Transitions out of Children and Young People's Mental Health Services (CYPMHS)

Indicator 5	
Indicator name	Transitions out of Children and Young People's Mental Health Services (CYPMHS)
Indicator weighting (% of CQUIN scheme available)	0.25%
Description of indicator	This CQUIN aims to incentivise improvements to the experience and outcomes for young people as they transition out of Children and Young People's Mental Health Services (CYPMHS). This CQUIN is constructed so as to encourage greater collaboration between providers spanning the care pathway. There are three components of this CQUIN: 1. a casenote audit in order to assess the extent of Joint-Agency Transition Planning; and 2. a survey of young people's transition experiences ahead of the point of transition (Pre-Transition / Discharge Readiness); and 3. a survey of young people's transition experiences after the point of transition (Post-Transition Experience). This CQUIN does not prescribe the wording for surveys, nor does it require a particular method for taking this information – such as online or telephone surveying. This is to be agreed at a local level and as appropriate for the young person, and signed off by the receiving service, commissioners, and young people. CCGs must be satisfied that the questionnaire wording and methods provide adequate evidence of young people's preparedness for, and experience of, transition. **<u>Key Definitions & Scope</u>** *Transition* 'Transition' and 'transitioning' in the context of young people's mental health, means the transfer of young people out of CYPMHS to other services (adult mental health services or otherwise), or being discharged, **as a consequence of reaching a certain age** according to local commissioning arrangements**.** The age of transition varies locally, with young people in most areas transitioning at 18 years, but others at 16 or at a needs-based or condition-specific time.

Indicator 5	
	Which young people does this CQUIN apply to? This CQUIN applies for any young person transitioning out of CYPMHS as a consequence of their age, whatever that age may be, as may be dictated by local commissioning arrangements. It therefore applies just as readily for a 16-year-old as for a 25-year-old leaving CYPMHS. It applies for the following transfers of care: • Young people transitioning out of CYPMHS into Adult Mental Health Services (AMHS); • Young people transitioning out of CYPMHS into other relevant CCG-commissioned services; and • Young people who are discharged from CYPMHS solely to primary care rather than to another service in addition to primary care at the locally agreed age for transition. In particular, it is important to ensure this group of young people are properly prepared for this discharge as they may not have the same level of support that those using other CCG-commissioned services have. In addition, it is expected that the relevant information in the form of a discharge summary is passed onto primary care and shared with the young person concerned. *Sending and receiving services* This CQUIN refers to 'sending' and 'receiving' services during the transition out of CYPMHS: • The 'sending' service is the children and young people's mental health service whose care the young person is receiving, be it inpatient or community care; • The 'receiving' service(s) refers to whatever CCG-commissioned service(s) the young person is moving into from CYPMHS. This might be adult mental health services (AMHS), or voluntary sector services.[1] *Which providers are in scope?* This CQUIN applies to: • All CCG commissioned providers of CYPMHS

[1] There may be multiple receiving services, in which case services will need to coordinate transition management so that the young person is not overburdened with extra transition processes on entering new care settings. It is recommended that CCGs take a pragmatic approach in awarding this CQUIN to receiving services in this instance, for example rewarding services for a single, coordinated survey of young people after transition – rather than requiring each receiving service to conduct one independently. Some young people may be referred for further treatment to adult IAPT services but would not anticipate a transfer during a course of treatment such as CBT which should be a time limited discrete episode of care. If a young person has begun a course of CBT with one service we would expect that course of treatment to be completed prior to discharge

Indicator 5	
	that extend to the age of transition; • All appropriate CCG commissioned providers of AMHS[2]; and • Providers of other relevant CCG-commissioned receiving services.[3] *Joint Working* The CQUIN has been designed so as to encourage collaboration between providers across the care pathway subject to transition. As such, while it takes account of different responsibilities for sending and receiving providers, the impact of performance by either provider will be shared across the pathway, and all providers subject to the CQUIN will be assessed against the achievement of an indicator specific to sending or receiving providers. Through this mechanism, the CQUIN is designed to incentivise all parties to contribute to better transitions for young people. Where there are a number of providers fulfilling the sending or receiving role for a given locality, their contribution to overall performance for that locality should be weighted in line with their respective levels of commissioned activity for that locality. In addition, while a number of key actors including primary care and non-CCG commissioned providers cannot be held to account through this CQUIN it is expected that their engagement will be central to the success of the efforts to achieve the CQUIN.
Numerator	1. The number of young people who have transitioned out of the sending service in question during the reporting period whose case notes evidence Joint-Agency Transition Planning, defined as: 1.1. Those service users approaching transition who have had a meeting to prepare for transition, at least six months before transitioning, or for individuals who are less than six months from transition age on joining the sending service and at least one month before transition. The meeting should include: • the young person; • the appropriate key worker from the sending service;

[2] This CQUIN also applies to those providers delivering both CYPMHS and AMHS.
[3] A relevant service is one that either impacts or is impacted by the young person's mental health needs. For example, a young person with complex needs may move into a number of services on transition out of CYPMHS. Some of these may not be AMHS, but would still be relevant to the young person's care pathway and should therefore be in scope for this CQUIN and incentivised as a receiving provider to be part of transition preparations and evaluation.

