Trust Policy

Worcestershire Acute Hospitals
NHS Trust

Transition of Care Policy for Young People to Adult Services

Department / Service:	Children's
Originator:	Dr Lucy Malpas Dr Anna Ratcliffe, Charlotte Hughes Lead Paediatric Transition Nurse
Accountable Director:	Dr James West
Approved by:	Paediatric Quality Improvement Meeting
Date of approval:	17th January 2024
First Revision Due: **This is the most current document and should be used until a revised version is in place**	17th January 2027
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	All departments involved in the care of Young People
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's 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.

Contents page:

Appendices

Supporting Documents

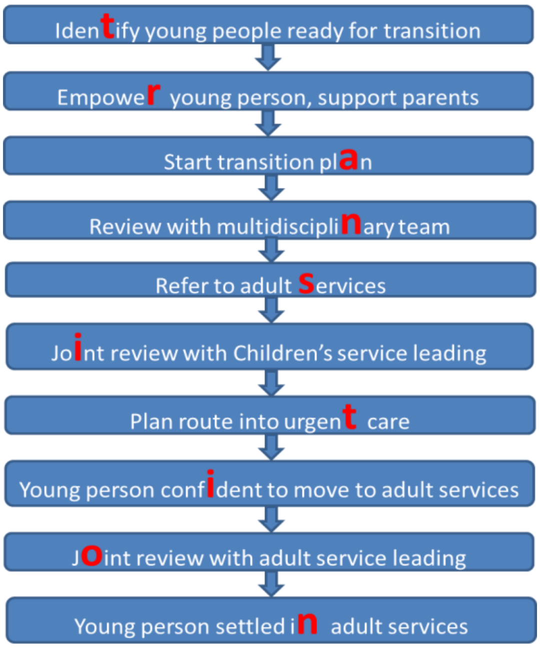
Quick Reference Guide

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

The policy applies to all young people (aged 13 and over) with long-term conditions that are expected to continue through adolescence into adulthood. It is also relevant to young people diagnosed with a long-term condition during the transition period.

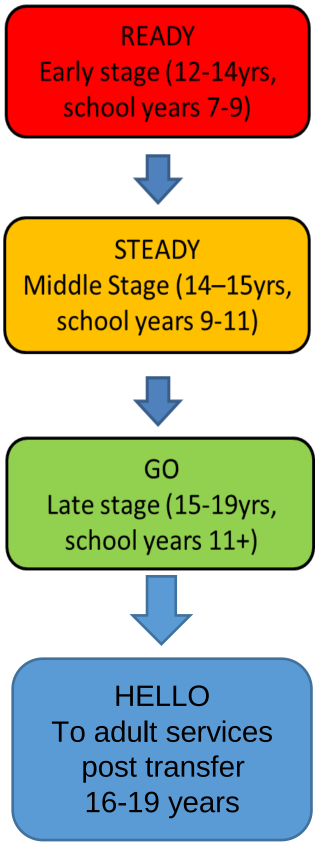
Young people (13-19 years of age) with long-term conditions require careful planning of their care in order for them to successfully transition to adult services at a time which is appropriate for the individual (generally this is by the age of 17 years). Transition covers the period before, during and after a young person moves from children's to adults' services. The process covers not only their medical conditions, but also their psychosocial, educational and vocational needs. It also addresses the transition of the re-orientation of their care from their parents/caregivers when appropriate.

This transition process can be broken down further into the following steps:



These ten distinct steps, each of which is supported by auditable standards (see section 8), require a coordinated approach. Some of these steps will continue for a considerable period of time and one step does not necessarily need to be completed before the next step is started.

The process has 4 main phases:



The timing of the move to adult services should be tailored to the individual needs of the young person depending upon their emotional maturity, cognitive and physical development. However, transition support also continues after the move until the young person is adequately settled into adult services. **A Transition plan using 'Ready, Steady, Go, hello' (or a suitable/specialty specific alternative) should be included in the young person's (YP) notes** (see appendix 1), which records the process through each stage with "tick boxes" and written notes. This should be culminated with **a Medical Summary of Transfer Report to be shared with all relevant health professions and the YP themselves** (appendix 2).

All practitioners working with young people during the transitional 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.

Additional guidance is available to support transition for young people with long-term conditions diagnosed or recognised during transition age, such as life threatening illness and conditions requiring ongoing treatment in children's services beyond normal transition age.

Implementation and ongoing monitoring of the Trust Transition Policy will be overseen by the Trust Transition Steering Group chaired by the Transition Lead and overseen by the Clinical Director and Executive Lead for Transition.

It is recognised that certain duties within this policy 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.

1. Introduction

Young people (12-19 years) with long-term conditions require careful planning of their care in order for them to successfully transition to adult services at a time which is appropriate for the individual (generally this is by the age of approximately 17 years). Transition covers the period before, during and after a young person moves from children's to adult services. It is essential that this process is well planned and executed in order 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 in care who will need support to manage their own health. It also addresses the transition of the reorientation of their care from their parents/caregivers when appropriate.

