5.5. Managing transitions in care within and across services

Transitions take place when the child/young person reaches an age cut-off for a service, when they move from one service pathway to another or when an episode of care ends. A poorly managed transfer of care can lead to their losing contact with the services or support they need. This means it is critical to make sure that transitions are organised appropriately.

Competences in this document overlap with those in the sections 'Ability to coordinate with other agencies and individuals' (5.3) and 'Ability to work with issues of confidentiality and consent' (3.3).

Knowledge

- An ability to draw on knowledge that transitions in care (within and across services) can be potentially destabilising, and:
  - an ability to draw on knowledge that anticipating the ending of treatment, services or relationships, and transitions from one service to another, can provoke strong feelings in the child/young person that should be acknowledged and discussed

Identifying transitions in care within and across organisations

- An ability to identify transfers of care that may represent points of greater risk, e.g.:
  - transfers within an organisation (e.g. from one practitioner to another)
  - transfers across organisations (e.g. from inpatient care to the community)
  - transfers to adult services
  - transfers from the health and social care system to the forensic or criminal justice system
  - unplanned transitions (e.g. because of 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 or professionals that the child/young person is being transferred to, using this information to ensure that the proposed transfer is:
  - appropriate to the child/young person's needs
  - is offered in an appropriate timescale

Helping the child/young person prepare for a transfer of care

- An ability to advise the child/young person of the proposed transfer, ensuring that they:
  - are given as much notice as possible
  - understand why the transfer is happening
  - are informed about the services that will be on offer and the professionals they will be linked to
  - are informed about the timescale
  - know what information will and will not be communicated to the new professional and/or service, and can discuss any concerns, and:
    - an ability to balance considerations of confidentiality against the risk of harm to the person, and to judge when it is their best interest to share information
- An ability to discuss the child/young 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 family/carers have been providing significant support, an ability to consider what information is appropriate to share with them about the transfer

- An ability to draw on knowledge that children/young people may require significant support and preparation to successfully navigate transfers of care, e.g.:
  - ensuring that the service to which they are referred is suited to their developmental stage and capacities
  - maintaining involvement with their family/carers (if this is something that the child/young person sees as helpful)
  - where possible, a joint handover appointment
- An ability to draw on knowledge of the increased vulnerability of children/young people who are already experiencing multiple transitions (e.g. from school to college, plus changes in living arrangements and transfer across clinical services)

- Where there are indications that transfers of care will present significant challenges to the child/young person, an ability to implement appropriate strategies, e.g.:
  - identifying a named individual who can maintain continuity of support during the transition
  - where appropriate helping the child/young person to develop skills in independence, assertiveness and self-advocacy

- An ability to draw on knowledge that family/carers may find transfer of care a challenge, e.g.:
  - by feeling excluded as the child/young person takes more ownership of their care
  - by feeling excluded where adult services do not routinely involve family and carers

Communication within and between services to whom the child/young 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 any concerns about risk
  - the rationale for the transfer (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 new service (e.g. confirming receipt of information 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, e.g.:
  - institutional/systemic factors (e.g. long waiting lists or organisational change)
  - lack of cooperation or trust between professionals (especially where it 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 will help the person to connect with the new service

Transitions in and out of care for looked-after children

- An ability to draw on knowledge that there is a significant impact on children/young people's emotional wellbeing and mental health when they move repeatedly in and out of care, and/or experience repeated placement breakdowns, and that this will impact on their reactions to transitions in and out of an inpatient ward

- An ability to draw on knowledge that while returning home from care is often the best outcome, for some this can result in further abuse/neglect and a cycle of moving in and out of care, and the ability to assess:
  - the risks the family could pose to their child
  - how much they are able to change
  - their ability to protect their child from harm, taking into account their history and current situation

- Where a return to home is possible, an ability to work with the child and their family to help strengthen their relationship
- An ability to agree with the parents what needs to happen before and after their child returns home

- An ability to liaise with relevant agencies and services, to:
  - share understanding and information
  - put in place support for the child and their family before and after the return home
  - return the child home gradually, and plan for what will happen if the return is not going well
  - monitor how the child and their family are managing