Indicator 5	
	• where applicable, a dedicated point of contact for transition from the receiving service; and • where appropriate and the young person agrees, the young person's parent(s)/carer(s). Where a face to face meeting is not practicable, for example when a young person is moving out of area, this indicator score may be fulfilled by evidence that there has been contact between all the above parties, for example, via a video conference; AND 1.2. Those service users with complete transition plans at least 6 months prior to transitioning, signed off by: • The sending service; • Where applicable, the receiving service; • The young person; • Where appropriate, and where consent is given, the young person's parent(s)/carer(s). The transition plan must include personal transition goals, jointly agreed with the young person. Where they are transitioning into a receiving service, these goals will be picked up later in a post-transition questionnaire on transition experience. For those entering CYPMHS less than 6 months before their date of transition, these requirements must be fulfilled on entry into CYPMHS and no later than one month before transition; AND 1.3. Those service users with a named and contactable transition key worker, at least 6 months prior to transition, in the sending service or, where transitioning into AMHS or other relevant CCG-commissioned services, at the receiving service. This key worker must be known to the young person and their contact details shared with the young person. For those entering CYPMHS less than 6 months before their date of transition, these requirements must be fulfilled on entry into CYPMHS and no later than one month before transition; AND 1.4. Those young people leaving CYP MH services who will not transition to a CCG commissioned

Indicator 5	
	service but back to primary care who have a discharge plan that has been developed and shared with the young person and shared with primary care. 2. The number of young people who reported feeling prepared for transition at the point of discharge from CYPMHS within the reporting period as captured by a Pre-Transition / Discharge Readiness survey. 3. The number of young people who have transitioned to AMHS from CYPMHS within the reporting period who indicate that they have met their personal transition goals as agreed in their transition plan as captured by a Post-Transition Experience survey.
Denominator	1. The number of young people who have transitioned out of the sending service in question during the reporting period. The data required for this audit is easily available to the sending providers who already have access to case notes and are best placed to assess the numbers of young people transitioning out of CYPMHS during the reporting period. Case notes are updated regularly as standard practice, so it is expected this data will provide information needed swiftly and at the required frequency to track transition planning. The audit is to be conducted retrospectively. 2. The number of young people who have transitioned out of the sending service in question during the reporting period. Sending providers must ascertain (through a survey, questionnaire, meeting or other appropriate medium) whether the young person feels prepared for transition at the point of discharge from CYPMHS. 3. The number of young people who have transitioned to AMHS or other CCG commissioned services from CYPMHS within the reporting period Receiving services must ascertain (again, through a survey, questionnaire, meeting or other appropriate medium) whether the young person has met their personal transition goals agreed in their transition

Indicator 5	
	plan (see above, 'Audit'). Where there are multiple receiving services, they must coordinate a single survey, meeting or questionnaire in order to avoid burdening the young person with multiple questions.
Rationale for inclusion	This CQUIN is intended to improve the outcomes for young people who transition out of CYPMHS; to improve young people's experience of transition; to improve young people, parent and carer involvement; and to incentivise the safe transfer of care for young people. The point of transition from CYPMHS is recognised as a point of potential upheaval for young people who may find it difficult to navigate new service settings, or to manage their mental health following discharge from CYPMHS, especially as the availability and offer of support can change dramatically from CYPMHS to AMHS, or voluntary sector services. It is estimated that more than 25,000 young people transition each year[4]. It is reported that this process is often handled poorly, which can result in repeat assessments and emergency admissions for this large cohort of service users at a critical stage in life.[5] Recent research has highlighted how few people make the transition across to adult services, which have a different culture to CYPMHS services and focus more on clear diagnostic categories (Singh, 2009; Singh et al, 2010), with the result that AMHS often exclude young people at the point of transition who may go on to develop more severe problems. Moreover, even when adult services do accept a referral, there is no guarantee that the young person's transfer will be handled properly, and they may go on to disengage with services altogether. The TRACK study (Singh, 2008) shows that transitions for young people at the age of 18 are poorly managed resulting in only 4% of young people receiving an 'ideal transition'. Transitions for vulnerable groups, such as those within the criminal justice system, can be particularly problematic. Audit data from Birmingham suggests 25-50% of under

[4] CYP IAPT data shows that over three quarters in 2015, 6,387 children or young people were seen with first appointments, 692 of which were aged 17 – or 10.8%. Rounding up to 11% as an estimated proportion of those receiving CYPMHS, which research suggests is 230,000 in total, gives us 25,300 young people aged 17 in CYPMHS each year. Some young people transition earlier and some later, so this does not represent a holistic view of those transitioning. The audit supporting this CQUIN will improve the evidence base in this regard.