The primary aims of transition are to:

1. provide high quality, well planned but flexible, uninterrupted care from children's 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)

Adolescents 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 of note are:

- National Service Framework for children, young people and maternity services (2003,2004)
- Every Child Matters (2004)
- Transition: Getting it right (2006)
- A Transition guide for all services. Key information for professionals about the transition process for disabled young people. (2007)
- Growing up Matters: Better transition planning for young people with complex needs (CSCI, 2007)
- You're Welcome - quality criteria for young person friendly health services (2011)
- Transition. Moving on well (2008)
- Healthy Lives, Brighter Futures (2009)
- Getting it right for children and young people: overcoming cultural barriers in the NHS so as to meet their needs. (2010)
- Report of the Children and Young People's Forum. The Children and Young People's Health Outcomes Strategy (2012)
- Transition from children's to adults' services for young people using health or social care services. National Institute for Clinical Excellence – (NICE) NG43 (2016)

2. Scope of this document

The purpose of this generic policy is to assist all healthcare professionals involved in the care of young people to ensure they receive an uninterrupted and quality service when transitioning from child-centred to adult-orientated services in Worcestershire Acute Hospitals NHS Trust in accordance with current national guidance and evidence. 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 and primary care 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.

3. 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.

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.

Long-term condition: A 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.

4. 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.

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

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

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.

5. Policy detail

"Children and young people should receive care that is integrated and coordinated around their particular needs, and the needs of their family. They, and their parents, should be treated with respect, and should be given support and information to enable them to understand and cope with the illness or injury, and the treatment needed. They should be encouraged to be active partners in decisions about their health and care, and, where possible, be able to exercise choice" (Department of Health 2003 page 9 and 'You're Welcome' Quality Standards DH 2011).

The following policy reflects the above statement and Care Quality Commission Quality Standards and acknowledges the unique needs of Young People. It should be made available to all staff involved in their care. Written information will also be provided for Young People and their parents/guardians.

5.1 The ten steps to adult services

Step 1

1.1. All young people with long-term conditions and their families are aware of the need for transition to adult services before their 14th birthday and have access to a transition programme (for example Ready, Steady, Go) to facilitate preparedness from the age of 13 years.

1.2. Consultants caring for young people with long-term conditions identify markers for complex or difficult transition before the young person's 14th birthday and explore provision in adult services to cater for the child.

1.3. Individual Specialties, the Paediatric Team, Adult Services, Commissioners from both Adult and Children's Services, and Patient Representatives meet via the Children's and Young People's Board at least annually to plan services for the cohort of young people with long-term conditions as they move into adult services.

Step 2

2.1 All young people with long-term conditions including diabetes, asthma, epilepsy, and gastroenterology have access to developmentally appropriate information and advice regarding their condition and its management, before their 15th birthday.

2.2 All young people with long-term conditions have the option to receive copy letters, together with opportunities for explanation and discussion of the letter and its contents.

2.3 All young people have the opportunity to be seen without their parents for part of their consultation with an option for letters to be addressed to the child.

Step 3

3.1 All young people have access to a handheld summary letter that describes their condition and supports their transition to adult services.

Step 4

4.1 All young people with long-term conditions who are supported by three or more specialist medical services have a clearly identified Key worker identified before their 15th birthday.

4.2 The young person's GP is actively involved in the young person's transition including routine prescriptions, reviews for minor illnesses and planning the young person's route into urgent care at the latest from their 15th birthday

Step 5

5.1 Each young person with a long-term condition is referred to adult services at the latest before their 16th birthday. The Lead Paediatric Consultant liaises with other involved consultants to plan referral to adult services where a young person is supported by three or more specialist medical services.

5.2 A detailed summary of the young person's medical records is available for each specialist medical service in the adult sector.

Step 6

6.1 Each young person with a long-term condition has at least one joint appointment with children's services leading up to transition.

6.2 Professionals from adult services introduce themselves to the young person and their family and explain their role.

Step 7

7.1 Each young person has a clear plan for access to urgent (emergency) care including a self-management plan and the role of their GP.

7.2 Young people have the opportunity to visit adult A&E and inpatient facilities before moving to adult services.

7.3 Support for young people with complex long-term conditions in inpatient settings includes carers (or parents) in-reaching to continue to support the young person's "everyday" care needs in the adult inpatient setting as appropriate.

Step 8

8.1 The young person themselves, adult and children's services decide and clearly communicate the date after which the young person will be admitted to adult services if they require inpatient care.

8.2 The young person themselves, adult and children's services decide and clearly communicate the date after which the young person's outpatient reviews will take place in adult services.

Step 9

9.1 Attendance at adult clinics for transition patients is actively monitored and non-attendance is followed up as per Trust Safeguarding Policy.

