The Royal Wolverhampton NHS Trust

Policy Number: CP09

Transition from Children's to Adult Healthcare Services

Contents

Policy Number CP09

Transition from Paediatric to Adult Healthcare Services

1.0 Policy Statement (Purpose / Objectives of the policy)

This policy has been developed in co-production with young people and their families who use our services. All young people deserve the best opportunity to achieve their full potential and in order to do this they need to be supported, valued and protected as they move from paediatric to adult health care.

Department of Health guidance (2006) and NICE guidance (2016) set out the principles and standards along with other current national policy for transition.

This policy document identifies expectations for safe and effective transition from children's to adult services at the Royal Wolverhampton NHS Trust (RWT) for all young people with long term health conditions.

The aim of the policy is to outline the Trust's arrangements for achieving and maintaining compliance with the NICE guidelines on 'Transition from Children's to Adult Services' for young people using health or social care services (NG 43 2016).

2.0 Definitions

2.1 Parent or carer

Person identified by the young person who has been closely involved with caring for them, this may be a mother, father, close relative or close friend who are of adult age (older than 18 years). This policy is to be read in conjunction with the consent policy for details of who has parental responsibility for consent.

2.2 Transition

A purposeful, planned process to firstly prepare young people moving from a child-centred to adult-orientated service and secondly address the medical, psychological and educational/vocational needs of adolescents and young adults with chronic physical and medical conditions as they move from child-centred to adult-oriented healthcare systems (Department of Health (DH), 2006).

2.3 Young person

For the purpose of this policy, the term is used to describe young people between the ages of 12 – 24 years.

2.4 Education, Health and Care Plan

A legally binding plan produced by the Local Authority that documents extra educational, healthcare and social support that is needed in an educational setting beyond that which the educational setting can provide.

3.0 Accountabilities

The Chief Nursing Officer as professional lead for nursing services has the responsibility to ensure that services meet the needs of patients. This includes ensuring that services are appropriate for the needs of young people and reflect the trust's values and standards.

The Chief Medical Officer as the responsible person for professional leadership of medical staff will ensure that there is planned health transition jointly provided by children's and adult services.

Clinical Leads will nominate a lead for transition within the clinical teams for which they will have accountability and responsibility to support and implement recommendations and policy.

Speciality Teams will adopt policies and produce local procedures and pathways within their speciality using approved documentation and audit practice.

Transition Steering Group has a responsibility to promote, influence and develop transition, ensuring that this Transition Policy is revised as practice evolves.

Clinical Staff will take into account the needs of young people when providing care and access training as agreed with their manager, ensuring that young people's transitional care is provided in accordance with trust policy.

All RWT staff will work across organisational boundaries and in partnership with other organisations to ensure effective co-ordination and communication of care.

4.0 Policy Detail

The policy applies to all areas of the Trust where young people are cared for. It is intended to support and align with current developments in city-wide transition.

Recommendations of Young People's Charter should be followed (Appendix 1).

The NHS England resource 'Ready, Steady, Go, Hello' should be used as a best practice approach as recommended by NICE (2016) (Appendix 2).

Routine use of health passports/summaries developed in conjunction with young people should be part of routine practice (Appendix 3).

The specific needs of those with learning disability and autism must be considered and reasonable adjustments made in line with the Equality Act (2010)https://www.gov.uk/guidance/equality-act-2010-guidance and the Learning Disability Strategy http://intranet.xrwh.nhs.uk/pdf/policies/ST-Learning-Disability-Strategy.pdf consulted.

NICE Transition Quality Standards from QS140 must be adhered to (Appendix 4).

Each directorate should develop speciality pathways to ensure a consistent approach to transition across the Trust (Appendix 5). This includes pathways where young people transfer into or out of other trusts during transition. Divisions will oversee adherence to this.

5.0 Financial Risk Assessment

1	Does the implementation of this policy require any additional Capital resources	No
2	Does t h e implementation of this policy require additional revenue resources	No
3	Does t h e implementation of this policy require additional manpower	No
4	Does the implementation of this policy release any manpower costs through a change in practice	No
5	Are there additional staff training costs associated with implementing this policy which cannot be delivered through current training programmes or allocated training times for staff.	No
	Other comments	

6.0 Equality Impact Assessment

An initial equality analysis has been carried out and it indicates that there is no likely adverse impact in relation to Personal Protected Characteristics as defined by the Equality Act 2010.

