

**TRANSITION OF YOUNG PEOPLE AGED 12 TO 21 YEARS FROM CHILD-CENTRED TO ADULT ORIENTATED SERVICES POLICY**

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| Version: | 1.0 |
| Approval Committee: |  |
| Ratified by: |  |
| Date ratified: |  |
| Date Issued: |  |
| Review date: |  |

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1. **Introduction**

Transition can be defined as “a purposeful, planned process that addresses the medical, psychosocial and educational/vocational needs of Young People with chronic physical and medical conditions as they move from child-centred to adult-oriented health care systems.” (‘Transition – Getting it right for young people’ Department of Health 2006)

There have been calls from the UK government that ‘services for adolescents should be given greater focus and priority.’ It is recognised that transition planning should be commenced at an earlier age (around 12 years ideally, but at least by the age of 14) but concentrated around the age of 16 With support continuing up to the age of 21 facilitated by a Key Worker designate.

Transition is widely recognised, in both policy and practice, as being a very stressful and difficult time for young people and their families. ‘Moving on well’ (Department of Health, 2008) stresses the importance of multi-disciplinary/multi-agency support, co-ordinated by a lead professional/key-worker. This lead professional is able to support the young person and their family to navigate the complex transition process and also signpost them to services. Young people with complex health needs should have a transition health action plan in place. Transition should be a flexible process not an ‘event’.

CQC’s document ‘From the pond to the sea’ (2014) also advocates the use of good transition plans, development of a Health Passport as appropriate to that Young Person’s individual needs and a lead professional be designated to co-ordinate the process and support the young person and their family. Paediatric and adult teams need to work more closely together. Young people and their families also need information on what to expect from adult services.

The Children and Families Bill (2013) was passed and became the Children and Families Act (2014). For children and young people with special educational needs and disabilities, the act aims to get education, health care and social care services working together. There should be one overall assessment at the same time for what help they need with their education, health and social care needs. They would also know what help they can get to meet these needs. This would then formulate a single Education, health and care plan (EHC) and can be from birth-25 years old.

The act also states that Preparing for adulthood outcomes should become a focus of person centred reviews from year 9 onwards. The outcomes are based on what disabled young people say is important to them. They cover employment, independent living, community inclusion and health.

http://www.preparingforadulthood.org.uk/what-we-do/pfa-outcomes

Teenage years can be a difficult time for young people especially for those who have on-going health needs, so it is essential that young people and their families under the care of the Bradford Teaching Hospitals NHS Foundation Trust (BTHFT), are confident and have a clear understanding about how the transfer of health care will take place from Children’s Services into Adult Orientated Services. BTHFT is committed to developing a working initiative to identify the gaps in the service provision between their Children and Adult Services. The Transition Forum at BTHFT was established in July 2011 to give that greater focus. Terms of Reference have been agreed (Appendix 1).

This initiative will include working with the Clinical Commissioning Groups to commission and BTHFT to provide comprehensive services to meet the needs of young people transitioning from children to adult orientated services. The Darzi Report (2008) suggested that “every Primary Care Trust will commission comprehensive and prevention services, in partnership with local authorities, with the services offered to meet the specific needs of the local population.

* 1. **Our vision is:**

Young people are supported to make the transition to adulthood and to achieve their maximum potential in terms of education, health, vocation, development and well-being.

Young people are taking responsibility for their own health and making informed choices and decisions regarding their emotional and social development, as well as their health and well-being both, now and in the future.

* 1. **Stages of Transition**

There are four main stages:

**1.2.1 Early stage (12-14yrs)**

In the early stage the aim is to introduce the young person and their family to the concept of transition to adult health provision and the need for the young person to develop their autonomy whilst being supported by their family. The young person should become aware of their own health care needs, and the full implications of their medical condition.

**1.2.2 Middle Stage (14–15yrs)**

During the middle stage the young person and their family further develop an understanding of the transition process and what to expect from the adult health care system. The young person should practice their skills, gather more information and begin to set their goals. Initiatives such as self-medication, self-care and ‘parent-free’ consultations can help young people begin to take responsibility for their own health care needs.

