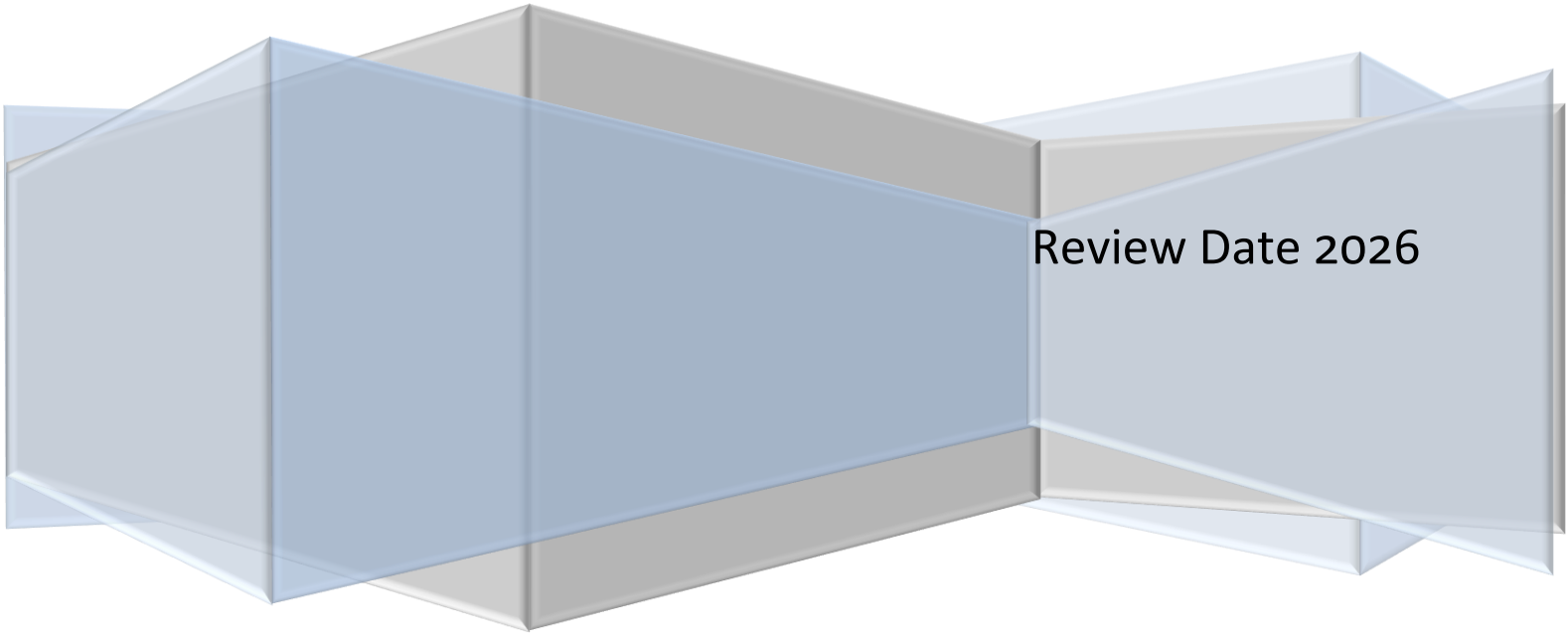
Manchester University
NHS Foundation Trust

Transition of Healthcare for Young People Strategy



Review Date 2026

Transition of Healthcare

Definitions

Healthcare Transition: is defined as a multi-faceted, active process that attends to the medical, psychological and educational/vocational needs of adolescents as they move from child to adult centred care (Blum 1993). It is now advocated that this process starts in early adolescence (NICE, 2016).

Transfer: is the event of leaving children's and entering adult services within primary/secondary/tertiary care/community services.

