Road, Handsworth, Birmingham, B19 1BP	0121 301 1710
Kingstanding CMHT	Northcroft, 190 Reservoir Road, Erdington, Birmingham. B23 6DW	0121 301 5200
Longbridge CMHT	10 Park Way, Birmingham Great Park, Off Bristol Road, Rubery, Birmingham, B45 9PL	0121 301 2900
Lyndon CMHT	Hobs Meadow, Solihull, B92 8PW	0121 301 4800
Newington CMHT	Newington Road , Hamar Way, Marston Green,Birmingham, B37 7RW	0121 301 4950
Riverside CMHT	42 Chapman Road, Small Heath, Birmingham. B10 0PG	0121 301 7204
Small Heath CMHT	42 Chapman Road, Small Heath, Birmingham. B10 0PG	0121 301 7200
Sutton CMHT	190 Resevoir Road, Erdington, B23 6DW	0121 301 6685
Warstock Lane CMHT	Warstock Lane, Billesley, Birmingham. B14 4AP	0121 301 3450
Zinnia CMHT	100 Showell Green Lane, Sparkhill, Birmingham. B11 4HL	