7.0 Maintenance

This policy will be reviewed every three years by the Transition Steering Group or earlier if warranted by a change in standards, guidance or legislation and/or if changes are deemed necessary from internal sources.

8.0 Communication and Training

The policy will be launched through communications department.
To be placed on the trust intranet.
Transition page available on the intranet.
Band 7/8 Forum/ Senior Nurses Group.
Matrons, Senior Nurses, Midwives & Health Visitors Group.
Head of Nursing/Matrons Operational Group.
The Royal Wolverhampton Hospitals Trust All User Bulletin.
Staff must be made aware of this policy on induction.

Professionals may need to consider further development of their knowledge and skills in working with young people, including: the biology and psychology of adolescence; communication and consultation strategies; multi-disciplinary and multi-agency teamwork; and an understanding of the relevant individual conditions and disorders and their evolution and consequences in adult life.
An e-Leaning package developed by Royal College of Paediatrics and Child Health (RCPCH), Royal College of General Practitioners (RCGP), Royal College of Nursing (RCN) and other Royal Colleges is available to all staff to enable them to develop the necessary skills to help young patients make necessary changes to lead a healthier and more active life. This can be found at:
http://www.e-lfh.org.uk/programmes/adolescent-health/ .

All professionals who have regular involvement in transitioning children to adult services should complete this training which includes a self-assessment questionnaire to identify individual learning needs and targets development.

9.0 Audit Process

Criterion	Lead	Monitoring method	Frequency	Committee
Compliance with 5 NICE quality standards (NG43, 2016)	Speciality Clinical Lead	Retrospective case notes review of number of patients with documented compliance	Annually	Transition Steering Group
Patient satisfaction survey	Speciality Clinical Lead	Engagement with young people	Annually	Transition Steering Group
Monitor compliance with standards set out in the policy	Speciality Clinical lead	Checklist	Annually	Transition Steering Group

10.0 References

- Department of Health (2006). Transitions: Getting it right for young people. London: HMSO
- NICE Guidelines [NG43] Transition from children's to adults' services for young people using health or social care services (2016)
- Equality Act (2010) accessed at https://www.gov.uk/guidance/equality-act-2010-guidance

Bibliography

- Department of Health (2004) National Service Framework for Children, Young People and Maternity Services (www.dh.gov.uk)
- Department of Health (2006). Transitions: Getting it right for young people. London: HMSO
- Department of Health (2008) Transition: Moving on Well: a good practice

guide for health professionals and their partners on transition planning for young people with complex health needs or a disability. London. HMSO

- Care Quality Commission (2014) From the Pond into the Sea: Children's transition to adult health services
- Nagra A, McGinnity P, Davis N, Salmon A (2015) Implementing transition: Ready Steady Go (Arch Dis Child) Dec; 100(6): 313–320.

Part A - Document Control

To be completed when submitted to the appropriate committee for consideration/approval

Policy number and Policy version: **CP09** **Version 1.0**	**Policy Title** **Transition from Paediatric to Adult Care**	**Status:** Final		**Author: Transition Steering Group** **Director Sponsor: Chief Medical Officer**
Version / Amendment History	Version	Date	Author	Reason
	1.0	Dec. 2021	Transition Steering Group	New Policy
Intended Recipients: All staff who have involvement in the transition of young people from paediatric to adult services				
Consultation Group / Role Titles and Date: • **RWT staff consultation** • **Parents of young people cared for at RWT** • **Young people undergoing transition or in adult services at RWT**				
Name and date of Trust level group where reviewed	Trust Policy Group – December 2021			
Name and date of final approval committee	Trust Management Committee – January 2022			
Date of Policy issue	February 2022			
Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated)	December 2024 (3 yearly)			
Training and Dissemination: To be placed on the Trust intranet Band 7/8 Forum/ Senior Nurses Matrons, Senior Nurses, Midwives & Health Visitors Group Head of Nursing/Matrons Operational Group Royal Wolverhampton trust all user bulletin Staff will be made aware of this policy on induction http://www.e-lfh.org.uk/programmes/adolescent-health/ All professionals who have regular involvement in transitioning children to adult services should complete this training which includes a self-assessment questionnaire to identify individual learning needs and target development.				
To be read in conjunction with: Local Guideline for the Admission of Young People who are aged 16 to 18 years of age CP06 Consent Policy CP36 Chaperoning of Patients and Clients				