**1.2.3 Late stage (15-19yrs)**

By the late stage at around 15 years old the young person and their family should be feeling confident about leaving the paediatric system, and wherever possible the young person should have a considerable degree of autonomy over their own care.

**1.2.4 Becoming engaged and attending with adult services (16-21yrs)**

During this stage the young person should be increasingly engaged and attending with adult services, feel that they have a autonomy over their own care which is facilitated by a good working relationship with their GP

**Definitions:**

**Transition**: “a purposeful, planned process to firstly prepare young people moving from a child-centred to adult-orientated service and secondly addresses the medical, psychological and educational/vocational needs of young people who have chronic physical and medical conditions as they move from child-centred to adult-oriented health care systems.”

**Clinician**: the professional responsible for the young person’s care i.e. doctor or nurse specialist.

**Key Worker**: a professional who has the responsibility for collaborating with professionals from their own and from other services and developing good working relationships with many professionals to ensure co-ordination of care for the young person.

**Parents:** a mother, father, close relative or close friend who are adults (older than 17 years) and who have been closely involved in caring for children prior to admission to hospital

1. **Purpose and Scope of Policy**

This policy aims to set out best practice for all healthcare professionals enabling the delivery of a well-planned transitional process for young people. The document sets out the requirements to ensure all young people (12-21years) receive a quality service when transitioned from child-centred to adult-orientated services. The purpose of this policy is to ensure all staff are clear about their roles and responsibilities when working with children and young people. This policy is designed to assist all healthcare professionals involved in the care of young people to ensure young people receive a seamless and quality service when transitioned from child-centred to adult-orientated services. The principles apply to doctors, nurses, allied health professionals, & other members of the multi-disciplinary team. The policy applies to all employees of BTHFT who may come into contact with children and young people who are directly involved in the care of young people that are undergoing transition from child-centred to adult-orientated services.

1. **Role and Responsibilities:**

**3.1 The Chief Nurse is responsible for:**

For ensuring that appropriate processes are in place for the transition of young people (12-21yrs) from child-centred to adult orientated services .

**3.2** **Heads of Nursing and Matrons are responsible for:**

Ensuring policy and procedures are implemented and monitored

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**3.3 Trust Transition Forum:**

Hasresponsibility for rolling out this policy, maintaining good communication links with all clinicians across the organisation and ensuring staff training is delivered.

**3.4 Consultants/ Matrons/ Departmental/Ward Managers/ Team Leaders are responsible for:**

Ensuring standards are met, actions are carried out and areas of concern are raised and escalated appropriately.

**3.5 All staff are responsible for:**

Ensuring that all children and young people receive appropriate information and are supported through the transition process. That a Key Worker has been identified from the professionals working with that young person to support that young person through transition. That Key Worker must identify a key worker designate (from adult services) to support that young person once discharged from children’s services to ensure that they are engaged and attending with adult services.

Involving Key Partners:

Ensuring that key partners in the Young Persons transition process are referred to, informed and involved at an early stage, the exact make up of key partners involved will vary depending on individual need.

This will always involve the Young Person’s GP as their role is crucial once the Young Person is under Adult Services. The key worker must identify a ‘named and responsible GP’ who will be the lead healthcare professional once the Young Person has been discharged by their Paediatrician.

If on-going care and/or nursing support is required key partners will include the Social Services Transition Team and the BDCT Continuing Healthcare/Personal Health Budgets Team

If the Young Person has a diagnosis of a Learning Disability key partners will include the BDCT Learning Disabilities Service

If the Young Person has a diagnosis of Autism and/or mental health problems, key partners will include Child and Adolescent Mental health services and Adult Mental health services.

For all Young People, Key Partners from the voluntary/non-statutory sector will include those who can support the Young Person directly or those involved in caring and/or supporting them.

**3.6** **The Transition Care coordinators for young people with complex and continuing physical health needs are responsible for:**

Ensuring that Young People who fall within this specific patient group, as well as families and professionals working with them. Receive appropriate information and support during their transition to adult orientated health services. They will be the Transition Key Worker (and key worker designate) for the young people on their caseload, and available to support that young person up to the age of 21 *(can we say 25 as per cqc aspirations?)*

They also have a responsibility for supporting Transition work in a wider context throughout the Trust, supporting various specialist teams and individual practitioners.

