Trust Policy		NHS Worcestershire Acute Hospitals NHS Trust

Transition of Care for Young People from Paediatric to Adult Services – Local Framework

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Approved by: Paediatric Governance and Children and Young People Board
Date of approval: 21st May 2025 (Governance) 14th May (CYP Board)
Review Due: 21st May 2028 This is the most current document and should be used until a revised version is in place
Target Organisation(s) Worcestershire Acute Hospitals NHS Trust
Target Departments All departments involved in the care of Young People 14yrs -25yrs
Target staff categories All staff involved in the transition of Young People

Policy Overview:
This policy outlines the Trust's vision of ensuring the effective transition for young people with long-term conditions from children to adult services to improve health outcomes and optimise quality of life.

Key amendments to this document

Date	Amendment	Approved by:
17/01/2024	Added Hello section, safeguarding, Transition and the Mental Capacity Act and Decision Making, link to the trusts transition website.	Paediatric Clinical Governance team.
21st May 25	Document reviewed and approved	

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Scope of this document

There is significant call for improvements and reform of transition services as poor healthcare transition can cause young people to disengage with the health service and consequently, their health can deteriorate. Healthcare transition is often associated with poor health and social outcomes in terms of disease control, social participation and educational achievement.

The NHS Long Term Plan suggests moving to a 0–25-year service model where appropriate, in order to enhance children's and young people's (CYP) experience of health, continuity of care and outcomes, and experience of transition between services. This model encompasses a comprehensive offer for 0-25-year-olds that spans mental health and physical health services for children, young people and young adults.

Whilst a 0-25 year model requires significant strategic planning and infrastructure change alongside commissioners to develop innovative models of care the purpose of this document is to therefore assist all healthcare providers involved in the care of young people in Worcestershire Acute Hospitals NHS Trust to provide a seamless transition in accordance with current national guidance and evidence.

It is recognised that certain duties within this document are outside of the Trust's control. Commissioners, Target Adult Services and General Practitioners are not bound by this policy but have responsibilities in achieving effective transition. The Trust will work in partnership with these stakeholders in order to implement the policy.

This policy will:

- ensure consistency of practice across Worcestershire Acute Hospitals NHS Trust,
- ensure equality for all young people served by the Trust,
- ensure well coordinated care between specialities, Trusts, primary care and community services for young people with more complex medical conditions.

This policy will not include:

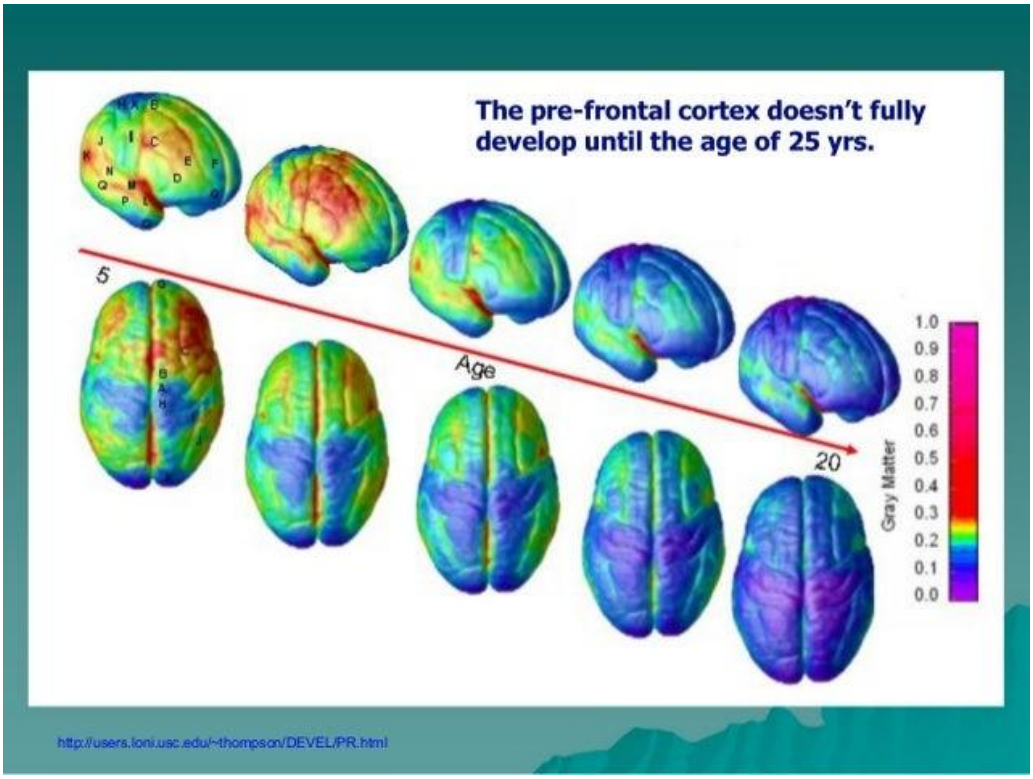
- the transition of CAMHS patients to adult psychiatric services

All persons working within Worcestershire Acute Hospitals NHS Trust who have contact with young people are expected to meet these standards.

Introduction

Imaging techniques show striking changes in white and grey matter between 11 and 25 years of age, with increased connectivity between brain regions, and increased

dopaminergic activity in the pre-frontal cortices, striatum and limbic system and the pathways linking them.



In healthcare settings these changes are especially relevant to young people with long term conditions as they move to their young adult life whilst adapting to the cognitive and behavioural changes caused by changes in their brain. (Arch Dis Child, 2013). Therefore, young people (12-25 years) with long-term conditions require careful planning of their care for them to successfully transfer to adult services at a time that is appropriate for the individual.

Transition should involve preparing the young person for moving to adult services, the formal transfer of their care to a lead adult health professional and the subsequent support to establish them in the adult service. It is essential that this process is well planned and executed to smoothly transition from child-centred to adult orientated services, to ensure young people have their voices heard, promote independence and decision making, and improve health outcomes. The process covers not only their medical conditions, but also their psychosocial, educational and vocational needs. This includes young people with learning disabilities and those Looked After Children who will need support to manage their own health. Services must work across primary and secondary care, physical and mental health, education providers (including early years, further education and higher education), social care, paediatric and adult services, SEND, learning disability and autism services, adult services, employment and housing.

The primary aims of transition are to:

1. provide high quality, well planned but flexible, uninterrupted care from children to adult services
2. promote a young person's independence and equip them with the skills to make and communicate their own thoughts and decisions regarding their own care and management of their long-term condition
3. provide support for the young person's parents/guardians/caregivers during the transition process
4. to promote lifelong functioning and potential (McDonagh 2008, Viner 2008)

Transition should also address the transition of the reorientation of their care from their parents/caregivers when appropriate.