CP53 Safeguarding Adults Policy CP41 Safeguarding Children Policy OP97 Confidentiality Code of Conduct for Staff Wolverhampton joint strategy for Children and young people with special Educational Needs and Disability 2015-2020 RWT All Age Learning Disability Strategy 2018-2021	
Initial Equality Impact Assessment (all policies): **Completed Yes** **Full Equality Impact assessment (as required):** **Completed Yes / No / NA** If you require this document in an alternative format e.g., larger print please contact Policy Administrator 8904	
Monitoring arrangements and Committee	Transition Steering Group Report compliance to the Quality and Safety Advisory Group
Document summary/key issues covered. Transition is a gradual process of empowerment that equips young people with the skills necessary to manage their own healthcare as they move towards and into adult services and lifestyles. It is a carefully planned process undertaken over time which includes (but is more than) a planned transfer to adult services. Inadequate transitional care impacts on long-term health outcomes for children and young people. The purpose of this policy is to provide guidance and principles of good practice in relation to the transition of young people from paediatric to adult services at The Royal Wolverhampton Trust	
Key words for intranet searching purposes	Transition

Part B **Ratification Assurance Statement**

Name of document: Transition from Paediatric to Adult Healthcare

Name of author: Lesley Barrett, Paediatric Rheumatology Clinical Nurse Specialist

I, Lesley Barrett, the above named author confirm that:

- The Strategy/Policy/Procedure/Guidelines (please delete) presented for ratification meet all legislative, best practice and other guidance issued and known to me at the time of development of the said document.
- I am not aware of any omissions to the said document, and I will bring to the attention of the Executive Director any information which may affect the validity of the document presented as soon as this becomes known.
- The document meets the requirements as outlined in the document entitled Governance of Trust- wide Strategy/Policy/Procedure/Guidelines and Local Procedure and Guidelines(OP01).
- The document meets the requirements of the NHSLA Risk Management Standards to achieve as a minimum level 2 compliance, where applicable.
- I have undertaken appropriate and thorough consultation on this document and I have detailed the names of those individuals who responded as part of the consultation within the document. I have also fed back to responders to the consultation on the changes made to the document following consultation.
- I will send the document and signed ratification checklist to the Policy Administrator for publication at my earliest opportunity following ratification.
- I will keep this document under review and ensure that it is reviewed prior to the review date.

Signature of Author: L Barrett

Date: 01/11/2021

Name of Person Ratifying this document (Director or Nominee):
Job Title:
Signature:

- I, the named Director (or their nominee) am responsible for the overall good governance and management of this document including its timely review and updates and confirming a new author should the current post-holder/author change.

To the person approving this document:

Please ensure this page has been completed correctly, then print, sign and email this page only to: The Policy Administrator

IMPLEMENTATION PLAN

To be completed when submitted to the appropriate committee for consideration/approval

Policy number and policy version	**CP09 Version 1.0**	
Reviewing Group		**Date reviewed:**
Implementation lead: Author		

Implementation Issue to be considered (add additional issues where necessary)	**Action Summary**	**Action lead / s (Timescale for completion)**
Strategy; **Consider** (if appropriate) 1. Development of a pocket guide of strategy aims for staff 2. Include responsibilities of staff in relation to strategy in pocket guide.	Launch Trust wide once ratified with educational event Transition webpage available.	3 months Transition Steering Group
Training; Consider 1. Mandatory training approval process 2. Completion of mandatory training form	Current signposting to e-lfh on line training.	Note: awaiting NHSE 3 tier training programme completion for national training guidance
Development of Forms, leaflets etc; Consider 1. Any forms developed for use and retention within the clinical record **MUST** be approved by Health Records Group prior to roll out. 2. Type, quantity required, where they will be kept / accessed/stored when completed	Ready/Steady/ Go documentation available from Medical Illustration Available for ordering by all departments caring for young people undergoing transition.	Relevant departments to be made aware of availability of documentation Transition Steering Group
Strategy / Policy / Procedure communication; Consider 1. Key communication messages from the policy / procedure, who to and how?	Key personnel and cascade identified in policy document.	3 months Transition Steering Group
Financial cost implementation Consider Business case development	Each speciality will be required to identify own gap and develop business case if necessary.	Speciality leads