1. **Equality and Diversity:**

In line with the BTHFT Equality and Diversity Strategy, this policy aims to support all children and young people irrespective of disability, mental capacity, race, religion/belief, language, birth, nationality, ethnic or national origin, gender identity, sexual orientation, marriage and civil partnership, responsibility for dependents, medical conditions, intellect, age, professional association or political belief while accessing BTHFT services.

BTHFT recognises that due to discrimination people may experience particular inequalities in accessing health services. The Foundation Trusts objective is to deliver high quality services that are accessible, responsive and appropriate to meeting the diverse needs of different groups and individuals.

All reasonable endeavours will be used to establish the person’s preferred method of communication and communicate in a way they can understand. This will ensure access to the interpreting service where people use language’s (including sign language) other than English. Every effort must be made to respect the person’s preferences regarding gender and background of the interpreter.

**4.1 Equality Assessment Statement**

This Policy was assessed in 2013 to determine whether there is a possible impact on any of the nine protected characteristics as defined in the Equality Act 2010.

It has potential impact on:

* Age.
* Disability
* Race and ethnicity
* Sexual orientation
* Gender
* Gender reassignment
* Marriage and civil partnership
* Maternity/pregnancy
* Religion and belief
* Human Rights

1. **Implementation:**

Paediatric services should retain primary responsibility for treatment until a clearly defined moment of transfer to adult services takes place. It is important to develop flexible transition arrangements which can deal with a range of needs.

One identified barrier to successful transition is coping with the different level of expectations between paediatric and adult services. For example, adult patients are expected to take more self-responsibility for their care and managing their medication, and may be expected to make on-the-spot decisions at clinics. These responsibilities can be difficult for young people newly transferred from paediatric services and who may be missing the support from paediatric services that they have been used to. Professionals should arrange where possible for support for the young person to develop these skills prior to the formal transfer of care. The young person should be able and encouraged to ask questions, give opinions and make decisions.

The time at which a young person is ready for transition to adult healthcare will depend on several factors. Not all young people will be ready to make the transfer to adult services at the same time and their cognitive and physical development, their emotional maturity and their state of health must be taken into account. The decision ‘when’ rests with the appropriate clinician, young person and their family. The clinician could be either the Consultant Paediatrician or Clinical Nurse Specialist responsible for the young person’s treatment and care.

There is no ‘right time’ for transition to adult healthcare although recommendations suggest that children and their families are introduced to the concept of transition from the age of 12-14yrs. It is expected that the majority of young people will be transferred to full adult care by 17yrs but for those with complex needs the process may take longer.

* 1. **Pathway**

When a clinician feels the time is right to consider transition from child-centred to adult-orientated services (considering the expected ages of the CQC) the young person and their family will need to be involved in all discussions. And a transition key worker identified. Even if this means separate meetings for the young person without their main carers present, to give them independence. For these young people, a transition programme between Paediatric and adult-oriented health services must provide co-coordinated, uninterrupted healthcare to avoid negative consequences, ranging from psychological distress and co-morbidity and mortality. (a young person’s non-engagement with adult health services can have serious consequences for their health and long-term outcomes.

A transition programme can be successful if organised with the active participation and interest of the receiving adult service. Prior to any transfer of care that involves a change in Consultant; the accepting clinical team is responsible for documenting, in the patient notes, their willingness to take over the young person’s care. The key worker will identify a key worker designate to support the young person once under adult services.

Young people who it is anticipated may present to the acute services either frequently or with complex care needs need to have this part of their transition process carefully managed. A clear pathway of care with identified lead adult consultants and a care plan should be developed with each such young person and relevant acute department of the Trust so that acute care can be safely accessed both within and out of regular working hours.

* 1. **Care Planning:**

It will be the responsibility of the key worker to ensure a plan of care has been devised and agreed with the young person and their family. This care plan will be clearly documented in the case notes to ensure all multi-professionals use and work to the same plan. Care planning at every stage of transition can usefully be divided into 6 broad headings: Self-advocacy, Independent healthcare behaviour, Sexual health and psychosocial support, educational and vocational planning and Health and lifestyle (RCN 2004) and (Benchmarks for transition from children’s to adult service doc). The paediatrician or clinical nurse specialist is responsible for ensuring the patients clinical notes are up-to-date, copies of key letters and summaries are given to the young person to keep in a Personal Health Record.