[5] The TRACK study (Singh, 2008) shows that transitions for young people at the age of 18 are poorly managed resulting in only 4% of young people receiving an 'ideal transition'.

Indicator 5	
	25s disengage from mental health services (Birchwood, Conference presentation, 2010). Disengagement from services can be a major problem, leading young adults to re-present in crisis or with greater severity of need later in life, with socially isolated young adults at greatest risk of poor health and offending. There are significant risks for young people disengaging or being lost in the transition process. This is a vulnerable point in their development as they leave secondary education, move towards more independent living, gain legal responsibility for their choices and lose those parts of their support network that are only available within CYPMHS.[6] The report of the Children and Young People's Mental Health and Wellbeing Taskforce, *Future in Mind*, recommended joint working and shared practice between services to promote continuity of care during transition. This requires careful planning on the part of both CYPMHS and the receiving service. It also depends upon consistent involvement of the young person. 69% of CYP MH Local Transformation Plans published in 2016 highlighted transition as a key area for development.[7] The transition out of CYPMHS must be supported by a robust and coordinated multi-agency approach to transition planning, with the full involvement of both the sending and the receiving service. This process is further strengthened by early and effective planning, which may start as young as 15 or as late as 25, and putting the young person at the centre of the process to help them prepare. The process, in many ways a preparation for adulthood, will need to support young people to be as independent as possible. In addition, *Future in Mind* recommended that vulnerable young people, such as care leavers and young people in contact with the youth justice system, should be taken into account in local strategic planning on transition. In spite of this, services remain often poorly coordinated, and it is vulnerable services users and their families who are left to suffer.

[6] Singh SP, Paul M, Ford T, Kramer T, Weaver T (2008); McLaren S, Belling R, Paul M, Ford T, Kramer T, Weaver T, Hovish K, Islam Z, White S, Singh SP (2013).
[7] North East Central London Commissioning Support Unit analysis of CYP MH Local Transformation Plans 2016

Indicator 5	
	This CQUIN seeks to incentivise more robust transition planning and better experiences of transition, and aligns with NHS England's Business Plan 2016-17 principles on: • Upgrading the quality of care and access to mental health and dementia services. • Strengthening primary care services- to break down boundaries to enable the NHS to work better with local communities. • Transforming Commissioning – integrating health and care. • If transition is handled poorly, this is a cohort that is at risk of isolation and escalating needs, and likely to require repeat admissions and reassessments if receiving services are not fully engaged in the transition process. • This represents a significant cost to receiving services, and wider societal costs for those left isolated at a critical point in their lives who may find it more difficult, for example, to find employment without the stability of a smooth transition as they enter adulthood. This CQUIN follows from published NICE guidelines on CYPMH transition, which recommend: • Ensuring transition support. • Ensuring health and social care service managers in children and young people's and adults' services should work together in an integrated way to ensure a smooth and gradual transition for young people. • Involving young people and their carers in service design. • Ensuring that service managers in both adults' and children and young people's services, across health, social care and education proactively identify and plan for young people in their locality with transition support needs. This CQUIN will incentivise providers to collaborate in order to improve transition planning between sending and receiving services, drawing together disparate elements of the care pathway, and to involve young people and (where appropriate) their families/carers in the process in order to improve young people's transition. This will not only provide continuity of support for young people during this important time; it will also encourage cross-agency working and improve