Our aims for Transition of Care

- **To provide safe, effective, developmentally appropriate transition and transfer from children's services to adult services for all young people with health conditions requiring on-going care**
- **To ensure young people and their parents/carers experience a transition process that prepares them with the required knowledge, skills and confidence to manage their health conditions in adulthood**
- **To care for young people and their families in adult services in a developmentally appropriate way, whilst maintaining the quality of services provided.**
- **To ensure there is on-going engagement with the young person and for transition to be a positive experience.**

What do we want to do?

We recognise that adolescence and young adulthood is a time of physical, psychological, educational and social change. Young people with health conditions are required to move from childrens to adult services. We know from evidence that good transitional care can improve on-going engagement with services and positive health outcomes.

Our aim is to provide a consistent, safe and individualised, high quality transition service that enables young people and carers to move into adult services with minimal disruption to their care and a good patient and carer experience of the change.

How will we do this?

We have based our strategy on national guidance and the views of young people and their families. In doing this we will deliver the objectives set out below.

Implementation of the strategy will be led by the Group Joint Medical Directors and overseen by experts from both children's and adult's services. The Group Quality and Safety Committee will be responsible in monitoring progress against this strategy. In addition, each hospital & MLCO will report into their local Quality and Safety Committees and the Trust Transition of Care for Young People Strategy Group.

Our Strategy:

This strategy aligns with our Trust values of Everyone Matters, Working Together, Dignity and Care

Open and Honest.

The work plan that underpins this strategy outlines our plans over the next three years to deliver healthcare transition services that meet the expectations of young people and their families who use our services.

It sets out objectives for delivering the best experience for young people and their families across care settings.

The successful delivery of this strategy will depend on professionals close partnership working with health, educational, social care and voluntary organisations.

The principles, infrastructures and pathways under this strategy will be afforded to young people entering healthcare through different portals in a developmentally appropriate manner.

Objective one: Every young person who is able to participate in shared decision making will be involved in discussions and make informed decisions about their own care.

What we will do:

- We will ensure that clinicians equip young people with shared decision-making skills early in the transition process using tools such as Ask 3 Questions (Shepherd HL, et al, 2011)
- Young people who do not have capacity and are therefore unable to be involved in their own decision making, will have transition arrangements undertaken in their best interest with support from the family and the team around the young person
- Transition planning will start at 11 years in each young person's clinical journey and be reviewed with the young person on a regular basis (at least annually)
- If a young person accesses specialist services later in adolescence their transition process will begin immediately
- For the hospitals using Epic electronic patient records, young people will be given access to the MyMFT portal so that they can access their own medical records
- We will ask young people whether the transition process helped them achieve their agreed outcomes and feedback the outputs of this work to young people, their parents/carers and clinical teams
- We will involve young people and their families in the review of transition policies and treat them as equal partners in the process
- We will utilise MFT Youth Forum and Youth Service which has representation from other Manchester University Foundation Trust (MFT) hospitals and other relevant national young people networks in the delivery of this strategy
- We will use peer support, coaching and mentoring, advocacy and digital technology to support delivery of the strategy

Objective two: There will be a Named Worker to support the transition and transfer of every young person from children's to adult health services.

What we will do:

- We will work with young people and their families to identify a named worker (or team) to coordinate their transition care and support
- The named worker could be a doctor, nurse, allied health or social care practitioner with whom the young person has a meaningful relationship. They can be from primary care or a specialist service.

- The named worker will initially be someone based in young people's services but will hand over their responsibilities to an appropriate professional in the adult service(s) after transfer
- The named worker will be the link between the young person and the various practitioners/professionals involved in their support including the named GP if they have one and if not, ensuring they are registered with a GP
- For young people with a special educational needs and disability and in education, the named worker should be integral to the educational health care plan process as required.
- The named worker will ensure relevant information such as any safeguarding concerns are shared with other organisations, in line with local information-sharing and confidentiality policies
- The named worker will ensure that the young person attends their first appointment in adult services before discharging from children's services to ensure there are no gaps in care or disengagement from services
- In addition to a named worker, a Lead Consultant will ensure transition is co-ordinated across all specialities

Objective three: Every young person moving/transferring across care settings will have a documented transition plan and / or a communication or healthcare passport to ensure relevant professionals have access to essential information about the young person.

What we will do:

- We will co-produce with young people and parents/carers transition documentation including healthcare passports and plans
- We will use the Ready Steady Go Transition Programme which is built into the HIVE Healthcare Transition Tab or other similar transition tool programmes, to assess the young persons readiness to transfer and to co-produce transition plans
- The Healthcare Transition Tab will a be available on HIVE for all young people age 11-25 years to monitor and record transition plans
- We will utilise HIVE or other electronic patient records to identify our young people going through the transition process
- We will review the documentation on an on-going basis to ensure it meets the needs of young people and the specialties they are attending
- We recognise that there is a possibility of young people becoming disengaged during this process and that there is a need to ensure shared records of care are maintained. Looked after children, care leavers and young carers are especially vulnerable and at risk of disengagement
- We will work closely with care providers to ensure ongoing provision of funding for equipment and continuing healthcare is made in a timely way and communicated clearly to young people and their families and carers
- Where there is no reciprocal adult service or if the young person disengages with healthcare, a comprehensive letter and plan will be provided to primary care. This will enable primary care to refer to adult services as required in future

Objective four: Every young person moving/transferring across care settings will have support and advice to prepare them and their families for the transition and transfer to adult care, including consent, confidentiality and advocacy.

What we will do:

- We will treat young people as individuals and talk with them about what to expect during and after transition, their passports, their transition plan and their personal goals

- We will ensure young people know their rights in healthcare, including confidentiality, consent and shared decision making
- We will support young people to engage with clinical appointments and consultations
- We will ensure transition support is strength-based on what is positive and possible for the young person rather than on a pre-determined set of transition options
- We will signpost the young person and their families to the support and resources available
- We will work with families and carers and talk to them about what to expect during and after transition
- Supported by MFT youth service, we will establish peer support mechanisms to prepare young people for transition
- We will ensure the young person and their families know how to access services in adult care including their route into urgent care

Objective five: All services will be inclusive and responsive to the needs of young people and their families during transition and including when transferring to adult services

What we will do:

- We will ensure that transition planning is developmentally appropriate and takes into account each young person's evolving capabilities, needs and hopes for the future as they grow up.
- The point of transfer will take place at a time of relative stability for the young person between age 16-18 yrs
- We will treat the young person as an equal partner in the transition process and take full account of their views and needs
- We will support the young person to make decisions and build their confidence to direct their own care and support over time
- We will support the young person to access advocacy services if required
- We will involve the young person in the way the transition is planned, implemented and reviewed
- We will put young people in touch with peer support groups if they want such contacts
- We will ensure all young people are helped to manage their own condition as part of the overall package of transition support
- We will carry out a gap analysis every three years and develop actions in order to respond to the needs of young people who have been receiving support from children's services
- We will ensure all young people have access to public health information and signposting to services such as reproductive, sexual health, drugs and alcohol etc
- We will ensure that services are young people friendly and adhere to the 'You're Welcome Standards'
- We will ensure young people with learning disabilities and autism are referred to the adult learning disability team to ensure their reasonable adjustments are met

Objective six: All staff involved in transition and transfer of care will have access to training and support to enable them to care for young people and manage transition of care effectively

What we will do:

- We will signpost staff to a competency framework related to adolescent health and transition
- We will signpost staff to training packages on adolescent developmentally appropriate transitional care
- We will ensure all staff involved in transition have access to training (e- learning), dependant on need, which covers:
    - Effective communication with young people

    - Young people's development (biological including sexual health, cognitive, psychological, social and vocational)
    - The legal context and framework related to supporting young people through transition, including their rights to confidentiality, consent and safeguarding
    - Special educational needs and physical disabilities
    - Learning disability
    - Autism
    - Youth friendly health services
    - How to involve young people, carers and families in their care, development of services and work in partnership
- We will identify health care professionals to be transition and You're welcome champions across all clinical areas and specialist services

Objective seven: The organisation will have up to date guidance and policies that supports a young person friendly transition service

What we will do:

- We will maintain an intranet page containing information for health professionals about adolescent and young adults and transition. This will include links to local and national guidance and policy, relevant transition tools and documentation to support young people friendly services and transition https://intranet.mft.nhs.uk/content/corporate-services/clinical-projects/transition-of-young-people
- We will continuously review our transition and transfer services and processes against national and regional guidance
- We will ensure each specialist services have either a specific transition policy, standard operating procedure or pathway that incorporates this strategy
- We will monitor patient and parent/carer reported experience of transition processes and transfer into adult services and use feedback to continuously improve
- Relevant services will implement the Trust Strategy on Transition and all clinical areas and departments will implement the "You're Welcome Standards"

Objective eight: The organisation will work closely with all health, social care, education and voluntary sector organisations to ensure the transition process is inclusive and efficient

What we will do:

- We will share our strategy and policy with our partners
- We will jointly review systems and practices to identify where changes are needed
- We will jointly review service provision to identify where there are no equivalent adult services to refer young people to, or where young people may need to transfer to more than one adult service. We will agree a joint protocol outlining what to do in such circumstances
- We will involve all practitioners providing support to the young person and their family or carer, including the GP

References:

Blum RW, Garell D, Hodgman CH, Jorissen TW, Okinow NA, Slap GB. Transition from child-centered to adult health-care systems for adolescents with chronic conditions. A position paper of the Society for Adolescent Medicine. J Adolescent Health. 1993 Nov; 14 (7): 570-6

From the pond into the sea - Children's transition to adult health services, *CQC, June 2014* *https://www.cqc.org.uk/sites/default/files/CQC_Transition%20Report.pdf*

Shared decision making NICE guideline [NG197] Published: 17 June 2021 https://www.nice.org.uk/guidance/ng197

Shepherd HL, et al, 2011. Three questions that patients can ask to improve the quality of information physicians give about treatment options: A cross-over trial. Patient Education and Counselling, 2011; 84:379-85

Transition from children's to adults' services, Quality standard, December 2016 http://nice.org.uk/guidance/qs140

Transition from children's to adults' services for young people using health or social care services, February 2016 http://nice.org.uk/guidance/ng43

You're Welcome Standards (Pilot) – *Quality criteria for making health services young people friendly*, NHS England, DH, PHE, 2017 http://www.youngpeopleshealth.org.uk/yourewelcome/wp-content/uploads/2017/02/YoureWelcome_RefreshedsStandards.pdf

Resources:

Adolescent Health Programme e-learning www.e-lfh.org.uk

Developmentally appropriate health care for young people toolkit https://www.northumbria.nhs.uk/quality-and-safety/clinical-trials/for-healthcare-professionals/

Education Health Care Plan: https://www.gov.uk/children-with-special-educational-needs/extra-SEN-help

Ready Steady Go: Moving on up together 16+ pathway (Ask 3 Questions) https://www.readysteadygo.net/uploads/4/7/8/1/47810883/final_for_website.moving_on_up_together_16pathway61.pdf

MFT Transition of Healthcare for Adolescents and Young People https://intranet.mft.nhs.uk/search?search=Healthcare%20Transition&type=All

Ready Steady Go: Moving on up together 16+ pathway (Ask 3 Questions) https://www.readysteadygo.net/uploads/4/7/8/1/47810883/final_for_website.moving_on_up_together_16pathway61.pdf

RCP Acute care toolkit for adolescents and young adults https://www.rcplondon.ac.uk/guidelines-policy/acute-care-toolkit-13-acute-care-adolescents-and-young-adults