Step 10

10.1 All young people previously cared for by the children's department will be transitioned to adult services by their 18th birthday.

5.2 The Transition Process – Ready, Steady, Go!

The transition process at WAHT is guided by the NHS England's 'Ready, Steady, Go' 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' may not meet the needs of all patients and in some instances an individualised transition pathway which shares the same philosophy may be used e.g. Diabetes, Cystic Fibrosis.

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. An example of this is included in Appendix 1 but can be downloaded from the supporting paperwork link below.

There are three main stages:

i) **READY - Early stage (12-14yrs, 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 may be suggested that the young person writes a transfer letter to the adult team including information which they feel is important for the adult team to know about them, what they are anticipating about their care and what they may be anxious about.

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 (14–15yrs, 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.

A “Steady” questionnaire should be completed by the young person’s 15th birthday.

iii) **GO - Late stage (15-19yrs, 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.

iiii) **A HELLO – (16years plus questionnaire should be completed in the first adult clinic post transfer to adult services.)**

The Young person +/- carer should complete the Hello Questionnaire. This will allow the opportunity for issues to be addressed in bite sized pieces. It should include clinic letters to be sent just to young person rather than their parents/carer.

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.

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.

5.3 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 1214yrs. 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 childcentred 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, unstable disease at the time of proposed transfer or life limiting disease during adolescent years.

5.4 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.

5.5 Patient Involvement and Service Development

As quoted in 'Bridging the Gaps' (RCPCH 2003) Article 12 UN Convention on the rights of the child states;

'State parties shall assure to the child who is capable of forming his or her own views, the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity and the child'

Also, The Report of the Children and Young People's Health Outcomes Forum, July 2012, clearly states:

'All health organisations must demonstrate how they have listened to the voice of children and young people, and how this will improve their health outcomes'.

Therefore:

- The young person will be consulted on the development of services that meet their specific needs, including existing services and those new developments, as well as materials and tools.
- The consultation method will be age appropriate and meaningful and done so in line with trust policy, e.g. in terms of consent etc.
- Young people will be asked if services helped them to achieve agreed outcomes.
- All consultations with young people regarding service development will be done with liaison of the matron for children's services. Feedback on their input will be provided.

5.6 Development and Emotional Needs

The NSF, Standard for Hospital Services states:

"Too often services neglect to see the child as a 'whole person' with basic developmental, physical, mental, and social needs that are very different from those of an adult" (DOH 2003, page 11).

Adolescence is often a difficult or challenging developmental stage for the young person. They are changing physically and psychologically, developing their own independence and often encountering new emotions and situations. Therefore, their needs are different to both children and adults and their care should reflect this. This should include:

- Staff working with young people should have an understanding and knowledge of the development, social and emotional needs of adolescents, including those with disabilities.
- Every adolescent is an individual and the needs of each should always be respected.
- Staff should be able to plan, encourage and promote the independence of the young person whilst including the parent/guardian in their care. A gradual change in responsibility will often evolve, with parents/guardians taking a diminished role.
- The privacy and dignity of the young person should always be respected. The safeguarding of all young people should always be considered.

5.7 Rights and Responsibilities of Young People

The rights of the young person should always be considered, as stated in the NSF, Standard for Hospital Services (DOH 2003, page 11).

- Young people need to be given sufficient and relevant information and/or preparation from appropriate health care personnel in order to empower them to make informed choices.
- Young people need to be consulted with on every aspect of their care, service delivery and development in conjunction with their families as appropriate. This partnership is fundamental in all aspects of planning care/treatment.
- Young people should be given the opportunity for individual, confidential conversations with staff unrestricted by the presence by other family members (DOH 2004, page 121).
- Young people need to be made aware of an appropriate adult that can act in a position of advocacy on their behalf, for example a PALS officer.
- Confidentiality should be maintained in line with the Data Protection Act and with the Caldicott guidelines.
- Young people should be involved with consent in line with the Trust and national policies.
- Clinical areas should provide set boundaries (rules) that are written with and visible to young people.
- The privacy and dignity of young people should be maintained at all times including their rights to chaperoning, same sex nursing and restraint (Royal College of Nursing (RCN) 2001 and 2003).
- Young people should give permission for students to observe any care, consultation or treatment.
- Young people need support from their peers and this should be reflected in the visiting arrangements for family and friends.

5.8 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

5.9 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 2011).
- 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.

5.10 Recreation and Specialist Activities

Support from a Play Specialist (with adolescent skills) can be sought for issues in relation to long-term and chronic illness, social isolation, advocacy, involvement with community organisations and supporting adolescents regarding the transition process. Social interaction with their peer group is vital at this stage of the young person's life.

5.11 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 are 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 or 01905 768300
Adult SPA – whcnhs.amhreferrals@nhs.net or for urgent referrals 01905 768490

Information on the resources young people can access relating to mental health issues and wellbeing are available. CYP can be directed to websites for local services such as Worcestershire Healthy Minds at https://www.healthyminds.whct.nhs.uk/ which hosts an array of useful information including self-help leaflets; the CYP can make a self-referral online.