Indicator 5	
	communication across service boundaries so that receiving services, as a consequence of being fully engaged in the transition planning process, will be better prepared to accommodate the young person transferring to them. <u>Cost and cost effectiveness:</u> • A failure to help young people engage with adult services may lead to increased health, welfare and service costs later on. The immediate impact is often in greatly elevated non-attendance rates and premature discharge. According to clinicians consulted during the preparation of this CQUIN, re-engagement involves both repeat assessment and additional appointments to re-establish engagement– both of which are costly. • This CQUIN indicator is based on one that has been implemented successfully in Liverpool and Sefton, where feedback has been positive and the CQUIN is perceived to be cost effective. • The CQUIN does not require a new or extra service to be put in place. It requires managed care pathways and proper discharge or transition planning. • Possible savings: if transition consisted of one discharge planning session with the young person and a key worker from CYPMHS, one 'handover' meeting with both CYPMHS and the receiving service present, and one session to follow up on transition outcomes with the young person, the process would take 4 sessions of clinical time in total. Discharge/transition planning should already be in place in CYPMH services as a matter of course so only 3 sessions should be required. If we anticipate these clinicians are in mid-Band 7 and cost the service £52,000 per annum, and these four sessions total 1.5 days, less than 1% of a clinician's time, the cost would be around £415 per transition. • Costs avoided: in comparison, one episode of crisis liaison is approximated at £222 per contact, and one occupied bed day for those in more severe need is calculated at £325. Beyond these two examples, it is anticipated that a well-planned transition will have a far wider impact on future costs by supporting the young person into adulthood and employment and avoiding escalating needs in the absence of liaison with services.

Indicator 5	
Data source	1. Joint-Agency Transition Planning to be assessed via Case note Audit. The data required for this audit is easily available to the sending providers who already have access to case notes and are best placed to assess the numbers of young people transitioning out of CYPMHS during the reporting period. Case notes are updated regularly as standard practice, so it is expected this data will provide information needed swiftly and at the required frequency to track transition planning. The audit is to be conducted retrospectively. 2. Pre-Transition / Discharge Readiness to be assessed via User Survey / Questionnaire. This CQUIN does not prescribe the wording for surveys, nor does it require a particular method for taking this information – such as online or telephone surveying. This is to be agreed at a local level and as appropriate for the young person, and signed off by the receiving service, commissioners, and young people. CCGs must be satisfied that the questionnaire wording and methods provide adequate evidence of young people's preparedness for, and experience of, transition. 3. Post-Transition Experience to be assessed via User Survey / Questionnaire. This CQUIN does not prescribe the wording for surveys, nor does it require a particular method for taking this information – such as online or telephone surveying. This is to be agreed at a local level and as appropriate for the young person, and signed off by the receiving service, commissioners, and young people. CCGs must be satisfied that the questionnaire wording and methods provide adequate evidence of young people's preparedness for, and experience of, transition.
Frequency of data collection	1. Joint-Agency Transition Planning to be subject to Half-Yearly case note Audit with the results presented to commissioners. 2. Pre-Transition / Discharge Readiness to be

Indicator 5	
	surveyed as a routine element of a Young Person's pre-transition pathway with CYPMHS. Data to be collated on a Half-Yearly basis and presented to commissioners. 3. Post-Transition Experience to be surveyed as a routine element of a Young Person's post-transition pathway with AMHS. Data to be collated on a Half-Yearly basis and presented to commissioners. Commissioners will submit results for all elements via UNIFY collection to NHS England on a half-yearly basis.
Organisation responsible for data collection	1. Joint-Agency Transition Planning data to be collected by sending CYPMHS providers. The data required for this audit is easily available to the sending providers who already have access to case notes and are best placed to assess the numbers of young people transitioning out of CYPMHS during the reporting period. Case notes are updated regularly as standard practice, so it is expected this data will provide information needed swiftly and at the required frequency to track transition planning. 2. Pre-Transition / Discharge Readiness survey data to be collected by sending CYPMHS providers. 3. Post-Transition Experience survey data to be collected by receiving AMHS providers.
Frequency of reporting to commissioner	Quarterly reporting to commissioner
Baseline period/date	Not Applicable
Baseline value	Not Applicable
Final indicator period/date (on which payment is based)	See below milestones
Final indicator value (payment threshold)	1. Joint-Agency Transition Planning : 80% 2. Pre-Transition / Discharge Readiness: 80% 3. Post-Transition Experience Survey: 70%
Final indicator reporting date	See milestones below

Indicator 5	
Are there rules for any agreed in-year milestones that result in payment?	Yes (see below)
Are there any rules for partial achievement of the indicator?	Yes see below.