* 1. **Preparation and Education of Young Person and family**

The philosophy of paediatric services is child and family centred where carers usually take the lead in their child’s care. For successful transition many young people will also benefit from help in developing skills in communication, decision making, assertiveness and self-care, helping them to manage social, educational and employment opportunities and challenges and develop the independent living skills which underpin fulfilment and well-being. Parent(s) or guardian(s) may also value support, information and guidance in advocacy. Adult services tend to be specialty focused and input from a number of adult services will be required to achieve a holistic approach for the young person. Healthcare professionals will provide continuous education and support to both the young person and their family, providing the young person with the necessary skills to take on full responsibility for their own care.

* 1. **Key worker & Co-ordination of care delivery**

Many professionals can be involved in a young person’s care, so establishing clear lines of accountability is essential. A key worker has responsibility for collaborating with professionals from their own and from other services developing good working relationships with many professionals to ensure co-ordination of care for the young person. Each young person should be allocated a named key worker within both children’s and adult services who work closely together taking responsibility for monitoring their health, social, psychological, educational and employment needs.

The transition process will take more time to establish if the young person has more than one health need. A key worker will be allocated to every young person who is going through the transition process and this information will be documented in the patient’s case notes, and transition health action plan to be developed with clear plan of actions needed, by the Key Worker from the beginning of the transition process

* 1. **Young Person Facilities**

Individual patients will be admitted under the direct care of the specialist, or seen by the relevant specialist dealing with their condition i.e. in outpatients, assessment areas or day- case units. In some departments Registered Children’s nurses will be working in the area and these staff can respond to the needs of young people by providing family-focused care, which is recommended in Child Health policies. As extra support and for advice to staff, Paediatricians and Registered Children’s nurses can be contacted from the Children’s Assessment Unit 24 hours a day. 01274 282311

Young people commonly feel uncomfortable in wards or clinics where they are surrounded by small children or elderly adults. Ideally, dedicated young person facilities are required for both in-patient and outpatient attendances with décor appropriate to this age group.

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A philosophy of care, which acknowledges the unique needs of young people, will be formulated within the Children’s Unit. These units are required because the psychological and developmental needs of young people are very different to those of children or adults and are unlikely to be met in children’s or adult wards. The common needs of young people unite sick young people more than the particular needs of their diseases separate them. As BTHFT does not have a dedicated young person’s unit, the individual needs of these young people should be considered, e.g. parental input, schooling etc. The Paediatric team are available to offer advice and support. 01274 382311

* 1. **Young Person In Patient Facilities**

The most appropriate place to care for young people with either medical or surgical conditions who require admission to hospital is in a Young Person unit, which may be attached to or entirely separate from the general, Children’s Unit. In Bradford the majority of young people (14-16 yrs.) are currently cared for in the Children’s Unit and those over 16yrs are admitted onto adult wards, the exception being young people with additional needs still under a paediatrician admitted with non-surgical issues to the children’s medical wards up to the age of 19

If young people with a learning and/or physical disability (over the age of 16 years) are admitted outside the Children’s Unit, Matrons and Clinical Leads should ensure that operating policies and facilities take into account the additional needs of these young people. All facilities must ensure consideration of the needs of people who have disabilities. If a young person has a physical, sensory or indeed any form of disability then facilities should be appropriate to that individual young person’s disability to encourage and enable independence.

Health should be promoted at every opportunity through education, written information and verbal reinforcement. All areas need to keep accessible and appropriate health promotion literature on topics such as safe sex, smoking and substance abuse. All this information should be in plain English and available in appropriate ethnic languages.

* 1. **Young Person Out Patient Facilities**

The requirements for adequate transition planning are often best met by the development of dedicated young person or ‘handover’ clinics. These should be multidisciplinary, may be led by non-medical professionals and consideration should be given to late afternoon and evening clinics.

