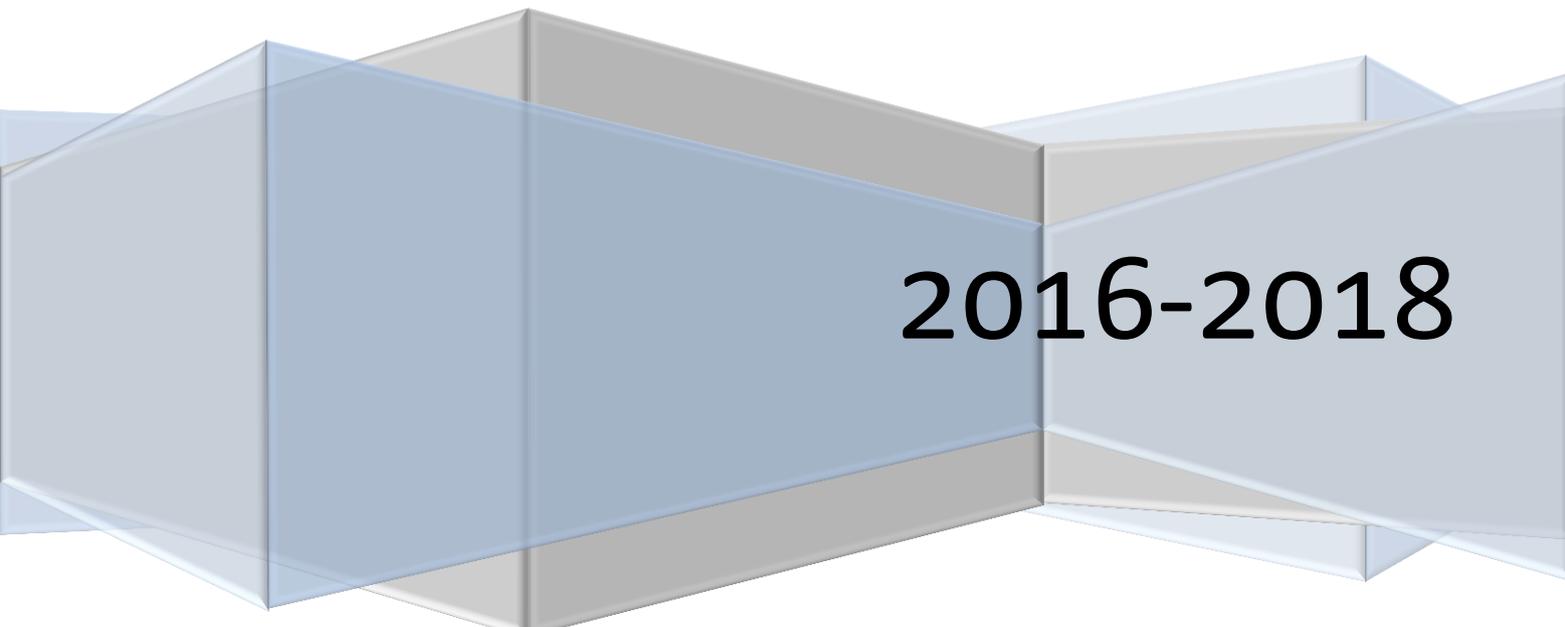


Transition of Care for Young People Strategy



2016-2018

Transition of Care

Definitions

Transition: is defined as a “a multi-faceted, active process that attends to the medical, psychological and educational/vocational needs of adolescents as they move from child to adult centred care” (Blum 1993). It is now advocated that this process starts in early adolescence (DH, RCH)

Transfer: is the event of leaving paediatrics and entering adult services within primary/secondary/tertiary care.

Our aims for Transition of Care

- **To provide safe and effective transition process and transfer (handover) from children’s services to adult services for all young people with complex and/ or long term conditions**
- **To ensure young people are prepared for transition and eventual transfer to adult services**
- **To care for young people and their families in adult services in a developmentally appropriate way without any loss in the quality of services provided, on-going engagement and a good patient experience**

What do we want to do?

