11 Transitions across regions and Trusts: an initiative to improve practice and provide a template for other areas

Dr Hassan Mahmood, Dr Dawn Simons, Dr Dave Perry

AIMS AND HYPOTHESIS The aim is to form a model of optimal psychiatric transition for patients with Learning Disability transitioning from Child to Adult services. It is hypothesised that a psychiatric transition model does not currently exist purely for people with Learning Disability (LD). BACKGROUND Transition between children and adult services has always been fraught with difficulty. Many Trusts have within house setup clear transition policies and pathways. However, recently, the Transforming Care Agenda has led to young people with complex needs often being moved out of area to avoid the necessity for hospital care. Consequently, this leads to complex and fragmented follow-up arrangements, often with different organisations inputting into patients from different geographical areas. Therefore there is a potentially higher risk of inpatient hospital admission during this time. A robust strategy is therefore needed to enhance the psychiatric quality of transition and prevent unnecessary hospital admissions. METHODS Recognising the increasing clinical risk issues, clinicians across the West Midlands looked at what would constitute a good model of psychiatric and MDT transition for people with Learning Disability. Some guidance was taken from the NICE guideline below related to transition:- https://www.nice.org.uk/guidance/ng43/evidence/full-guideline-pdf-2360240173 whilst taking into account personal clinical and non-clinical experiences. RESULTS The ideal model of psychiatric transition of care should include the following:- - Meeting between the proposed adult LD psychiatrist and child LD psychiatrist 6 months before they are closed to Child services - Joint child and adult psychiatry appointments towards the end of the patient's time in Child services. - Child and Adult psychiatrists should be aware of the personalised transition keyworker. - An understanding and discussion about the impact of environment on a person's presentation and management plan e.g. a person with challenging behaviour living in a family home in a multicultural setting will present different challenges to a person living in supported living who has their own staff. - Discussion about risk particularly those cases where there have been previous psychiatric hospital admissions - A handover of work carried out by the CAMHS MDT (e.g. Positive Behavioural Support (PBS) plan) to allow, if needed, referrals immediately post-transition within Adult Community Learning Disability Team (CLDT). CONCLUSIONS Transition from child to adult services is an important time in the life of a patient with LD. We recommend a new model of care to ensure an optimal psychiatric transition which could potentially reduce unnecessary hospital admissions and ensure the targets of Transforming Care Agenda are met.