1. **Consent to medical treatment for young people:**

Please refer to BTHFT Consent Policy:

[**http://nww.bradfordhospitals.nhs.uk/Medical%20and%20Healthcare%20Library/Policies/Current/PatientMan&ClinicalPolicies/CP08%202014%20Consent%20Policy.pdf**](http://nww.bradfordhospitals.nhs.uk/Medical%20and%20Healthcare%20Library/Policies/Current/PatientMan&ClinicalPolicies/CP08%202014%20Consent%20Policy.pdf)

1. **Safeguarding Children and Young People:**

Safeguarding children and protecting them from harm is everyone’s responsibility. Everyone who comes into contact with children and families has a role to play. (HM Government 2015)

Safeguarding and promoting the welfare of children is defined for the purposes of this guidance as:

- Protecting children from maltreatment

- Preventing impairment of children’s health and development;

- Ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and

-Taking action to enable all children to have the best outcomes.

For children up to the age of eighteen where safeguarding children’s concerns have been identified, please refer to Bradford Teaching Hospitals NHS Foundation Trust Safeguarding children’s policy for fuller guidance. (HYPERLINK) Alternatively access the safeguarding children’s webpage via the trust intranet, where contact details for the team can be found and complex cases can be discussed directly.

Children who are in the care of the local authority (either in foster care, or alternative living arrangements) are referred to as being a Looked After Child (LAC). Although they remain a child up to 18 years, they continue to have additional health and social care input up to the age of 21 to help them make the transition into adulthood via the pathway planning team at children’s social care. All children who are a Bradford LAC are highlighted (flagged as a code 15) within the trust on IPM, to help identify that they may have additional liaison requirements. Full details can be found within the flags and alerts policy and on the safeguarding children’s website and policy.

Non- compliance and failure to attend appointments for medical treatment can be a common theme where there are safeguarding concerns. For all young people up to the age of eighteen who fail to attend an appointment a second appointment should be offered. Should the young person fail to attend the second appointment the consultant with whom the child is under should make a decision based on the clinical details available as to the implications of the child not attending for treatment. In cases where the child is deemed to be at risk of significant harm as a result of a failure to attend for medical treatment, then the case should be discussed with the consultant on call for child protection or the Named Dr for child Protection. Help and advice may also be sought from the safeguarding children’s team. The young person’s GP and either Health Visitor or School Nurse should be consulted for less serious concerns, where community follow up may be appropriate.

For young people over the age of eighteen please refer to the Safeguarding Adults Policy.

[**http://nww.bradfordhospitals.nhs.uk/Medical%20and%20Healthcare%20Library/Policies/Current/Other/OP01%202013%20Safeguarding%20Adults%20Main%20Document.pdf**](http://nww.bradfordhospitals.nhs.uk/Medical%20and%20Healthcare%20Library/Policies/Current/Other/OP01%202013%20Safeguarding%20Adults%20Main%20Document.pdf%20)

A vulnerable adult is described as an individual aged 18 or over who may be in need of community services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself or protect themselves against significant harm or exploitation (No secrets, 2000).

Reference

HM Government (2015) Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children.

* 1. **Procedure to be followed if a Young Person Absconds from the ward/area**

For Children and Young People up to the age of eighteen please refer to BTHFT Safeguarding Children Policy (section 2.8)

[**http://nww.bradfordhospitals.nhs.uk/Medical%20and%20Healthcare%20Library/Policies/Current/PatientMan&ClinicalPolicies/CP59%202014%20Safeguarding%20Policy.pdf**](http://nww.bradfordhospitals.nhs.uk/Medical%20and%20Healthcare%20Library/Policies/Current/PatientMan&ClinicalPolicies/CP59%202014%20Safeguarding%20Policy.pdf)

For young people over the age of eighteen please refer to the Adult Missing Person’s protocol.

[**http://nww.bradfordhospitals.nhs.uk/Medical%20and%20Healthcare%20Library/Policies/Current/Other/OP01%202013%20Appendix%20F%20-%20Missing%20Patients%20Protocol%20(February%202013).pdf**](http://nww.bradfordhospitals.nhs.uk/Medical%20and%20Healthcare%20Library/Policies/Current/Other/OP01%202013%20Appendix%20F%20-%20Missing%20Patients%20Protocol%20(February%202013).pdf)

* 1. **Confidentiality and Information sharing**

Personal information held by professionals and agencies, is subject to a legal duty of confidence, and should not normally be disclosed without the consent of the subject. However, the law permits the sharing of confidential information necessary to safeguard and protect children or vulnerable adults. The protection of children and vulnerable adults overrides the duty of confidentiality. BTHFT has a support mechanism Trust wide. Matron (ward/area), Safeguarding Children Team, Safeguarding Adults Team, Social Services, Discharge Team and Clinical Site Co-ordinators can all assist.

