Managing transitions in care within and across services

Competences outlined in this document overlap with those set out in the sections detailing competences relating to: 'Ability to operate within and across organisations' 'Knowledge of, and ability to work with, issues of confidentiality and consent'

Knowledge relevant to transitions in care

An ability to draw on knowledge that transitions in care (within and across organisations) can be potentially destabilising and so represent times of greater risk of self-harm and/or suicide
an ability to draw on knowledge that anticipating the ending of treatment, services or relationships, as well as transitions from one service to another, can provoke strong feelings and increase the risk of self-harm or suicide
an ability to draw on knowledge that where transfers in care are prompted by services feeling unable to manage the emergence of self-harm or suicidal ideation or behaviour, the transition between services represents a period of potentially increased risk that needs to be managed

Identifying transitions in care within and across organisations

An ability to identify transfers of care that may represent points of greater risk, such as:
transfers within an organisation (e.g. from one professional to another within a service)
transfers across organisations (e.g. from inpatient care to the community, or from health care to social care)
transfers from services for young people to adult services
transfers from the health and social care system to the forensic or criminal justice system
unexpected transitions (e.g. resulting from a change in address or the departure of a key worker)
planned transitions (e.g. a worker taking annual leave)

Knowledge about the transfer

An ability to draw on up-to-date knowledge of the services to which a transfer is being considered, using this information to ensure that the proposed transfer is:
appropriate to a person's needs
can be offered within an appropriate timescale

Helping a person prepare for a transfer of care

An ability to advise a person of the proposed transfer, ensuring that they:
given as much notice as is practically possible
understand the rationale for a transfer of care
are informed about the services that will be on offer
are informed about the likely timescale of the transfer
know what information will (and won't) be communicated to the new professional and/or service, and can discuss any concerns
an ability to balance considerations of confidentiality against the risk of harm to a person and to judge when it is their best interest to share information
An ability to discuss a person's feelings about the transfer and to work with them to:
identify barriers that make it less likely that they will maintain contact with the new service (e.g. anxiety or anger about starting afresh, upset over loss of contact with valued professionals)
discuss their concerns and feelings
identify issues that will make a transfer of care problematic (and so signal a potential increase in risk)
Where families or carers have been providing significant support, an ability to consider what information it is appropriate to share with them about the transfer

Transfer of care

An ability to draw on knowledge that people may require additional support and preparation to successfully navigate transfers of care, for example in the form of:
ensuring that the service to which they are referred is suited to their developmental stage and capacities
involving their family or carers (if this is something that a person sees as helpful)
An ability to draw on knowledge of the increased vulnerability of people who are experiencing multiple synchronous transitions (e.g. from school to college, changes in living arrangements and transfer across clinical services)
Where there are indications that transfers of care will present significant challenges to a person an ability to implement appropriate strategies, such as:
identifying a named individual who can maintain continuity of support during the transition
where appropriate helping a person to develop skills in independence, assertiveness and self-advocacy
An ability to draw on knowledge that families and carers may find transfer of care a challenge (e.g. by feeling excluded where services do not routinely involve families and carers)

Communication within and between services to which a person is being transferred

An ability to assure effective communication with professionals within and between services by providing written communication that identifies:
the relevant clinical issues, the current care plan and the reasons for concerns about risk
the rationale for referral (i.e. the areas for which help is sought and the services which it is hoped the service or other professionals will offer)
expectations regarding feedback from the service (e.g. confirming receipt and advising on the actions taken)

Recognising and managing challenges to transfers of care

An ability to monitor the progress of a transfer	
An ability to identify when a transfer has been compromised and to identify the reasons for this, for example:	
	institutional/systemic factors (such as long waiting lists or organisational change)
	lack of cooperation or trust between professionals (especially where this reflects the 'legacy' of previous contacts, or a lack of understanding of what has been requested)
	lack of clarity about who is responsible for acting on a transfer request (leading to a failure to act)
An ability to address concerns about a compromised transfer, for example, through further verbal and/or written communication	
Where possible and appropriate, an ability to offer bridging support and contact if this increases the probability that a person will engage with the new service	