Trust Policy





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

Start healthcare transition early (around 11-13 years of age) or on entering the children's service if they do so when older than 14 and ensure there:
consideration of young people's abilities, needs and hopes for the future. Notify Transition Specialist Nurse of patient as the start of the process Commence RSGH toolkit and complete **Ready** questionnaire (usually around 11-13 years old or developmentally appropriate age) or specialty equivalent paperwork If the TYA will be transferring at 16 years to adult services then complete the 16 plus pathway to start to identify adult teams and use the ask 3 questions model of care to involve them within this process. Ensure Young Person is provided with written Patient Information Leaflet - 'Transition: moving into adult care. Information for young people and families' Develop a healthcare transition plan that is developmentally appropriate. Ensure: - person centred

- that healthcare transition plans are jointly agreed with young pe

- that plans have a positive focus (strengths based)

- the young person will have a named worker* The young person's healthcare transition plan should be linked to other care plans and information should be shared with all those involved in delivering care to the young person. See 16+ pathway Consider regular MDT meetings or team around the child meetings where there are multiple agencies involved as the young person transitions. Parents need healthcare transition preparation and support alongside the young person's healthcare transition programme and plan. The young person should be asked regularly how they would like their parents to be involved throughout the healthcare transition process. Complete Steady Questionnaire (usually around 15-16years old or developmentally appropriate) or specialty equivalent paperwork If the TYA will be transferring at 18 years to adult services then complete the 16 plus pathway to start to identify adult teams and use the ask 3 question Copy young people and, where appropriate, their parent/carer into all correspondence regarding ongoing healthcare needs. The correspondence should a. Be developmentally appropriate, allowing for a learning disability, au Offer to see the young person alone for part of the appointment Complete Go Questionnaire (usually around 16-17 years old) or specialty equivalent paperwork The point of healthcare transfer should not be rigid and should take place at a relatively stable point for the young person Hold joint transition clinics for young people moving from child into adult healthcare services, involving healthcare staff from the young person's paediatric team and the adult service(s) they will move to. Ensure Transition Care Plan +/- Speciality Specific Transition Summary Document or Transfer to GP Proforma is shared with all healthcare professionals involved in care and hand held copy given to young person Complete Hello Questionnaire at first adult appointment after the joint clinic or specialty equivalent paperwork Thereafter the Young Person will be admitted as inpatients under adult healthcare services and attend adult clinics. Attendance for transition patients should be actively monitored. Non-attendance is followed up as per Patient Access Policy for Adults

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

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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 appropriate 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

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