5.12 Transitional 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:

Allergy:	Dr Dawson
Asthma:	Dr Watson
Cardiology:	Dr Van der Velde
Diabetes:	Dr West and Dr Ahmad
Endocrinology:	Dr West
Epilepsy:	Dr Gallagher
Haematology/Oncology:	Dr Kamalarajan
Nephrology:	Dr Ahmed
Respiratory/CF:	Dr Onyon

5.13 Adult Services

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 persons care. A Transition Plan should be included in the adult set of notes also, an example of which is included in the Appendix 1 and can be downloaded through the link in the Supporting Paperwork Section.

The accepting team is also responsible for ensuring that the change is entered onto the Oasis patient management system, and that the details entered are correct.

5.14 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.

5.15 Medical Summary of Transfer Report

A copy of the medical summary report includes all important information which has been agreed between the children’s and adult teams and the young person themselves. It should not only be included in both the children’s and adult specialty sets of notes, but also be provided to the GP, any other medical or allied health personal essential to their care, and the young person themselves. This can be used during the transfer process but also serves as a key element to be used at the end when care is finally transitioned.

A template of this report is available to download through the document finder or can be found on the ‘M’ drive. An example is included in appendix 2.

Supporting Paperwork
Supporting paperwork can be downloaded from the document finder or ‘M’ drive, or downloaded from: - https://www.readysteadygo.net/rsg.html

5.16 Inpatient Facilities

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.

5.17 Safeguarding

For young people who are preparing for transition or transitioning to adult teams who are known to Children’s Services, under Child Protection Plans or have ongoing safeguarding concerns such as those involved with county lines and MASH team, then it is the responsibility of the key worker and clinical teams to ensure that Children services and appropriate safeguarding teams are communicated with and involved, with regards to their transition from paediatric services to adult teams or their GP.
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. 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 CLIP. This will state:
Alert - preparing for transition – moving to adult care
This can be set up through the secretarial support staff.

5.18 Transition and the Mental Capacity Act Mental Capacity and Decision Making

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.

5.19

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

6. 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 (transition checklist)

7. Implementation of key document

7.1 Plan for implementation

The actions in this policy will be phased in over a three year period, in parallel with transition planning with the young person. The Trust Transition Team will support each specialty by sharing the NICE NG43 Transition Standards. 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 10 Steps Transition Pathways auditable standards, including measuring 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.

7.2. Dissemination

The trust policy will be on the Trust intranet and on the 'M' drive.

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.

7.3 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.

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. The E-module is available 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

8. 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

9. Policy Review

The policy and the use of associated documentation will be audited annually. The policy will be reviewed on a 2-yearly basis.

10. References

Crowley R, Wolfe I, Lock K, McKee M. Improving the transition between paediatric and adult healthcare: a systematic review. Arch Dis Child. 2011 Jun;96(6):548-53.

Department for Education and Skills (2004). Every Child Matters: Change for Children. DfES Publications, Nottingham, UK.

Department of Health (2003). Getting the right start: National Service Framework for Children. Standard for Hospital Services www.dh.gov.uk

Department of Health (2004). National Service Framework for Children, Young People and Maternity Services. www.dh.gov.uk

Department for children, Schools and Families (2007). A Transition guide for all services. Key information for professionals about the transition process for disabled young people. https://www.gov.uk/government/publications/every-child-matters

Department of Health (2011). You're welcome quality criteria. Making health services young people friendly. (www.dh.gov.uk)

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 Publications, London www.dh.gov.uk/transition

McDonagh JE (2008). Young People first – JIA second. Arthritis Care and Research 59:1162-1170

NHS England (2018) Quick Guide: Commissioning for transition to adult services for young people with Special Educational Needs and Disability (SEND) (www.england.nhs.UK)

Royal College of Paediatrics and Child Health (2003) Bridging the Gaps: Health Care for Adolescents.(www.rcpch.ac.uk)

Royal College of Paediatrics and Child Health (2010) Not Just a Phase. A guide to the participation of children and young people in health services. (www.rcpch.ac.uk)

Royal College of Physicians of Edinburgh (2008). Think Transition: Developing the essential link between paediatric and adult care. Royal college of Physicians of Edinburgh, Edinburgh

Viner R (2008). Transition of care from paediatric to adult services: one part of improved health services for adolescents. Arch Dis Child 93(2); 160-163

11. Background

11.1 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

11.2 Financial risk assessment

See supporting document 2

11.3 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

Contribution List

This key document has been circulated to the following individuals for consultation;

Designation
Dr Naeem Ahmad
Dr Munir Ahmed
Dr Tom Dawson
Dr Andrew Gallagher
Dr Anna Gregory
Dr Liza Harry
Dr Baylon Kamalarajan
Dr Clare Onyon

Dr Wasi Shinwari
Dr Peter Van Dr Velde
Dr Watson
Dr Weckemann

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, 17th November 2021
Children and Young Peoples' Board 9th March, 2022

11.4 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.