* 1. **Young People who May Pose a Risk**

For Young People over the age of sixteen who pose a risk please refer to the BTHFT violence management and reporting policy

[**http://nww.bradfordhospitals.nhs.uk/Medical%20and%20Healthcare%20Library/Policies/Current/RiskManagement/RM29%202014%20Policy%20on%20the%20prevention%20and%20management%20of%20violence%20and%20aggression.pdf**](http://nww.bradfordhospitals.nhs.uk/Medical%20and%20Healthcare%20Library/Policies/Current/RiskManagement/RM29%202014%20Policy%20on%20the%20prevention%20and%20management%20of%20violence%20and%20aggression.pdf)

1. **Research Involving Young People:**

Please refer to BTHFT Research Policy.

[**http://nww.bradfordhospitals.nhs.uk/Medical%20and%20Healthcare%20Library/Policies/Current/PatientMan&ClinicalPolicies/CP72%202014%20Policy%20for%20the%20Management%20of%20Research.pdf**](http://nww.bradfordhospitals.nhs.uk/Medical%20and%20Healthcare%20Library/Policies/Current/PatientMan&ClinicalPolicies/CP72%202014%20Policy%20for%20the%20Management%20of%20Research.pdf)

It is important that research involving young people is carried out properly. Without it, we would not improve our knowledge and the care we deliver to young people

Research may provide information that can be applied generally to an illness, disorder or condition, demonstrate how effective and safe a new treatment is, add to evidence that one form of treatment works better, or safer, than another or may examine wider issues.

When a study involves participants under the care of a doctor, nurse or social worker for the condition to which the study relates, those care professionals are informed that their patients or users are being invited to participate, and agree to retain overall responsibility for their care.

When the research involves a service user or carer or a child, looked after or receiving services under the auspices of the local authority, the agency director or her deputy agrees to the person (and/or their carer) being invited to participate, and is fully aware of the arrangements for dealing with any disclosures or other relevant information.

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1. **Complaints**

Please refer to BTHFT Complaints Policy

[**http://nww.bradfordhospitals.nhs.uk/Medical%20and%20Healthcare%20Library/Policies/Current/PatientMan&ClinicalPolicies/CP07%202014%20Management%20of%20Complaints%20and%20Concerns%20Policy.pdf**](http://nww.bradfordhospitals.nhs.uk/Medical%20and%20Healthcare%20Library/Policies/Current/PatientMan&ClinicalPolicies/CP07%202014%20Management%20of%20Complaints%20and%20Concerns%20Policy.pdf)

1. **Monitoring**

The Transition Form Group will produce a bi annual report for the Chief Nurse and Divisional Managers in relation to Transition within BTHFT.

1. **Financial Implications**

There are currently no financial implications for the BTHFT in relation to this policy.

1. **Review Arrangements**

This policy will be reviewed by the BTHFT Transition Forum in 2 years’ time, unless a change in legislation or procedures requires earlier review of the policy.

1. **Training:**

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. AnE-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 so they can develop the necessary skills to help young patients make necessary changes to lead a healthier and more active life. It is an interactive on line sessions. This can be found on: [**www.rcpch.ac.uk/AHP**](http://www.rcpch.ac.uk/AHP)**.** It is easy to register and is free. Professionals within the Children’s Unit can be a resource for practitioners particularly in respect of communication, team working and understanding conditions and disorders and their evolution, as now many children and young people survive into adult hood with complex conditions that previously would have been lethal in infancy. Our adult colleagues also have a role to play to educate Paediatric staff on the age range 16-19 years.