Other specific Policy issues / actions as required e.g. Risks of failure to implement, gaps or barriers to implementation		

Appendix 1 – Young People's Charter

Young people either undergoing or who have completed transition to adult services at RWT have created a podcast to document their experiences and thoughts on transition. This is to support other young people undergoing transition, to hear the experience of others to help them prepare for their own journey and also for healthcare staff to gain insight to ensure that transitional healthcare can be designed and delivered in an acceptable and relevant way.

Short podcast (7 minutes)
http://trustnet.xrwh.nhs.uk/EasySiteWeb/GatewayLink.aspx?alId=12218

Long podcast (18 minutes)
http://trustnet.xrwh.nhs.uk/EasySiteWeb/GatewayLink.aspx?alId=12219

This charter is a summary of the practices that young people and their families involved in listening events expressed a need for in order to make the transition from paediatric to adult healthcare at RWT a good experience.

Building Trusting Relationships – It is important to meet the adult team in advance of transfer of care so that an open relationship can be built. An overlap of services such as transition clinics should be organised and where possible informal meetings such as transition events would help in getting to know new teams. Young people want to be able to be honest in information sharing and have the confidence to speak up about lifestyle issues.

Education to Facilitate a Gradual Move to Independence - Central to this gradual move to independence is ongoing education about treatment, medication and lifestyle as well as discussions around the young person's rights, consent, confidentiality and capacity. There should be an opportunity to discuss educational and occupational aspirations and offer advice and support relating to their condition around this. Information and/or signposting relevant to their condition and any peer support should be available in different forms in clinics as well as information about transition. This information should be age appropriate and adjustments should be made according to young people's level of understanding.

Being Seen Independently - Being offered the opportunity to be seen alone for part of the consultation as a gradual move to independence is important with young people taking increasing control of their decision making and self-management. It is important to do this in small steps over a period of time throughout transition to build confidence and skills in self-disclosure. Feedback on how well young people are doing with this is significant and should be ongoing.

Environment – Visiting the adult environment before eventual transfer is principal to a smooth transition. The environment should be welcoming with positive patient information available. An awareness by RWT staff members that this can be a difficult time, with recognition of outside stressors influencing young people's decision making is crucial and measures taken to provide reassurance and information to young people to mitigate this is essential. The differences in service provision between children's and adult services need to be explained prior to transfer, with key contacts and organisation explained.

Communication – Young people should have a written copy of their ongoing clinic letters and transition summary. Young people noted to have a learning disability should have an "alert" put on their record and reasonable adjustments made. Accessible communication with healthcare teams is fundamental to aid self-management, and young people need a service that is easily contactable and approachable. A range of communication methods can be used such as text, telephone or e-mail.

Appendix 2

Using 'Ready Steady Go Hello'

1. All young people moving from children's to adult services will undergo a transition programme - 'Ready Steady Go Hello' (RSGH): TIER Network - TIER Professionals Homepage (readysteadygo.net)
This will be initiated in children's services and completed after a successful transition to adult services. Transition should address the medical, psychological and educational/vocational needs of the young person and acknowledge those of their parents/carers.

2. Young people and their parents/carers start the RSGH transition programme, around 12 years of age, age 14 at the latest. Other condition specific programmes may be used in conjunction with RSGH.

3. Young people and carers are introduced to RSGH through the `Transition: moving into adult care' information leaflet, in addition to any service specific information. https://www.uhs.nhs.uk/Media/UHS-website-2019/Patientinformation/Childhealth/ReadySteadyGo/Transitionmovingintoadultcare-patientinformation.pdf.

4. During consultation the young person completes a "Ready" questionnaire, designed to establish what needs to be in place for a move to adult services. This is monitored during each outpatient appointment until the young person is deemed ready to move to the "Steady" questionnaire. These are addressed over time rather than during a single consultation.