11.5 Version Control

This section should contain a list of key amendments made to this document each time it is reviewed.

Date	Amendment	By:

Appendices

Supporting paperwork can be downloaded from the document finder or ‘M’ drive, or downloaded from: -
https://www.readysteadygo.net/rsg.html

Appendix 1 - Transition Plan

Transition programme

DATE	SECTION NUMBER	PROGRESS NOTES/GOALS

Transition programme

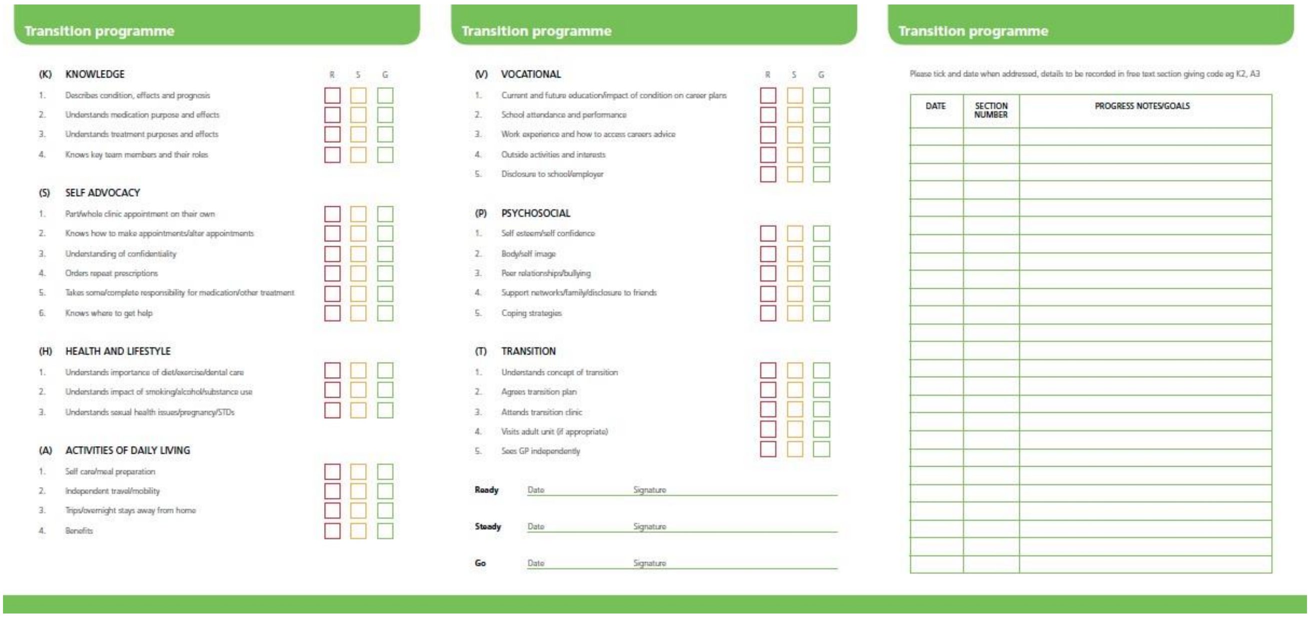
NOTES

NHS

Transition programme

Ready Steady Go programme

Name: **Hospital no:**
Address: **DOB:**
Transition start date:
School/college:
Home tel no:
Email: **Mobile no:**
Diagnosis:
Target date for transfer adult services:
Discharge summary completed:
Resources: **Date:**
Transition leaflet for young people
Transition leaflet for parents/carers
Other (please specify)
Offer copy of clinic letters Date:
MDT involvement
Youth worker
Social worker
Psychology
Specialist nurse
Dietitian
Other
Key worker
Adult unit team contacts
Date of planned visit to adult unit



Transition programme

		R	S	G
(K)	**KNOWLEDGE**			
1.	Describes condition, effects and prognosis	☐	☐	☐
2.	Understands medication purpose and effects	☐	☐	☐
3.	Understands treatment purposes and effects	☐	☐	☐
4.	Knows key team members and their roles	☐	☐	☐
(S)	**SELF ADVOCACY**			
1.	Part/whole clinic appointment on their own	☐	☐	☐
2.	Knows how to make appointments/alter appointments	☐	☐	☐
3.	Understanding of confidentiality	☐	☐	☐
4.	Orders repeat prescriptions	☐	☐	☐
5.	Takes some/complete responsibility for medication/other treatment	☐	☐	☐
6.	Knows where to get help	☐	☐	☐
(H)	**HEALTH AND LIFESTYLE**			
1.	Understands importance of diet/exercise/dental care	☐	☐	☐
2.	Understands impact of smoking/alcohol/substance use	☐	☐	☐
3.	Understands sexual health issues/pregnancy/STDs	☐	☐	☐
(A)	**ACTIVITIES OF DAILY LIVING**			
1.	Self care/meal preparation	☐	☐	☐
2.	Independent travel/mobility	☐	☐	☐
3.	Trips/overnight stays away from home	☐	☐	☐
4.	Benefits	☐	☐	☐