Young people with long-term conditions make up a significant proportion of children's services and therefore it is essential for their care to seamlessly transition to adult services. It has consequently been highlighted in many national policies, which underpin the transition process at Worcestershire Acute Hospitals NHS Trust (WAHT). The national policies and frameworks of note are:

- Care Quality Commission (2014) *From the pond into the Sea: Children's transition to adult health services CQC Transition Report Summary lores.* (2014).
- Facing the Future: Standards for Children with Ongoing Health Needs. RCPCH 2018
- Lost in transition (2024) Moving young people between child and adult health services. Royal College of Nursing
- NHS England (2023) Mental Health of Children and Young People in England, 2023 - wave 4 follow up to the 2017 survey, NHS Digital.
- Ready Steady Go - TIER Network www.readysteadygo.net/rsg.html
- The Inbetweeners. A review of the barriers and facilitators in the process of the transition of children and young people with complex chronic health conditions moving into adult health services. NCEPOD 2023
- The NHS Long term plan (2019)
- Transition from children's to adults' services for young people using health or social care services. National Institute for Clinical Excellence (NICE) 2016 NG43
- Transition from children's to adults' services. Quality standards. National Institute for Clinical Excellence (NICE) 2016 QS140
- Transition to Adult Services Pathway from Together for Short Lives (2023) www.togetherforshortlives.org.uk/resource/transition-adult-services-pathway
- You're Welcome - quality criteria for young person friendly health services (updated 2023)

Definitions

Transition: The planned process of preparing and moving the care of a young person with long-term conditions from child-centred to adult services.

Transfer: The actual point at which the responsibility for providing care and support to a person moves from a children's to an adults' provider.

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

Parent: The young person's mother, father or other adult who holds parental responsibility, and who have been caring for the young person.

Young person: There is no clear definition or consensus of what age a child turns into a young person, on average this is between the age of 10-19 years (Word Health Organisation 1977). The Royal College of Paediatric and Child Health (RCPCH), however states that adolescence is a developmental stage with no defined age period. For the purposes of this framework we refer to a Young Person up to the age of 25 years.

Long-term condition: A physical or mental health condition which lasts for over 6 months and will require ongoing management and monitoring from adolescence into adulthood.

Complex long-term condition: a long-term condition which often affects more than one organ system and requires involvement of more than one specialty.

Duties and Responsibilities

Executive Lead
An executive representative to ensure processes in place to enable implementation within WAHT and provide adequate assurances.

Divisional Director/Nursing Director
Are responsible for ensuring that the appropriate processes are in place in order to implement the transition policy.

Clinical Director/Matrons
Are responsible for ensuring the policy and processes are in place and are being adhered to. Appropriate action must be taken for non-compliance with this policy.
Ensure that staff receive appropriate training in accordance with the identified training needs analysis.

Paediatrician
Is responsible for the young persons' medical care until transfer to adult services has taken place, i.e. doctor or nurse specialists.

Adult Clinician
Is responsible for the young persons' medical care from transfer across to adult services

Transition Lead
Doctor or specialist nurse nominated to take responsibility to support and monitor implementation of the policy on an individual basis.

Transition Nurse Clinical Specialist
Supports the Paediatric Multi-disciplinary Team and adult service team to ensure seamless Transition is embedded within the Trust. Acts as an advocate for families giving expert support and advice based on best practice and close communication with the paediatric and relevant adult service.

All Clinical Staff
Must work to and comply with this policy and its associated procedures.

Must ensure that they receive appropriate training and are competent to undertake the procedures as detailed

Identify any issues of concern in relation to the use of the policy and bring this to the attention of their line manager in a timely way.

Children's Board
Is responsible for rolling out this policy and ensuring the standards are met across the Trust.

Pathway for Good Quality Transition Care within Worcester Acute Hospitals Trust

Please see Appendix 1 for flowchart

The Transition Process – Ready, Steady, Go, Hello!

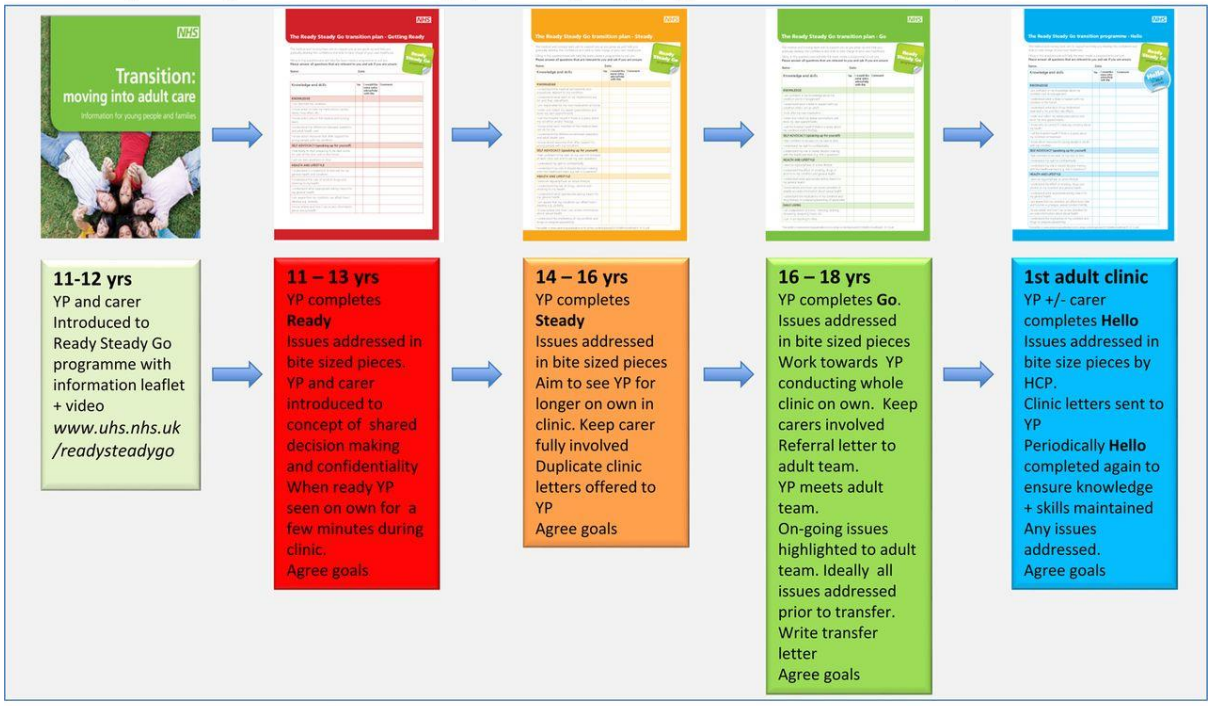
The transition process at WAHT is guided by the NHS England's and TIER network '**Ready, Steady, Go, Hello**' initiative. It is expected that the majority of young people will be transferred to full adult care by 17 years but for those with complex needs the process may take longer. The process should be strengths-based and focus on what is positive and possible for the young person rather than on a pre-determined set of transition options. It should identify the support available to the young person, which includes but is not limited to their family or carers.