5. In time the young person completes the "Steady" questionnaire which explores topics in greater depth and is used to confirm progress as well as addressing any on-going issues or concerns.

6. The "Go" questionnaire is completed in the final 1-2 years in children's services to ensure that the young person has all the skills and knowledge in place to go to adult services. Any gaps identified in skills or knowledge must be referred onto the adult services.

7. The young person will be introduced to the adult team within the year prior to the planned transfer. At this stage, a named worker should be identified in the adult team.

8. Where it has not been possible to transfer a young person to a single adult service, the GP will have a co-ordinator role in the young person's care, it is important to ensure the GP is involved and fully informed that responsibility for overseeing care for the young person's chronic condition is most appropriately managed by Primary Care and Community teams. Therefore, the Lead Clinician from the specialist team in children's services must write to the GP to ensure they are aware of their on-going responsibilities.

9. The young person and parents/carers must know who is responsible for any on-

going care prior to discharge from children's services within the trust.

10. The actual timing of the move to adult services is one that should be mutually agreed by the young person, parents/carers and health care professionals.

11. Any issues, concerns and progress should be documented in the RSGH questionnaires by the healthcare team or keyworker. On transfer to adult services the "Hello to Adult Services" programme and "Hello" questionnaire are completed by the adult services.

12. The "Hello" questionnaire should be monitored annually by the healthcare team until completed to ensure that the knowledge and skill levels or new/on-going concerns and problems are addressed.

13. In conjunction with the young person there is an option for the parent/carer to complete a separate questionnaire. This follows the same format as the RSGH questionnaires and may assist in supporting them throughout the process.

14. Any young person who is new to RWT and first presents to any adult services with a long-term condition should start the Hello to Adult Services programme at a time considered appropriate to the health care team – this follows the same format as RSGH and it is designed for use for all young people regardless of age or sub-specialty.

15. Where the young person has learning disabilities, the parent/carer should work through the RSGH programme with them, engaging them as much as possible, utilising an easy read version as appropriate. If deemed appropriate, carers with a young person who has a severe disability can also start RSGH, so that they too are prepared for the move to adult services allowing all concerns/issues to be carefully addressed and progress monitored prior to transfer. There will be close liaison with the young person's GP and those with learning disabilities will be encouraged to attend the GP annual health review from age 14 years. Young people with an EHCP(Education, Health and Care Plan) will have a discussion around preparing for adult outcomes and support required within their plan.

16. A referral to the Learning Disability Liaison Nursing team (e-mail: rwh-tr.LearningDisabilities@nhs.net) should be offered for support with transition http://trustnet.xrwh.nhs.uk/departments-services/l/learning-disabilities-service/. A referral may also be appropriate if it is predicted that the person will have complex needs to be addressed in the future when admitted to the adult ward or for general support. A 'Hospital Passport' should be offered to anyone who has a learning disability for use on admissions, these can be found on the Learning Disability Intranet Site http://trustnet.xrwh.nhs.uk/departments-services/l/learning-disabilities-service/hospital-passport.

17. Clinical Directors and Operational Service Managers must ensure there are appropriate services for children, young people and adults to support transition with age-banded clinics (e.g. adolescent clinics, transition clinics, young adult clinic etc..).

Ready Steady Go: Moving through the programme

Ready Steady Go: Each Young person (YP) progresses at their own pace

11-12 yrs
YP and carer Introduced to Ready Steady Go programme with information leaflet + video
www.uhs.nhs.uk /readysteadygo

11 – 13 yrs
YP completes **Ready**
Issues addressed in bite sized pieces.
YP and carer introduced to concept of shared decision making and confidentiality
When ready YP seen on own for a few minutes during clinic.
Agree goals

14 – 16 yrs
YP completes **Steady**
Issues addressed in bite sized pieces
Aim to see YP for longer on own in clinic. Keep carer fully involved
Duplicate clinic letters offered to YP
Agree goals

16 – 18 yrs
YP completes **Go**.
Issues addressed in bite sized pieces
Work towards YP conducting whole clinic on own. Keep carers involved
Referral letter to adult team.
YP meets adult team.
On-going issues highlighted to adult team. Ideally all issues addressed prior to transfer.
Write transfer letter
Agree goals

1st adult clinic
YP +/- carer completes **Hello**
Issues addressed in bite size pieces by HCP.
Clinic letters sent to YP
Periodically **Hello** completed again to ensure knowledge + skills maintained
Any issues addressed.
Agree goals

Carer completes parent/carer questionnaire alongside YP questionnaires. Any issues discussed. Goals agreed.