Transition programme

		R	S	G
(V)	**VOCATIONAL**			
1.	Current and future education/impact of condition on career plans	☐	☐	☐
2.	School attendance and performance	☐	☐	☐
3.	Work experience and how to access careers advice	☐	☐	☐
4.	Outside activities and interests	☐	☐	☐
5.	Disclosure to school/employer	☐	☐	☐
(P)	**PSYCHOSOCIAL**			
1.	Self esteem/self confidence	☐	☐	☐
2.	Body/self image	☐	☐	☐
3.	Peer relationships/bullying	☐	☐	☐
4.	Support networks/family/disclosure to friends	☐	☐	☐
5.	Coping strategies	☐	☐	☐
(T)	**TRANSITION**			
1.	Understands concept of transition	☐	☐	☐
2.	Agrees transition plan	☐	☐	☐
3.	Attends transition clinic	☐	☐	☐
4.	Visits adult unit (if appropriate)	☐	☐	☐
5.	Sees GP independently	☐	☐	☐

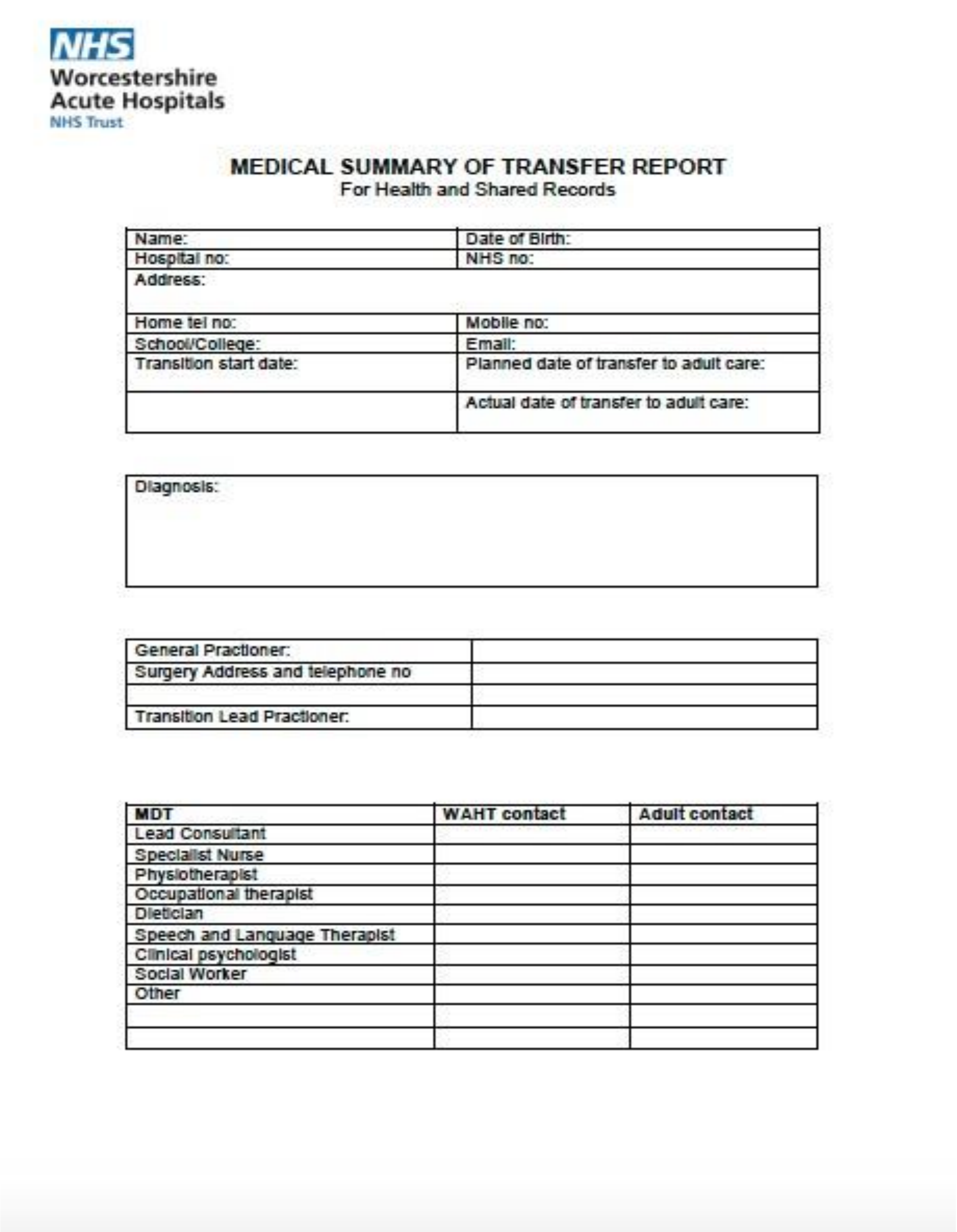
Ready Date Signature
Steady Date Signature
Go Date Signature