**Appendices:**

1. **General pathway for transition to adult services for children and young people**

**GENERAL PATHWAY FOR TRANSITION TO ADULT SERVICES FOR CHILDREN AND YOUNG PEOPLE**  **(to be initiated by age 15 years)**

**Potential Collaborators**

**In transition process**

Children’s nurse

Specialist Nurse

Paediatrician

School Nurse

Children’s outreach

Community Nurse

School assistant

Play specialist

LD Team

Is transition to adult hospital services needed?

**Young person by age 15 years**

With complex and continuing health needs requiring on-going adult care

**(Also consider new referrals aged 15+ years)**

Follow local transitional guideline

No

Yes

Transfer to GP care

**CONSIDER**

* Role of independent advocate to support the young person.
* From 14 years, young people with learning disabilities should be offered a Health Action Plan and VIP passport
* From 14 Years al young people should have health passport (unless above more appropriate
* Copies to the young person, carer advocate, GP and school nurse.
* Consider Direct Access/admission pathway
* Copies to the young person, carer advocate, GP and school nurse.
* Mental Capacity Act: consent and best interest.
* Deprivation of Liberty

Lead transition worker identified from Transition Team

Produce plan for GP to refer to adult services using agreed criteria

**From 15 years**

Yearly review at OPA

* Paediatrician/Adult physician
* Young person
* Parent and key worker
* Set objectives for the year
* Identify targets
* Work with key worker to meet goals
* Provide written information about transition

Consider input from adult teams

Checklist

Key worker identified

Age started planning …………

Which service/physician ……...

Acute care needs addressed

Health Plan produced

**Handover**

**16 – 17 – 18 – 19 years**

Yearly review at OPA

* Adult physician
* Paediatrician (as appropriate)
* Young person
* Parent and key worker
* Review transition programme
* Debrief and discuss paediatric event
* Identify specific targets

Liaison with GP as required

Transition Complete –

send information to

* OPA young person
* Parent/carer
* Community Matron
* General Practitioner
* All professional’s involved

**2. References**

Bradford Teaching Hospitals NHS Foundation Trust (2014) Consent Policy

Bradford Teaching Hospitals NHS Foundation Trust (2014) Safeguarding children: policy, procedures and guidance

Bradford Teaching Hospitals NHS Foundation Trust (2014) Management of complaints and concerns policy

Bradford Teaching Hospitals NHS Foundation Trust (2008) Equality and Diversity strategy 2008-2015

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Department of Health (2006) Transition: getting it right for young people. Improving the transition of young people with long term conditions from children’s to adult health services. Department of Health & Department for Education and Skills

HM Government (2015) Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children.

1. **Useful resources**
2. **https://www.togetherforshortlives.org.uk/professionals/.../transition\_taskforce**

Together for short lives is a national charity for children with a life limiting or life threatening condition. They offer support and advice to parents and professionals. They also campaign for children and their families to have equal access to resources and support. They have established a Transition Taskforce to lead the development of a co-ordinated strategic approach to providing care and support to young people with life-limiting or life-threatening conditions.

1. [**http://www.preparingforadulthood.org.uk/resources/pfa-resources/factsheet-the-children-and-families-act-and-the-care-act**](http://www.preparingforadulthood.org.uk/resources/pfa-resources/factsheet-the-children-and-families-act-and-the-care-act)

**https://**[**www.preparingforadulthood.org.uk/**](http://www.preparingforadulthood.org.uk/)

The Preparing for Adulthood programme (PfA) is funded by the Department for Education as part of the delivery support for the SEN and disability reforms.

1. [**https://www.edcm.org.uk/campaigns-and-policy**](https://www.edcm.org.uk/campaigns-and-policy)

Every Disabled Child Matters (EDCM) is the national campaign fighting for rights and justice for disabled children. It is a consortium campaign run by four national organisations working with disabled children and their families - [Contact a Family](http://www.cafamily.org.uk/), the [Council for Disabled Children](http://www.councilfordisabledchildren.org.uk/), [Mencap](http://www.mencap.org.uk/) and the [Special Educational Consortium](http://www.councilfordisabledchildren.org.uk/what-we-do/networks-campaigning/special-educational-consortium).

1. **https://www.uhs.nhs.uk/.../TransitiontoadultcareReadySteadyGo/Transitiontoadultcare.aspx**

A transition tool developed for use in children over 11 years old with a long term medical condition.

‎ **4 . Publications**

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