Milestones for indicator 5

Date/period Milestone relates to	Rules for achievement of Milestone (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Q1 2017/18	Sending and Receiving Providers to jointly develop engagement plan across all local providers Sending and Receiving Providers to map the current state of transition planning/level of need and to submit joint report on findings to commissioners. Sending and Receiving Providers to develop implementation plan to address identified needs and agree with approach with commissioners	31st July 2017	10% 15% 15%
Q2 2017/18	Sending and Receiving Providers to update and assure commissioners as to implementation of joint plan to support better transition planning	31st October 2017	10%
Q3 2017/18	No Milestones		
Q4 2017/18	Sending Provider to undertake Casenote Audit assessing those who transitioned out of CYPMHS from Q4. Performance rewarded as per rules for partial achievement of the indicator; Reward to be applied to all providers subject to this CQUIN. Sending Provider to undertake assessment of discharge	30th April 2018	Up to 25% Up to 10%

Date/period Milestone relates to	Rules for achievement of Milestone (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
	questionnaires for those who transitioned out of CYPMHS in Q4. Performance rewarded as per rules for partial achievement of the indicator; Reward to be applied to all providers subject to this CQUIN. Receiving Provider to undertake assessment of post-transition questionnaires of those who transitioned to AMHS from CYPMHS through Q4. Performance rewarded as per rules for partial achievement of the indicator; Reward to be applied to all providers subject to this CQUIN. Sending & Receiving Providers to present to commissioners a joint report outlining overall CQUIN progress to date. Results to be submitted to NHS England via Unify2 Collection		Up to 10% 5%
Q1 2018/19	Sending and Receiving Providers to refresh implementation plan in light of Year1 results and confirm arrangements with commissioners.	30th July 2019	5%
Q2 2018/19	Sending Provider to undertake case note Audit assessing those who transitioned out of CYPMHS from Q1-Q2. Performance rewarded as per rules for partial achievement of the indicator; Reward to be applied to all providers subject to this CQUIN. Sending Provider to undertake assessment of discharge questionnaires for those who transitioned out of CYPMHS in Q1-Q2. Performance rewarded as per rules for partial achievement of the indicator; Reward to be applied to all providers subject to this CQUIN.	31st October 2019	Up to 15% Up to 15%

Date/period Milestone relates to	Rules for achievement of Milestone (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
	Receiving Provider to undertake assessment of post-transition questionnaires of those who transitioned to AMHS from CYPMHS through Q1-Q2. Performance rewarded as per rules for partial achievement of the indicator; Reward to be applied to all providers subject to this CQUIN. Sending & Receiving Providers to present results to commissioners.		Up to 15%
Q3 2018/19	No Milestones		
Q4 2018/19	Sending Provider to undertake case note Audit assessing those who transitioned out of CYPMHS from Q3-Q4. Performance rewarded as per rules for partial achievement of the indicator; Reward to be applied to all providers subject to this CQUIN. Sending Provider to undertake assessment of discharge questionnaires for those who transitioned out of CYPMHS in Q3-Q4. Performance rewarded as per rules for partial achievement of the indicator; Reward to be applied to all providers subject to this CQUIN. Receiving Provider to undertake assessment of post-transition questionnaires of those who transitioned to AMHS from CYPMHS through Q3-Q4. Performance rewarded as per rules for partial achievement of the indicator; Reward to be applied to all providers subject to this CQUIN. Sending & Receiving Providers to present to commissioners a joint report outlining overall CQUIN	30th April 2019	Up to 15% Up to 15% Up to 15% 5%

Date/period Milestone relates to	Rules for achievement of Milestone (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
	progress to date. Results to be submitted to NHS England via Unify2 Collection		

Rules for partial achievement of indicator 5

For Year 1 (2017/18):

1. Joint-Agency Transition Planning:

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
80% and above	25.0%
70-79.9%	20.0%
60-69.9%	15.0%
50-59.9%	10.0%
49.9% or less	5.0%

2. Pre-Transition / Discharge Readiness Survey:

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
80% and above	10.0%
60-79.9%	8.5%
40-59.9%	7.5%
20-39.9%	5.0%
19.9% or less	0.0%

3. Post-Transition Experience Survey:

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
70% and above	10.0%
50-69.9%	8.5%
30-49.9%	7.5%
10-29.9%	5.0%
9.9% or less	0%

These payment thresholds are slightly lower than above, in recognition that there may be instances where a young person does not meet their transition goals for reasons beyond the control of the receiving provider. The intention is for this threshold to allow for these instances but simultaneously incentivise receiving providers to do everything in their power to help the young person achieve their transition goals, and to ensure these goals are realistic when set during transition planning.

For Year 2 (2018/19)

1. Joint-Agency Transition Planning:

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
80% and above	15.0%
70-79.9%	12.5%
60-69.9%	10.0%
50-59.9%	5.0%
49.9% or less	0.0%

2. Pre-Transition / Discharge Readiness Survey:

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
80% and above	15.0%
60-79.9%	12.5%
40-59.9%	10.0%
20-39.9%	5.0%
19.9% or less	0.0%

3. Post-Transition Experience Survey

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
70% and above	15.0%
50-69.9%	12.5%
30-49.9%	10%
10-29.9%	5.0%
9.9% or less	0%