Transition programme

Please tick and date when addressed, details to be recorded in free text section giving code eg K2, A3

DATE	SECTION NUMBER	PROGRESS NOTES/GOALS

Appendix 2 - Medical Summary of Transition Report



NHS
Worcestershire
Acute Hospitals
NHS Trust

MEDICAL SUMMARY OF TRANSFER REPORT

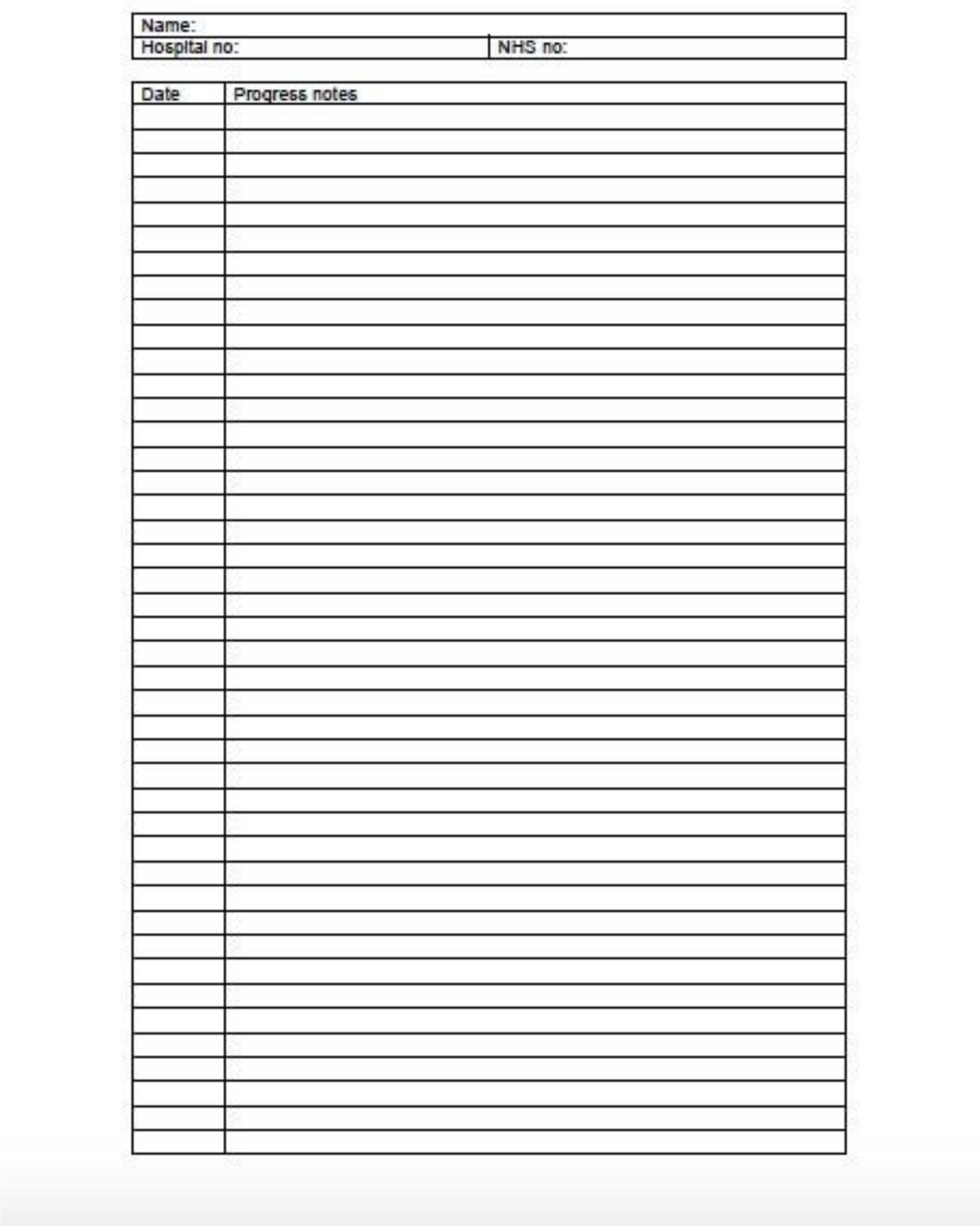
For Health and Shared Records

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		



Name:	
Hospital no:	NHS no:

Date	Progress notes

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and included as an appendix to key document when submitted to the appropriate committee for consideration and approval.