YP with learning difficulties completes as much as possible alongside carer who is YP advocate.

Appendix 3 – Passports and Summary Letters

http://trustnet.xrwh.nhs.uk/departments-services/l/learning-disabilities-service/hospital-passport/

Documentation required by the adult providers should include the following.

1. A medical summary from diagnosis.

2. A summary of the young person and their family dynamics, how the young person would like their parents/carers involved in their future care.

3. Any safeguarding issues.

4. Transition care plan.

5. Progress against transition documentation e.g. Ready Steady Go.

6. This information will be required by all of the services to which the young person will be transitioning to include any supportive service e.g. allied health care professionals.

7. Completed transition documentation must been copied, scanned and filed within the medical notes to include a record of transition planning such as a transition checklist completed by the patient or their parent/carer. Effective transfer should be documented by a speciality specific process e.g. copies of clinic letters from adult services sent to paediatric team.

8. The GP will be informed of the transfer via clinic letters and should already be aware the patient has been through transition. An overall medical summary will be provided by the Paediatric Consultant and sent to the GP, adult speciality, young person and their family. Individual speciality procedures will identify contributors to this summary dependant on need.

Appendix 4 - NICE Quality Statements

Statement 1 Young people who will move from children's to adult services start planning their transition with health and social care practitioners by school year 9 (aged 13 to 14 years), or immediately if they enter children's services after school year 9.

Statement 2 Young people who will move from children's to adults' services have an annual meeting to review transition planning.

Statement 3 Young people who are moving from children's to adults' services have a named worker to coordinate care and support before, during and after transfer.

Statement 4 Young people who will move from children's to adults' services meet a practitioner from each adults' service they will move to before they transfer.

Statement 5 Young people who have moved from children's to adults' services but do not attend their first meeting or appointment are contacted by adults' services and given further opportunities to engage.

Appendix 5 - Example of transition care planning pathway

Young person aged 12 years or over - identify whether likely to have ongoing needs once aged 16 years, if so..
Concept of transition introduced by member of MDT, introductory resources given to young person and parent/carer.

EARLY TRANSITION
Completion of 'Ready' materials by young person in clinic.
Option for parents to complete parent questionnaire.
Transitional planning issues in letter to GP at each visit and copied to the young person.
Review checklist at each visit and complete transition plan when issues addressed.
Identify Current services.
Identify transition lead.
Young person encouraged to keep/given a personal health record/ passport
On conclusion of early transition, transfer to adolescent clinic where available.

MID TRANSITION
First appointment in adolescent clinic, where available.
Completion of 'Steady' materials by young person.
Review checklist at each visit (at least annually) and complete transition plan when issues addressed.
Identify key adult services and make referrals as appropriate.
Identify any gaps in adult services.
Introduce young person to adult services.
Transitional planning issues in letter to young person, copied to GP and relevant MDT
For complex needs - MDT meeting(s), including the GP instigated.

LATE TRANSITION
Completion of 'Go' materials by young person.
Joint transition planning with young person, family/carers, appropriate health and social care providers.
Transitional planning issues in letter to young person, copied to GP and relevant MDT.
Transfer summary provided to all services included in the transfer process.
If lead for care returning to GP, lead clinician writes to GP to inform of ongoing responsibilities.
Introduced to adult team within a year of transfer and named worker identified in the adult team.
Joint clinic, where available between paediatric and adult services.
Gaps in skills or knowledge referred to the adult service.

HELLO TO ADULTS
Discharged from paediatric teams when needs being met by adult services.
Completion of 'Hello' questionnaire and commence 'Hello to adult services' programme instigated by adult team.
If young people do not attend their first adult appointment, they must be contacted by the adult team.