We recognise that adolescence and young adulthood is a time of physical, psychological, educational and social change. Young people with a chronic health condition are expected to move from paediatric to adult services. We know from evidence that good practice in transitional care can improve on-going engagement with services and positive health outcomes.

Our aim is to provide a consistent, safe and individualised, high quality transition service that enables young people and carers to move into to adult services with minimal disruption to their care and a good patient and carer experience of the change.

How will we do this?

A transition of care event was held in the Royal Manchester Children’s Hospital which captured the views of some young people on how transition of care could be improved. We have based our strategy on these views, lessons learnt from other organisations and national guidance. In doing this we will deliver the objectives set out below.

Implementation of the strategy will be led by the Medical Director and overseen by experts from both children’s and adult’s services. The Clinical Effectiveness Committee will be responsible in monitoring progress against this strategy.

Our Strategy:

This strategy aligns with our Trust values of compassion, empathy, dignity, consideration and respect.

The work plan that underpins this strategy outlines our plans over the next three years to deliver transition of care services that meet the expectations of young people and their families who use our services.

It sets out objectives for delivering the best experience for young people who are moving/transferring across care settings.

The successful delivery of this strategy will depend on close partnership working with our commissioners, schools and colleges, voluntary sector organisations, local networks and other health and social care providers including general practice.

The principles, infrastructures and pathways under this strategy will be afforded to young people entering healthcare through different portals up to age 25.

Objective one: Every young person who is able to participate in decision making will be involved in discussions and make informed decisions about their own care

What we will do:

- We will seek the views of young people and their families in the development of strategy and policy documentation
- We will involve young people and their families in the development of transition policies and supporting documents and treat them as equal partners in the process
- We will utilise RMCH Youth Forum in the delivery of this strategy
- We will use peer support, coaching and mentoring, advocacy and mobile technology to support delivery of the strategy
- We will ask young people whether the transition process helped them achieve their agreed outcomes and feedback the outputs of this work to young people and their parents/carers
- Transition and transfer processes will be developmentally appropriate taking into account their maturity, cognitive abilities, need in respect of, long term conditions, social and personal circumstances and psychological status
- The transition plan will start early in each young person's clinical journey and be reviewed with the young person on a regular basis (at least annually)

Objective two: There will be a key accountable individual responsible for supporting the transfer of every young person from children's to adult health services.

What we will do:

- We will work with young people and their families to identify a single named worker to coordinate their transition care and support
- The named person will be a doctor, nurse, health or social care practitioner with whom the young person has a meaningful relationship
- The named person will initially be someone based in young people's services but will hand over their responsibilities to an appropriate professional in the adult service when appropriate
- The named person will be the link between the young person and the various practitioners/professionals involved in their support including the named GP if they have one and if not, ensuring they are registered with a GP
- For disabled young people in education, the named worker should liaise with education practitioners to ensure comprehensive student-focused transition planning is provided
- The named person will ensure relevant information such as safeguarding is shared with other organisations, in line with local information-sharing and confidential policies
- The named person will support the young person and their family for a minimum of 6 months before and after the transfer of care, the exact time will be negotiated with the young person

- In clinical areas where large numbers of young people transfer to adult services (for example those caring for young people with long term conditions) there will be a lead individual in that specialty with responsibility for transition

Objective three: Every young person moving/transferring across care settings will have a documented transition plan and a communication or 'health passport' to ensure relevant professionals have access to essential information about the young person.

What we will do:

- We will develop, in consultation with young people and parents/carers where appropriate, transition documentation including passports and plans
- These plans will address all relevant outcomes including those related to education/training/employment, community inclusion, health and well-being including emotional health and independent living
- We will set up a database of young people in transition to ensure accurate shared records are maintained
- We will review the documentation on an on-going basis to ensure it meets the needs of young people and the specialties they are attending
- We recognise that there is a risk of young people becoming disengaged during this process and that there is a need to ensure shared records of care are maintained. Looked after children, care leavers and young carers are especially vulnerable and at risk of disengagement.

Objective four: Every young person moving/transferring across care settings will have training and advice to prepare them and their families for the transition and transfer to adult care, including consent, confidentiality and advocacy.

What we will do:

- We will engage with young people as individuals and talk with them about what to expect during transition and after transfer, their passports, their transition plan and their personal goals
- We will support young people to maximise clinical appointments and consultations
- We will ensure the support we provide focuses on what is positive and possible for the young person rather than on a pre-determined set of transition options
- We will identify the support available to the young person, which includes but is not limited to their family or carers
- We will work with families and carers and talk to them about what to expect during and after transition
- We will develop e learning resources for young people, their families and carers
- We will establish peer support mechanisms to prepare young people for transition

Objective five: All services will be inclusive and responsive to the needs of young people and their families during transition and including when transferring to adult services

What we will do:

- We will ensure that transition planning is developmentally appropriate and takes into account each young person's evolving capabilities, needs and hopes for the future as they grow up. The point of transfer will not be based on a rigid age threshold and will take place at a time of relative stability for the young person
- We will treat the young person as an equal partner in the transition process and take full account of their views and needs

- We will support the young person to make decisions and build their confidence to direct their own care and support over time
- We involve the young person in terms of the way the transition is planned, implemented and reviewed
- We will put young people in touch with peer support groups if they want such contacts
- We will ensure where a young person has a long term condition they are helped to manage their own condition as part of the overall package of transition support.
- We will carry out a gap analysis and respond to the needs of young people who have been receiving support from children's services, including child and adolescent mental health services, but who are not able to get support from adult services.
- We will ensure that everyone working with young people in transition up to the age 25 in children's and adults services will be appropriately trained in transition processes and skilled in communicating with young people.

Objective six: Responsibility for funding will be agreed early in the process and clearly communicated to the young person and their family in order to minimise distress or worry.

What we will do:

- We will work closely with commissioners and other care providers to ensure arrangements are made in a timely way and communicated clearly to young people and their families and carers

Objective seven: All staff involved in transition of care will have training and support to enable them to care for young people and manage transition of care effectively

What we will do:

- We will develop a competency framework related to adolescent health and transition
- We will identify a minimum of two medical leads for training and development on transition
- We will identify nursing and AHP transition champions across all clinical areas
- We will ensure all staff involved in transition have access to training (face to face and e learning), dependant on need, which covers:
 - Effective communication with young people
 - Young people's development (biological including sexual health, cognitive, psychological, social and vocational)
 - The legal context and framework related to supporting young people through transition, including their rights confidentiality, competency, consent and safeguarding
 - Special educational needs and disabilities
 - Youth friendly health services
 - How to involve young people, carers and families in their care, development of services and work in partnership

Objective eight: The organisation will have up to date guidance and policy support for young person friendly transition services which will have measurable outcomes for monitoring

What we will do:

- We will maintain a suite of transition documentation based on local and national guidance
- The policies and transition documentation will be subject to a programme of clinical audit in order to monitor progress

- We will monitor patient and parent/carer reported experience of transition processes and transfer into adult services and use feedback to continuously improve
- Relevant departments will implement the Trust Strategy on Transition and have a written local standard operating procedure

Objective nine: The organisation will work closely with primary care colleagues; commissioners and general practitioners to ensure the Transition process is efficient

What we will do:

- We will share our strategy and Policy with our commissioners and GPs
- We will jointly review systems and practices to identify where change are needed
- We will jointly review service provision to identify where there is no equivalent adult services to refer young people to, or where young people may need to transfer more than one adult service. Outline a joint protocol outlining what to do in such circumstances
- We will involve all practitioners providing support to the young person and their family or carer, including the GP

References:

Transition from children's to adults' services, *NICE Guidance, February 2016*

From the pond into the sea - Children's transition to adult health services, *CQC, June 2014*