Please complete assessment form on next page;

Worcestershire Acute Hospitals NHS Trust

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	x	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	**Anna Ratcliffe**

<table>
<tr><td>Details of individuals completing this assessment</td><td>
<table>
<tr><th>Name</th><th>Job title</th><th>e-mail contact</th></tr>
<tr><td>Anna Ratcliffe</td><td>Consultant Paediatrician</td><td>Anna.ratcliffe2@nhs.net</td></tr>
<tr><td>James West</td><td>Consultant Paediatrician</td><td>jameswest@nhs.net</td></tr>
<tr><td>Lucy Malpas</td><td>Paediatric Clinical Fellow</td><td>Lucymalpas3@nhs.net</td></tr>
</table>
</td></tr>
<tr><td>Date assessment completed</td><td></td></tr>
</table>

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** Transition of Care Policy for Young People to Adult Services

What is the aim, purpose and/or intended outcomes of this Activity?	This policy outlines the Trust's vision of ensuring the effective transition for young people with long-term conditions from children's to adult services to improve health outcomes and optimise quality of life.

Who will be affected by the development & implementation of this activity?	X X X ☐	**Service User** **Patient** **Carers** Visitors	X ☐ ☐	**Staff** Communities **Other Patient families_**
Is this:	☐ Review of an existing activity **x New activity** ☐ Planning to withdraw or reduce a service, activity or presence?			

What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	Crowley R, Wolfe I, Lock K, McKee M. Improving the transition between paediatric and adult healthcare: a systematic review. Arch Dis Child. 2011 Jun;96(6):548-53. Department for Education and Skills (2004). Every Child Matters: Change for Children. DfES Publications, Nottingham, UK. Department of Health (2003). Getting the right start: National Service Framework for Children. Standard for Hospital Services www.dh.gov.uk Department of Health (2004). National Service Framework for Children, Young People and Maternity Services. www.dh.gov.uk Department for children, Schools and Families (2007). A Transition guide for all services. Key information for professionals about the transition process for disabled young people. https://www.gov.uk/government/publications/every-child-matters Department of Health (2011). You're welcome quality criteria. Making health services young people friendly. (www.dh.gov.uk) 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 Publications, London www.dh.gov.uk/transition McDonagh JE (2008). Young People first – JIA second. Arthritis Care and Research 59:1162-1170 NHS England (2018) Quick Guide: Commissioning for transition to adult services for young people with Special Educational Needs and Disability (SEND) (www.england.nhs.UK) Royal College of Paediatrics and Child Health (2003) Bridging the Gaps: Health Care for Adolescents.(www.rcpch.ac.uk) Royal College of Paediatrics and Child Health (2010) Not Just a Phase. A guide to the participation of children and young people in health services. (www.rcpch.ac.uk)
	Royal College of Physicians of Edinburgh (2008). Think Transition: Developing the essential link between paediatric and adult care. Royal college of Physicians of Edinburgh, Edinburgh Viner R (2008). Transition of care from paediatric to adult services: one part of improved health services for adolescents. Arch Dis Child 93(2); 160-163

Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	Engagement with young people, paediatricians, regional advisor on transition
Summary of relevant findings	The purpose of this generic policy is to assist all healthcare professionals involved in the care of young people to ensure they receive an uninterrupted and quality service when transitioning from child-centred to adult-orientated services in Worcestershire Acute Hospitals NHS Trust in accordance with current national guidance and evidence. 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 and primary care for young people with more complex medical conditions.

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	**Potential positive impact**	**Potential neutral impact**	**Potential negative impact**	**Please explain your reasons for any potential positive, neutral or negative impact identified**
Age	x			Preparing young people for adult services and to ensure good continuity of care as they transition to different medical and nursing teams
Disability	x			The policy and process will be child and family centred taking into account patients with disabilities and ensuring the correct services are available to them
Gender Reassignment	x			The policy and process is child and family centred taking into account patients with gender dysphoria
Marriage & Civil Partnerships		x		
Pregnancy & Maternity		x		
Equality Group	**Potential positive impact**	**Potential neutral impact**	**Potential negative impact**	**Please explain your reasons for any potential positive, neutral or negative impact identified**

Race including Traveling Communities	x			The policy and process is child and family centred and can include those from travelling communities
Religion & Belief	x			The policy and process is child centred and so takes into account patient's religious and cultural beliefs
Sex	x			
Sexual Orientation	x			
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)	x			
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)	x			

Section 4

What actions will you take to mitigate any potential negative impacts?	**Risk identified**	**Actions required to reduce / eliminate negative impact**	**Who will lead on the action?**	**Timeframe**
		.		
How will you monitor these actions?				
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)				

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	
Date signed	16/8/22
Comments:	
Signature of person the Leader Person for this activity	
Date signed	16/8/22
Comments:	

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

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

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval