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| **Main points the document covers** | • An understanding of the importance of a safe effective transition from children’s to adult services  
• Standards and process underpinning transition  
• Training resources to support practitioners  
• Transition care plan template. |
| **Who is the document aimed at?** | All children and adult services who support young people to transition to adult health services |
| **Author** | Sally Crighton, CCN Service Manager  
Jo Gregory, Head of Nursing & Quality (Children & Families)  
Helen Unsworth, Consultant Paediatrician |

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Policies, Procedures, Guidelines and Protocols

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1 Introduction

“There is plenty of guidance on what makes good Transition planning, but we found a significant shortfall between policy and practice” (CQC 2014) For young people, their families and sometimes staff the process of moving children into adult services can be confusing and frustrating, often resulting in gaps in essential care because this has not been ‘joined-up’ or planned around the individual in a timely way. The publication of the full Children’s National Service Framework (NSF, 2004) highlighted the importance of well-planned transition of young people (12-19 yrs.) from child–centred to adult-oriented services. These are views mirrored by NICE (2016) Transition from children’s to adult’s services

Transitional care is a multi-dimensional, multi-disciplinary process that addresses not only the medical needs of young people but also their psychosocial, educational and vocational needs. Transition is recognised as a gradual process of empowerment that equips young people with the skills necessary to manage their own healthcare as they move towards and into an adult lifestyle. It is a carefully planned process undertaken over time which includes (but is more than) a planned transfer to adult services.

The transition from child to adult services can be a difficult time for young people. During this time there may be many other changes in a young person’s life, including: changes from school to further/higher education or employment; changes in self-identity and relationships; and, changes which arise from the shift from childhood to adulthood, all of such can result in uncertainty, anxiety and stress. It is important that any required transition process is managed sensitively and collaboratively to support continued engagement of the young person and their parents /carers and safe and effective service delivery. The involvement of the young person and their carers, collaborative working and effective communication between everyone involved is central to successful transition arrangements.

There is a growing need for health services to ensure a seamless transition of young people to adult health care services. This is achieved by maintaining good liaison between Paediatricians, Physicians, General Practitioners (GP), Nurses, Allied Health Professionals (AHP), and external agency professionals. More children with long-term and complex conditions now live into adulthood and these are seen as at particular risk of falling into service gaps, also in this risk group are children and adolescent mental health service users, young people with palliative care needs/life limiting conditions and young people leaving residential care.

We know from widespread evidence that inadequate transitional care impacts on long-term health outcomes for children and young people. Professionals need to ensure transition planning is implemented in a coordinated way placing the young person’s needs and aspirations at the centre of the transition process.
2 Aims

The aim of this guidance is to support staff achieve a safe transition for CYP through:

- The provision of high quality, co-ordinated, health-care that is patient-centred, age and developmentally appropriate and culturally competent, flexible, responsive and comprehensive with respect to all persons involved
- Promotion of skills in communication, decision-making, assertiveness and self-care, self-determination and self-advocacy;
- Enhancement of the young person’s sense of control and move towards independence;
- Provision of support for the parents/carers of the young person during this process.

3 Purpose

The purpose of this guidance is to set out principles and guidance for effective transition to adult care for CYP who are being cared for within current children’s services in Shropshire Community Health Trust.

This document has recognised current guidance:

- CQC from Pond into the Sea (2014)
- NICE (2016) Transition from children’s to adult’s services

Consideration has also been given to examples of transition procedures from other organisations in establishing this guidance. It is recognised that staff working in Children’s Services will have very variable inputs into transition plans; this may range from taking the key transition lead to having a specialist advisory role only. However it will be essential that professionals continue to work in partnership with relevant statutory and voluntary organisations that have involvement with the child and family in order that transition is as seamless as possible. Services identified for ‘moving on to’ will also vary dependant on individual needs.

4 Roles and responsibilities

The Medical Director is responsible for providing clinical leadership within our Trust for the provision of senior clinical advice. The Medical Director has the overall responsibility of ensuring that the Transition Guideline is implemented.

The Service Delivery Group Managers are responsible for ensuring that the guideline is implemented across the Children & Families and Adult Service Delivery Groups (SDG) to support safe transition for young people.
Shropshire Community Health NHS Trust

Guidelines for the Transition of Young people Moving to Adult Service  4 Oct 2018

The Heads of Nursing and Quality for both Children & Families and Adult SDG’s are responsible for overseeing compliance of the guideline and quality of transition experienced by young people within our Trust.

Service and Clinical Managers for both children and adult services are responsible for implementation of this guidance within their areas of responsibility. They will monitor that all relevant staff are aware of the guidance and undertake training as appropriate.

Community Clinical Staff responsible for the care of young people must ensure they have access to this guideline for reference. All staff will work collaboratively with colleagues in Children & Family/Adult services to ensure that the transition needs of the young person are met. The young person will remain at the centre of the process with their thoughts and wishes taken into account at all times.

5 Philosophy

The guiding principle of transition is to enable the young person to reach optimum independence and facilitate a smooth transition to adult services. In facilitating the transition process we need to consider the following points:

- For transition to be effective we need to recognise that transition of health care is only one part of the wider transition from dependent child to independence.
- The needs of parents/carers should be acknowledged during transition as their role is evolving too.
- When moving from child to adult services young people will experience cultural as well as clinical change.
- A multi-disciplinary approach will support both paediatric and adult services.
- Effective transition relies on the identification of a key worker to ensure a seamless transition.
- Transition is an active process which must begin early, be planned and reviewed regularly. Transition is not a single one off event

6 8 Steps to transition

It is crucial that professionals work in partnership with young people and their families to ensure that they get the support they need for effective transition. The young person and their family should be kept informed every step of the way and understand what is happening, feel confident and in control.

Some young people will have long term conditions (e.g. asthma, diabetes or epilepsy) and transition will be mainly concerned with moving on to Adult Health Services. Other young people may have learning disabilities or social care needs. Their transition will be more concerned with moving on to adult social or learning disability services. A small number of young people with complex long term conditions will have support from health, social care and special education. When this happens it is important that these services work together to coordinate the different transitions.

The following diagram shows the eight steps which we feel are important to an effective and successful transition for young people and their family.
8 Steps to Transition (Adapted from 10 Steps to Transition Brooke & Rogers 2018)

7 Standards
The following standards are underpinned by NICE Quality Standards QS140 Transition from children’s to adults’ services (NICE 2016). We will use the standards for monitoring the effectiveness through clinical audit and experience feedback from young people, parents/carers and wider stakeholders.

- Young people who will move from children’s to adults’ services start planning their transition with their key health practitioner by school year 9 (aged 13 to 14 years), or immediately if they enter children’s services after school year 9.
- Young people will be transferred with a transition care plan (Appendices)
- Transition planning for individual young people will be reviewed on an annual basis.
- Young people who move from children’s to adults’ services should meet a health practitioner from each adult’s service before they transfer.
- Young people who have moved from children’s to adults’ services but do not attend their first meeting or appointment are contacted by adults’ services and given further opportunities to engage

8 Training
This is recognised as an essential component to support delivery of a multi-disciplinary approach to the transition process within our Trust. Professionals need to consider further development of their knowledge and skills in working with young people, including the biology and psychology of adolescence; communication and consultation strategies; multi-disciplinary team work and an and understanding of how health impacts into adulthood. Training will be available for health care practitioners across children and adult services working with young
people and their families. **It is recommended that one E-learning module is completed every two years.**

E-learning available to all staff:

**Adolescent Health Programme**
The Adolescent Health Programme (AHP) is an e-learning programme for all healthcare professionals working with young people. It is the third programme in the Healthy Child Programme 0-18 series of e-learning resources, following the Healthy Child Programme and Healthy School Child Programme. [https://www.e-lfh.org.uk/programmes/adolescent-health/](https://www.e-lfh.org.uk/programmes/adolescent-health/)

**Disability Matters programme**
Disability Matters is developed by disabled young people, parent carers and other experts. This E-learning is by bite-sized learning package matching the needs of different individuals offering practical advice about supporting disabled children, young people and their families to achieve the outcomes that matter to them. [https://www.disabilitymatters.org.uk/Catalogue/TileView](https://www.disabilitymatters.org.uk/Catalogue/TileView)

**Making healthcare work for young people**
This toolkit gives practical suggestions about how healthcare can be tailored to young people’s needs as they develop and change through adolescence into young adulthood – such care is termed ‘Developmentally Appropriate Healthcare’ – or DAH.
The toolkit is designed to support everyone working in the NHS, from clinicians to chief executives, to promote the health of young people and to play their part in making healthcare work for this age group. [https://www.northumbria.nhs.uk/quality-and-safety/clinical-trials/for-healthcare-professionals/](https://www.northumbria.nhs.uk/quality-and-safety/clinical-trials/for-healthcare-professionals/)

**Queens Nursing Institute Transition of Care Programme**
The transition of Care Programme’ is for community nurses, to help them understand the issues that young people (and their families) face. The resource aims to improve practice in this key area and improve the experience of young patients. [https://www.qni.org.uk/nursing-in-the-community/from-child-to-adult/](https://www.qni.org.uk/nursing-in-the-community/from-child-to-adult/)

9** Equality and Diversity**
On 1st October 2010, the Government introduced the Equality Act. The Act makes it unlawful to discriminate either directly or indirectly because of a protected characteristic in relation to employment, supply of goods and services including healthcare, education etc. We have a legal responsibility to assess the services we provide and identify how we will protect people from discrimination on the basis of the following ‘protected’ characteristics:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
Children and young people must be protected from discrimination during the transition process. This includes discrimination in relation to protected characteristics under the Equality Act. There must be a focus on assessing the impact on children and young people with protected characteristics. This involves anticipating the impacts of transition on these groups and making sure that, as far as possible, any negative consequences are removed or minimised and opportunities for promoting equality are maximised.

## Mental capacity

Capacity means the ability to use and understand information to make a decision, and communicate any decision made. It is important that we consider capacity when working with a young person and their family to support effective transition.

A young person may lack capacity if their mind is impaired or disturbed in some way meaning that they are unable to make a decision at that time e.g. a mental health condition or a severe learning disability.

People aged 16 or over are entitled to consent to their own treatment/transition plan, and this can only be overruled in exceptional circumstances. Like adults, young people (aged 16 or 17) are presumed to have sufficient capacity to decide on their own medical treatment, unless there's significant evidence to suggest otherwise.

Children under the age of 16 can consent to their own care and treatment if they’re believed to have enough intelligence, competence and understanding to fully appreciate what’s involved in their treatment/transition. This is known as being Gillick competent. Otherwise, someone with parental responsibility can consent for them.

This could be:
- the child’s mother or father
- the child’s legally appointed guardian
- a person with a residence order concerning the child
- a local authority designated to care for the child
- a local authority or person with an emergency protection order for the child

## References


Appendices

The Ready Steady Go transition plan – Getting Ready

The Ready Steady Go transition plan - Steady

The Ready Steady Go transition plan - Go

Transition plan

Parent/carer’s transition plan

Transition: moving into adult care