Children's Services recognise that '**Ready, Steady, Go, Hello** may not meet the needs of all patients and in some instances an individualised, specialty specific transition pathway which shares the same philosophy may be used e.g. Diabetes, Cystic Fibrosis.

The transition documentation process is illustrated below. A transition plan should be included in the young person's notes which record the process through each stage through "tick boxes" and written notes. This should be completed by/with the young person and answers discussed at clinic appointments. An example of this is included in Appendix 1 but can be downloaded from the Transition intranet page, or the Tier Network website at www.readystedygo.net. Forms are also available in as Easy Read and in number of other languages through the website.

Ready Steady Go: Moving through the programme

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



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.

There are four main stages to transition:

READY
Early stage 11-13y
School years 7-9

STEADY
Middle Stage 14-16y
School years 9-11

GO
Late stage 16-18+
School years 11+

Hello
…to adult services
Post-transter 16y+

Start 16 plus pathway to start to identify adult teams and use the
3 decisions model of care to involve them within this process.

i) READY **- Early stage (11-13yrs, school years 7-9)**

The primary aim of the early stage is to introduce the young person and their family to the concept of transition to adult health care 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.

It is suggested that clinic letters are copied to the adult teams starting at this stage for them to become aware of the young person, their management and any other important information.

A "Ready" questionnaire should be completed by the young person by their 14th birthday in order to initiate the transition process.

ii) STEADY **- Middle Stage (14–16yrs, school years 9-11)**

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. They begin to take more responsibility for their own health with initiatives such as self-medication, self-care and 'parent-free' consultations which can help young people begin to take responsibility for their own health care needs. It is also recommended, where appropriate and agreed, that a copy of the clinic letter should be addressed to the young person from the age of 14 years to help encourage responsibility for management of their own health.

A "Steady" questionnaire should be completed by the young person's 15th birthday.

iii) GO - Late stage (16-18+yrs, school years 11+)

By the late stage (at around 15 years of age) the young person and their family should be feeling confident about leaving the Children's service, and the young person should have a considerable degree of autonomy over their own care.

A "Go" questionnaire should be completed prior to, or at the beginning of this process.

It is recommended that during the 'Go' phase a 1st joint appointment led by the Paediatric team is made. This may be with specialist nurses or consultants.

A 2nd joint appointment should be made led by adult services including nurse specialists and consultants involved with the young person's care and this may represent the official transfer over to adult services

It is strongly recommended that clinic letters are addressed to the young person during this stage, and copied to their parents and other healthcare professionals to encourage autonomy and independence.

During transfer the young person should be given details of their first visit to adult care and what to expect. The time interval between their last appointment in children's services and first appointment in adult services should be limited to maximise adherence and attendance.

iv) HELLO – Post Transition – to be completed at first adult clinic appointment

The Hello questionnaire is the 16y+ questionnaire that the young person +/- carer should complete at their first adult clinic appointment. This will allow the opportunity for issues to be addressed in bite sized pieces.

The Hello Questionnaire is completed periodically to ensure knowledge and skills are maintained. Any issues addressed and goals agreed by the new adult clinical team. This will give the new adult team an opportunity to get to know the young person and identify any areas they need to give more information on and discuss further.

The Timing of Transfer

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 11

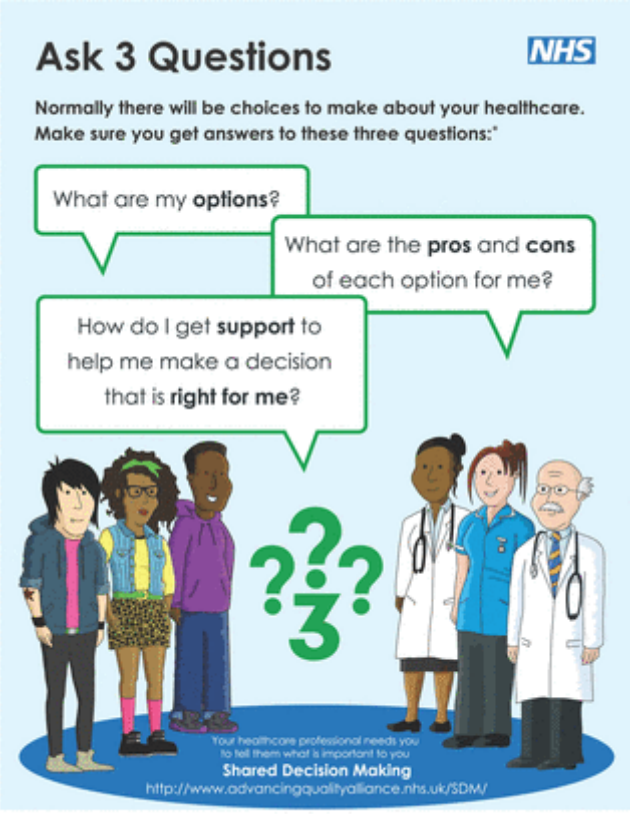
years. Not all young people will be ready to make the transfer to adult services at the same time and their cognitive and physical development, their emotional maturity, communication needs, caring responsibilities and their state of health must be taken into account. It may also be important to consider transition in terms of their school year and note important stages and responsibilities in school to ensure not only transition is initiated at an appropriate time, but all future transition stages are considered. For example, it is not appropriate for transition to be completed while a young person is sitting their GCSE exams. The time at which a young person is ready for transition to adult healthcare rests with the appropriate clinician, young person and their family. The clinician could be either the Consultant Paediatrician or Nurse Specialist responsible for the young person's treatment and care.

When a clinician or the young person feels the time is right to consider transition from child centred to adult-orientated services, discussions must involve the young person and their family, and at times separate meetings may be needed from their main carers in order to promote their independence. Transition between Paediatric and adult-oriented health services will provide co-coordinated, uninterrupted healthcare to avoid negative consequences, ranging from psychological distress and anxiety to medical catastrophe or premature death.

Transfer may be delayed if the young person has a learning disability, cognitive impairment, neurodivergence or unstable disease at the time of proposed transfer or life limiting disease during adolescent years.

Shared Decision Making and "Ask 3 Questions"

Shared Decision Making is core to the Transition process and encouraging health autonomy and independence as the young person moves into adulthood. The **'Ready, Steady, Go, Hello'** process supports patient focused "Ask 3 Questions initiative. Research shows that encouraging patients to ask 3 simple questions leads clinicians to provide higher quality information about their care, management, risk/benefits and future options. Posters will be displays in patient areas, but prompting to ask 3 questions during clinic appointments is encouraged.


Ask 3 Questions
NHS
Normally there will be choices to make about your healthcare.
Make sure you get answers to these three questions:*
What are my options?
What are the pros and cons of each option for me?
How do I get support to help me make a decision that is right for me?
Your healthcare professional needs you to tell them what is important to you
Shared Decision Making
http://www.advancingqualityalliance.nhs.uk/SDM/
AQuA

Ready Steady Go:

Moving on up together 16+ pathway

A '**Young Person (YP) Transfer of Care Checklist**' (appendix 4) has been designed to use as a prompt for the clinician to complete when the patient turns 16 and the transition hand-over begins. The proforma documents the decisions made during the pathway, by clinician and patient, around the YP's transfer of care. The proforma also documents whether A3Q was used during the decision making and that SDMQ9 +1 was used to follow up discussions for patient reflection.

YP turns 16.
Where will their long-term adult care be?

Adult hospital team	Ensure YP is engaged in Shared Decision Making. Use **Ask 3 Questions**.	GP
Refer to adult team in this hospital.		Inform GP of intention for primary care follow-up.
Complete 'Go' questionnaire and identify any areas that need to be addressed before YP leaves paediatric care to ensure YP is empowered to manage their condition.		Complete 'Go' questionnaire and identify any areas that need to be addressed before YP leaves paediatric care to ensure YP is empowered to manage their condition.
Make a plan with the YP of expected number of joint clinics with adult team and book in first paediatric-led appointment.		Make a plan with the YP regarding alternating appointments with the GP (if appropriate) and inform GP of follow-up plan.
Paediatric consultant to liaise with adult consultant. MDT members to hand over to adult counterparts (where applicable).		Write a discharge letter confirming follow-up plan and transfer of care..
Confirm plan with adult team for transition/transfer. Organise joint appointments if required.		Invite to celebration event.
Write a discharge letter confirming follow-up plan and transfer of care.		
Invite to celebration event.		

Late presentation
Start them on the appropriate transition path. Introduce to the 'Ready Steady Go' Programme with the 'Steady' questionnaire as a starting point.

Important note
Patient remains under children's services until first attendance at adult services.

Ensure any missed appointments (WNB or DNA) during this transition process are recognised and discussed between paediatric and adult partners to agree a plan of action.

Transfer may be delayed if replacement appointments are considered necessary to provide thorough handover.

If a patient DNA's repeatedly in initial year of transfer, liaison with Paediatric Team is recommended to agree next steps.

Shared Decision Making

Transition Leads

CYP have the right to receive high quality evidenced based care delivered by staff who have the correct set of skills (DOH 2003, page 21). Specialty leads act as transition leads for their service to implement and maintain these standards:

Speciality	Paediatric Lead	Adult Lead
Allergy	Dr Dawson and Dr Seager	GP
Asthma	Dr Watson and Dr Onyon	Dr Bethan Barker
Cardiology	Dr Van der Velde	Allocated Adult Cardiologist
Diabetes	Dr West and Dr Hield	Dr Irfan
Endocrinology	Dr West	Dr Ramalingam Bhaskar
Epilepsy	Dr Gallagher and Dr Ratcliffe	Dr Laura Alvis
Gastroenterology	BCH Gastroenterology +/- General Paediatrician	Dr Samuel Smith
General Paediatrics	General Paediatrician	GP +/- appropriate adult consultant specialist
Gynaecology	Miss Blackwell	Miss Blackwell
Haematology	Dr Kamalarajan	Dr Kaddam
Metabolic	BCH Metabolic Consultant	Tertiary (QE) Consultant
Nephrology	Dr Ahmed	Dr Oh or QE Renal Transition Clinic
Oncology	Dr Kamalarajan	Dr Kaddam
Respiratory	Dr Onyon and Dr Watson	Bronchiectasis: Dr Jamie Johnstone CF: Birmingham Heartlands Hospital Other diagnosis: adult specialist depending on diagnosis
Rheumatology	BCH Rheumatologist +/- General Paediatrician	Dr Caroline Cardy (18yrs onwards)
Surgical Specialities (General, Urology, ENT, Vascular, Breast)	Consultant General or Specialist Surgeon	Consultant General or Specialist Surgeon

Speciality specific transition support can also be provided by the Clinical Nurse Specialists.

Safeguarding

For young people who are known to Children's Services, under Child Protection Plans or have ongoing safeguarding concerns then it is the responsibility of the clinical teams to ensure that Children services and appropriate safeguarding teams are involved in the transition from paediatric services to adult teams. This is particularly important for those involved with county lines and MASH teams.

Young people are particularly vulnerable to being lost to follow up during this transition period and once entering adult services. It is therefore imperative that young people are not discharged without ongoing follow up arrangements.

Alterations have been amended to the adult 'patient access policy' as below.

Children and Young People
"Patients who have transitioned from paediatric teams must be given further opportunities of appointments if they DNA to allow consideration for the adjustment of care and time to settle within the adult teams.

If the young person DNA their first appointment offered, then a further appointment must be offered within a timely manner and a letter sent by the adult team to the young person and family and GP. The family need to be included as the young person may have moved out of the area to university for example.

If the young person further DNAs their 2nd appointment then a further appointment should be offered however contact should be sought with the young person to try and understand the reason behind the DNA. This could be done by the Consultant, Clinical nurse specialist, the GP or by the transition nurse if referred via generic email wah-tr.transitionintoadultcare@nhs.net"

If there are concerns about Young People not attending appointments, then appropriate referrals should be made to Worcestershire Children's Services via Family Front Door or Social Services.
Further advice can be sought by the hospital Safeguarding Teams.
https://www.worcestershire.gov.uk/info/20501/children_young_people_and_families/1842/how_to_contact_childrens_social_care
https://www.worcestershire.gov.uk/info/20980/i_am_a_professional_and_wish_to_refer_to_adults_services

In order to remind clinical teams and highlight the vulnerability of young people preparing for, going through and on entering adult services an Alert can be set up on PAS. This will state:
Alert - preparing for transition – moving to adult care
This can be set up through the secretarial support staff.

Self Neglect:
As a Young Person transfers to adult services then health care professionals should be mindful of self neglect.
Self-neglect typically features a triad of behaviours –
a. Lack of self-care to an extent that it threatens their personal health and safety.
b. Failure to attend to their living environment to the extent that it becomes hazardous to self or
others e.g. fire risk, infestation, lack of sanitation.
c. Failure to seek help or access services to meet their critical health and social care needs.

For further information and resources are found on the Worcestershire Safeguarding Website:

https://www.safeguardingworcestershire.org.uk/wsab/sars/themes-from-sars/self-neglect-2/

Admission of Children and Young People to the Inpatient ward at Worcestershire Acute Hospitals NHS Trust

Young people <17 years of age are admitted to Riverbank Ward under the care of the paediatric team. 17-18 year olds can choose to be admitted to an adult ward or to Riverbank Ward under the care of the adult specialty and a named adult consultant if nursing staff are able to meet the young person's care needs. The paediatric team are able to provide support if joint care is required. The Children's Directorate Management Team have oversight of those young people under 18 years of age who are admitted to adult wards throughout the Trust. Rarely, young people over the age of 18 may be admitted to Riverbank Ward if they are still under the care of a Consultant Paediatrician.

On Riverbank Ward, young people 13-18 years of age are admitted to either side rooms 6 or 7 or into bay 10 depending on capacity. A parent or carer is able to stay overnight with the young person. There is an adolescent room where young people are able to socialise and participate in recreational activities. The play specialists are also available to provide activities or help with educational provision. Young people's friends are able to visit them on Riverbank Ward after discussion with the nurse in charge.

Young people aged 18 and over will not be admitted to the paediatric wards (with very occasional exceptions when a young person has:
a) complex neurodisability **and** is under the care of a paediatrician
b) has ongoing oncology treatment

This distinct group of young people will be admitted to CYP ward should they or their parents choose, until they are a maximum of 18 year and 364 day olds.

Primary Care

It is essential that the young person's GP is notified and involved in the transition of the young person to adult services, and all documentation including all letters and a medical summary of transfer report is copied to the GP. A GP transition document is available. (Appendix 1) This should ensure there are clearly documented plans and expectations within Primary Care after the transfer of care has occurred.

Mental Health

The NSF, Standard for Hospital (DOH 2003, page 26) states:
'It is essential for a hospital with children's services to ensure that staff have an understanding of how to assess and address the emotional wellbeing of children'

Adolescents with long-term health conditions should have access to a multidisciplinary mental health liaison service as an outpatient as well as an inpatient. Staff should be aware of the referral arrangements for CAMHS patients under the age of 17 years, or adult mental health single point of access for those over 17 years.

CAMHS SPA:
WHCNHS.CAMHS-SPA@nhs.net
01905 681 961
https://www.hacw.nhs.uk/search/service/camhs-spa-131/

Adult SPA:
WHCNHS.amhreferrals@nhs.net
01905 681477

Information on the resources young people can access relating to mental health issues and wellbeing are available on our Trust transition website Transition - Worcestershire Acute Hospitals NHS Trust and intranet page for staff. These include:

Talking Therapies:
This is a psychological help and wellbeing service available through Worcestershire Talking Therapies for young people age 16-18 years who have a chronic health condition and who are experiencing anxiety or low level depression especially those that are transitioning to adult services (which may be to their GP).

This may be also useful for patients who have anxiety surrounding the following:
- Admission to adult ward
- Going to adult outpatient appointment
- Going to new area
- Meeting new HCP's
- Not knowing what to expect
- Not sure if parents are allowed with them
- Navigating adult A&E
- Being expected to know everything
- Making decisions
- Ordering medications/dealing with prescriptions
- Receiving appointments/ managing time
- Who to call for advice.

We are hoping the service will be useful to help with:
- Sharing responsibilities
- Not having parents around
- Engagement with HCP
- Advocacy skills
- Decision making
- Adjustment

You can make a professionals online referral by filling in the online for at Referral Form (mayden.co.uk)

or by visiting their website at Information for professionals | Talking Therapies (hwhct.nhs.uk

Melo delivered by ONSIDE is also a service working to improve the emotional wellbeing and mental health of children and young people aged 0-25. https://www.onside-advocacy.org.uk/melo

Life threatening illness or Palliative Care

Diagnosis of a life threatening or life shortening condition does not automatically negate the requirement for transition to adult services, as increasingly these children are living into adulthood. A parallel planning approach is required. Active management with a view to achieving stability or improvement in the young person's condition, including transition to adult services, should continue alongside planning for a potential deterioration in the young person's condition and end of life care.

Active transition should be paused if a young person is critically unwell and is not expected to live, and professionals would be surprised if the young person were alive beyond a few weeks' time or if survival is uncertain and professionals would not be surprised if the young person died within the next few months.

The following link has been specifically designed to help support young people with life-limiting illness for Herefordshire and Worcestershire and contains a collection of resources and information to support the transition of young people with life-threatening or life-limiting conditions from children's services to adult services. Within the toolkit there are separate sections that can be accessed by health care professionals as well as young people, family and carers.

Transition to Adulthood Toolkit :: Herefordshire and Worcestershire Integrated Care System
www.hwics.org.uk/priorities/children-young-people-transformation-plan/transition

Additional practical support may also be accessed from the charity Child Bereavement UK which helps families to rebuild their lives when a child grieves or when a child dies. They support children and young people (up to the age of 25) when someone important to them has died or is not expected to live, and parents and the wider family when a baby or child of any age dies or is dying. They provide training to professionals in health and social care, education, and the voluntary and corporate sectors, equipping them to provide the best possible care to bereaved families. www.childbereavementuk.org.

Information and Health Promotion

CQC Essential Care Standards (2009) and the NSF, Standard for Hospital (2003) states that health care personnel should provide health promotion information that is age appropriate, appropriate to specialty, informative, up to date and clear.

Important areas for health promotion include:

- Accident prevention

- Healthy eating
- Sexual and reproductive health
- Alcohol and substance misuse
- Mental health
- Smoking cessation
- Injury

The **'Ready, Steady, Go, Hello'** process supports the opportunity to ask teenagers and young adults about these areas that may impact on their life in relation to their chronic health condition. Clinical teams can then ascertain if they need to signpost patients to suitable support.

In addition, clinical teams can use the acronym HEADDSSS (Home, Education/Employment, Activities, Drugs/Drinking, Sex, Self-harm/depression/suicide, Safety (including online/social media) as a prompt to discuss these areas if deemed developmentally appropriate and the patient is competent to understand and answer the questions. The common causes of adolescent morbidity and mortality are: accidental deaths, suicide, mental health concerns, substance use and sexual experimentation (RCPCH, 2021). The HEADSSS assessment is a quick screening tool to help identify these preventable areas of risk. Every admission of an adolescent is an opportunity for a positive intervention that may improve outcomes well into adult life.

Transition and Trauma Informed Care

A trauma-informed approach (Cavell & Curtis, 2024) underpins all aspects of this framework. Trauma-informed practice is not designed to treat trauma-related difficulties. It seeks to address the barriers that those affected by trauma can experience when accessing care and services by using core principles. The seven principles of trauma-informed practice are: safety, trust, choice, collaboration, empowerment, cultural consideration and connection (Cavell & Curtis, 2024). The West Midlands Trauma Informed Workforce Learning and Development Framework highlights that central to this ethos are the person-centred values of empathy, kindness, and humility. Trauma-informed practice is an approach which is grounded in the understanding that trauma exposure can impact an individual's neurological, biological, psychological and social development, thus shaping a person's worldview and relationship development.

A trauma informed approach in the transition of care uses a tiered approach that includes universal, targeted, and specialty levels. TIC recognises the widespread prevalence of trauma exposure so that all staff are prepared to respond to YP and their families' behaviours, interactions, and needs using a trauma-informed approach. Targeted and speciality interventions are offered based on a known history of trauma exposure with presenting difficulties - for the YP and/or parent by signposting to community services.

Being trauma-informed means assuming that people are more likely than not to have a history of traumatic experiences and that these experiences may impact on their ability to feel safe within or develop trusting relationships with services and their staff. Providing trauma-informed care across the transition pathway is important because trauma exposure, with additional illness, can negatively affect a YP's experience of medical care (Johnson &

Martin-Herz, 2010). Health care visits and/or treatment can be re-triggering and compound the impact of previous trauma (Delahanty et al., 2015).

Education, Schooling and Career Planning

It is a statutory right and obligation for local education authorities to provide schooling for children and young people up to the age of 16 years. This also includes any periods of hospitalisation. There is no hospital education facility at WAHT, but for those young people who are still in school, college or full-time education beyond the age of 16 years, their care will facilitate their education where possible.

- Medical outpatient appointments are arranged, where possible, at a convenient time to minimise the impact on their education (You're Welcome Quality Standards 2023).
- Education of young people should continue during periods of admission. The young person and/or their parents should be encouraged to arrange some work to be provided from school for those admissions of more than a few days, especially if the admission is planned. Written confirmation of admission for their school will be provided if necessary. Steps should be taken on the ward to facilitate the completion of this work.
- With appropriate consent, communication links between the hospital and mainstream/special schools/colleges should be facilitated.
- Children and young people should be signposted to appropriate information and support for career planning e.g. Connexions (DOH 2004, page 136), and health care personnel should facilitate career planning discussions in relation to their medical condition.

Recreation and Specialist Activities

Support from a Play Specialist (with adolescent skills) or other young person specialist such as Wellbeing Emotional Support Practitioners through Melo Onside can be sought where available for issues in relation to long-term and chronic illness, social isolation, advocacy, involvement with community organisations and supporting young people regarding the transition process. Social interaction with their peer group is vital at this stage of the young person's life. Access to the Trusts peer support group which is run monthly the first Thursday of the month provides an opportunity for clinical teams to signpost young people aged 13-19 years old to a regular group which facilitates the opportunity to meet other young people with chronic long term conditions in a safe and encouraging environment.

Transition and the Mental Capacity Act Mental Capacity and Decision Making

All practitioners working with young people during the transition process should be able to determine whether the young person has the required level of competence (age under 16) or the mental capacity (age 16 and 17) to make specific decisions for themselves. They should also be aware that unlike adults, decisions made by competent young people under the age of 18 are not determinative and there are occasions when their right to make decisions for themselves needs to be balanced with the responsibility to keep them safe from harm. The legal framework underpinning this for children under the age of 16 is the Gillick test and for young people aged 16 and 17 is the Mental Capacity Act (2005). Further guidance is

available in the Trust's Consent to Examination or Treatment Policy and the Policy for Assessing Mental Capacity and Complying with the Mental Capacity Act 2005.

As a child approaches adulthood you will need to think about the shift towards their legal status as decision-makers and the role of parent / carers in supporting them to make decisions. Prior to this time parents would be making such decisions in keeping with the role of having 'parental responsibility'.

The Mental Capacity Act 2005 ("MCA 2005") provides the legal framework for decision-making for people who lack mental capacity to make certain decisions for themselves. Much of the MCA 2005 applies to those aged 16yrs and above. However, parents can still provide consent to certain care and treatment matters until their child reaches the age of 18yrs if their child does not have capacity to provide or refuse consent themselves.

When a child /young person reaches the age of 18yrs they legally become an adult. In terms of the Mental Capacity Act, this means that they will be deemed able to make their own decisions about all aspects of their life, unless it is established that they lack the mental capacity to do so. Through the Mental Capacity Act every adult is supported to take as much control over their own lives as possible.

Mental capacity is "decision-specific", which means that the child /young person could have capacity to make certain decisions, but not others. If the child /young person is assessed to lack the mental capacity to make a particular decision, decisions must be made in his or her best interests. ***A parent does not automatically have the right to make decisions for their child once they have turned 18yrs.***

Parents /carers know the child /young person really well, their likes and dislikes and how they communicate their wishes. In the absence of any Court Appointed Deputy then the 'decision maker' has a duty to consult with both the child /young person and others closest to them in order to ascertain mental capacity (decision specific) and where appropriate, what would be in their best interests. Best interest decisions should take into account all the things that the person who lacks capacity would consider important, if they were able to make the decisions themselves. In some situations, it may be appropriate to consider the need for a Court appointed personal welfare deputy. A deputy is a person (or persons) who is (are) given authority by the Court of Protection to make certain decisions for a person who lacks capacity to make those decisions for themselves.

Rights and Responsibilities of Young People

As part of the government's Your Welcome Standards (2023) all staff should be trained and skilled to inform young people of their rights around confidentiality, consent and the right to complain.

The transition team encourage patient feedback through the use of a QR code linking to a patient feedback form which involves the patient feedback plus the parents/carer. This is accessible on the posters displaying transition information across WAHT sites.

Transition Website

A web page linked to the Trust has been created to aid as a resource for young people and their families to use to support them further with their transition and transfer to adult services. It includes definitions and what to expect along with some practical signposting of further national and local resources including emotional wellbeing, health promotion such as good sleep, exercise, sex, alcohol and drugs, prescription costs etc. It also has a link to our short patient survey to audit patients transition and transfer experience.

www.worcsacute.nhs.uk/transition

Training and awareness

All staff working with CYP should have an understanding and knowledge of the development, social and emotional needs of adolescents, including those with disabilities. Professionals may need to further their knowledge and skills and seek further educational opportunities.

NHSE are due to publish a National Framework for Transition which will include core competencies for staff to complete defined by tiers depending on the staff's individual level of responsibility and care of young people. Until this is widely available the below education resources are available;

A free E-Learning package has been jointly developed by the Royal College of Paediatrics and Child Health (RCPCH), Royal College of General Practitioners (RCGP) and Royal College of Nursing (RCN) and is recommended to help staff develop their skills in helping CYP and also to recommend health promotion advice for them to live healthy and active lives. This E-module is available along with other modules on adolescent mental on the Electronic Library for Health through the link https://www.e-lfh.org.uk/programmes/adolescent-health/

There is also an additional E-module which also covers substance misuse as well as other aspects of adolescent development, available at https://www.rcpch.ac.uk/resources/healthydevelopment-young-people-substance-misuse-elearning

We can talk – mental health communication programme which helps amplifies staff's existing expertise, supporting them with the context and confidence to apply their core skills to people in mental health crisis.
Home - We Can Talk

There are also Ted talks on adolescent brain development to add context to adolescent care.
The mysterious workings of the adolescent brain - Sarah-Jayne Blakemore

Other resources are available on MindEd - free mental health eLearning

The Trusts staff intranet page the source features a designated page on transition within the Trust which lists resources for staff to signpost young people and families to plus details of how to contact the transition team for those complex patients who may need extra support or guidance.

Specialty Specific Transition Policy Links

Specialty specific transition documents can be found on the paediatric key documents page: http://www.treatmentpathways.worcsacute.nhs.uk/paediatrics-information-portal/

Policies include: Diabetes
Epilepsy
Allergy
Asthma

Implementation of key document

The Trust Transition Team will support each specialty to follow this framework. The development of an action plan will be required where Children's services do not meet the standards.

Teams should also monitor their compliance against the NCEPOD standards and other measurable transition outcomes and 'You're Welcome' criteria. Progress against the action plan will be reported through the Trust Transition Steering Group to the Quality Improvement Meeting and the Children's Board.

Incidents and near misses relating to transition to adult services will be reported in the first instance via Datix. These will be reviewed by the Transition Steering Group and an action plan developed.

Dissemination

The trust policy will be on the Trust intranet

Reference to this policy will be made to all staff on its initial publication via email and on the intranet. All new staff joining WAHT should be made aware of the policy on their induction to the department.

Monitoring and compliance

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
	These are the 'key' parts of the process that we are relying on to manage risk. We may not be able to monitor every part of the process, but we MUST monitor the key elements, otherwise we won't know whether we are keeping patients, visitors and/or staff safe.	What are we going to do to make sure the key parts of the process we have identified are being followed? (Some techniques to consider are; audits, spotchecks, analysis of incident trends, monitoring of attendance at training.)	Be realistic. Set achievable frequencies. Use terms such as '10 times a year' instead of 'monthly'.	Who is responsible for the check? Is it listed in the 'duties' section of the Policy? Is it in the job description?	Who will receive the monitoring results? Where this is a committee the committee's specific responsibility for monitoring the process must be described within its terms of reference.	Use terms such as '10 times a year' instead of 'monthly'.
	Named adolescent lead identified in all specialities	Audit	Annually	Transition lead	Matron of Children's Services	Annually
	Evidence of an updated medical summary of transition for all young people who have entered the transition process	Audit	Annually	Transition lead/Consultant paediatrician	Matron of Children's Services	Annually
	Patient experience of the transition process approximately 6 months after transition to adult services has been completed.	Patient questionnaire	6 months after transition	Transition lead	Matron of Children's Services	Annually
	DNA rates for 1st and 2nd appointments in adult services (DH 2006)	Audit	Annually	Transition lead	Matron of Children's Services	Annually

	Staff completing training in areas of importance for adolescence (i.e. RCPCH E-modules)	Monitoring of evidence of completion of training (e.g. certificate, screen capture of completion)	Annually	Transition lead	Matron of Children's Services	Annually

Policy Review

The policy and the use of associated documentation will be audited annually. The policy will be reviewed on a 3 yearly basis.

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Equality requirements

WAHT is committed to ensuring that equality is achieved and maintained in the transition process and the services it provides, particularly with respect to age, gender, ethnicity or sexual orientation.

Specific attention should be made to the following young people, and appropriate provisions made where necessary, to ensure there is no negative impact on their care:

1. where English is not their first language
2. where they may have cognitive impairment, whether it be primary to their condition or not

Consultation

A regularly updated database will be kept of the nominated leads for each area. These include:

All Specialty Group Leads in Paediatric Team
All Specialty Group Leads in Adult Services
Child and Adolescent Mental Health Services
Chair of Senior Medical Staff committee
Palliative Care Team
Allied Health Professionals: Physiotherapy, Occupational Therapy, Speech & Language Therapy
Healthcare Scientists: Neurophysiology
Play Services
Chaplaincy
Emergency Dept
Clinical Nurse Specialist/Liaison and Health Facilitator for Learning Disability

Designation

This key document has been circulated to the chair(s) of the following committee's / groups for comments;

Committee
Paediatric Governance Team at Quality Improvement Meeting,
Children and Young Peoples' Board

Approval Process

The policy has been approved following dissemination to all Paediatric consultants and approval at Paediatric Quality Improvement Meeting and at Childrens and Young Peoples' board.

Appendices and Supporting Documents

Supporting paperwork can be downloaded from the document finder or downloaded from: -

https://www.readysteadygo.net/rsg.html

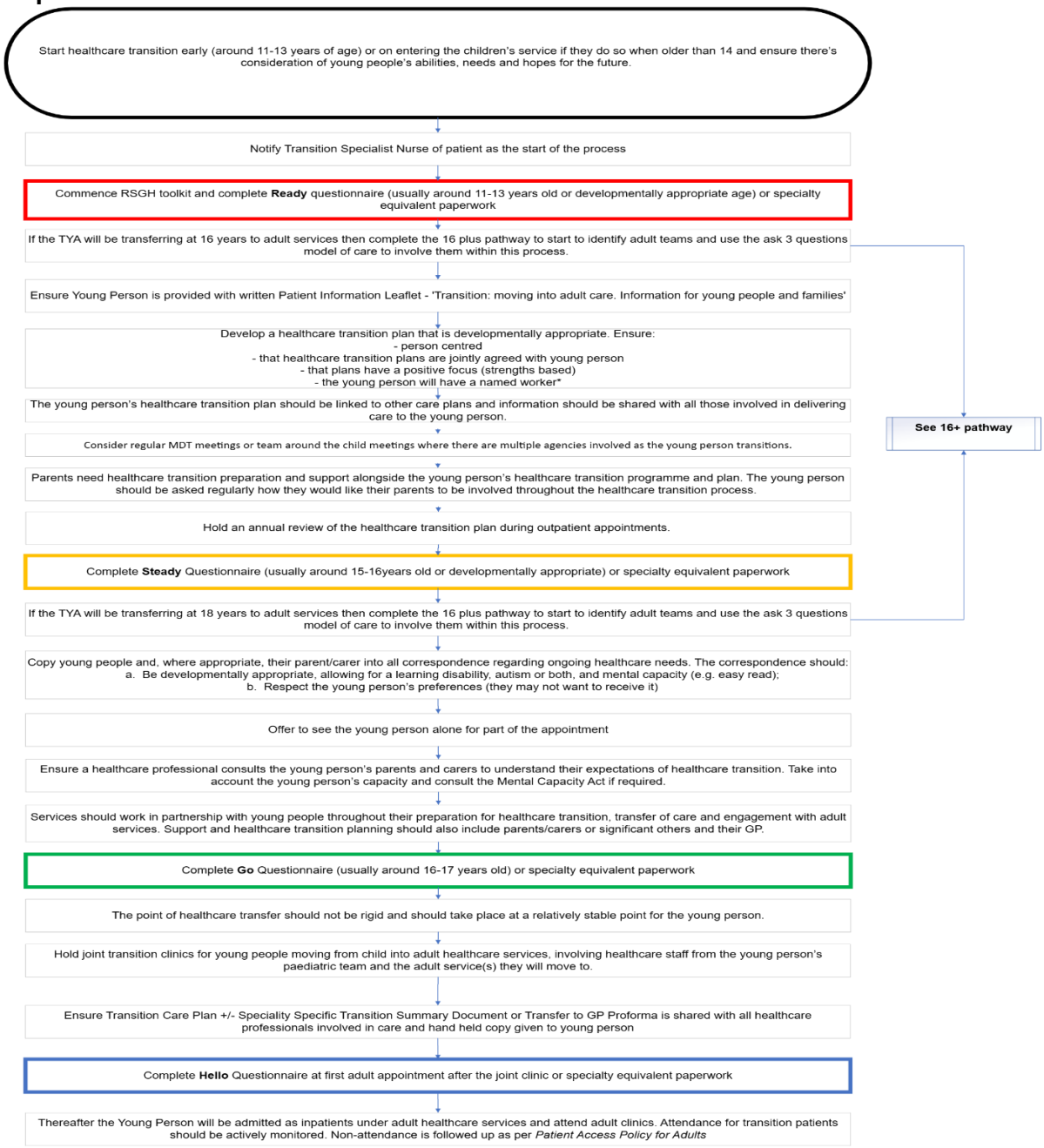
https://www.readysteadygo.net/rsg-easy-read.html

Appendix 1 - Pathway for Good Quality Transition Care within Worcestershire Acute Hospitals Trust

Appendix 2 – GP Summary Document

Appendix 3 – Medical Summary of Transfer Report

Appendix 1 – Pathway for Good Quality Transition Care Within Worcestershire Acute Hospitals Trust



A named worker* (either one in children services and one in adult services, or one overarching both) should be nominated for each young person during healthcare transition. If the young person requires multiple service transitions, the named worker should co-ordinate these with the support of an administrator.

The named worker in adults should stay with the young person until they are engaged and settled in the adult service

Important Notes

The minimum length of an appointment should be 30 minutes, either within a routine appointment or as a dedicated one.

The young person should have opportunity to be seen alone for all or part of the appointment

Age/developmentally appropraite communication tools and literature/information should be available/provided

Young people should develop confidence when dealing with adult services, including to raise concerns themselves

Before transfer: young people should be given the opportunity to meet or see a practitioner from the adult service before they are transferred and are supported to visit adult services

After transfer: the young person should see the same practitioner in the adult service for the first two appointments as a minimum

Appendix 2 – GP Summary Document

Name: DoB:

Hospital No: NHS no:

IMPORTANT INFORMATION – PATIENT HANDHELD COPY TO BE BROUGHT TO MEDICAL APPOINTMENTS

Transition Key Information

Young Person's Details		
Name:	**DOB:**	**Sex:** ☐ **Gender identity** ☐
Address: **Postcode:**	**NHS Number:** **Hospital Number:**	
Telephone Number: **Email:**	**First Language:** **Interpreter required? Yes** ☐ **No** ☐	
Next of Kin: **Relationship:**	**Next of Kin Address:** **Telephone Number:**	
Diagnosis:	**Allergies:**	**Transition tool completed? (i.e Ready, Steady, Go, Hello) Yes** ☐ **No** ☐ **Pending** ☐
Medical History:	**Current medication:**	
Professional's involved including contact details:		
Consent: **Safeguarding concerns? Yes** ☐ **No** ☐ **Social worker? Yes** ☐ **No** ☐ **N/A** ☐ **Name:** **EHCP Yes** ☐ **No** ☐	**Does this young person have capacity? Yes** ☐ **No** ☐ **If no - has 'best interest decisions' been discussed? Yes** ☐ **No** ☐ **Respect Document? Yes** ☐ **No** ☐ **Advanced Care Plan (ACP)? Yes** ☐ **No** ☐ **Health Passport? Yes** ☐ **No** ☐	
Expected level of self-management after transition: Are there any reasonable adjustments required? i.e parental/next of kin involvement to continue.	☐ **Independent**	☐ **Assisted** ☐ **Fully supported**

Name: DoB:

Hospital No: NHS no:

IMPORTANT INFORMATION – PATIENT HANDHELD COPY TO BE BROUGHT TO MEDICAL APPOINTMENTS

GP Requirements post transition	
Date of last review:	Next due:
Date of last bloods:	Next due:
Date of last medication review:	Next due:
Form completed by:	
Date form filled in:	
Date of transfer to GP:	
Young person and next of kin aware of transition and transfer: Yes ☐ No ☐	

Any other relevant information

Appendix 3 – Medical Summary of Transfer Report

NHS
Worcestershire
Acute Hospitals
NHS Trust

MEDICAL SUMMARY OF TRANSFER REPORT
For Health and Shared Records

Name:	Date of Birth:
Hospital no:	NHS no:
Address:	
Home tel no:	Mobile no:
School/College:	Email:
Transition start date:	Planned date of transfer to adult care:
	Actual date of transfer to adult care:

Diagnosis:

General Practioner:	
Surgery Address and telephone no	
Transition Lead Practioner:	

MDT	WAHT contact	Adult contact
Lead Consultant		
Specialist Nurse		
Physiotherapist		
Occupational therapist		
Dietician		
Speech and Language Therapist		
Clinical psychologist		
Social Worker		
Other		