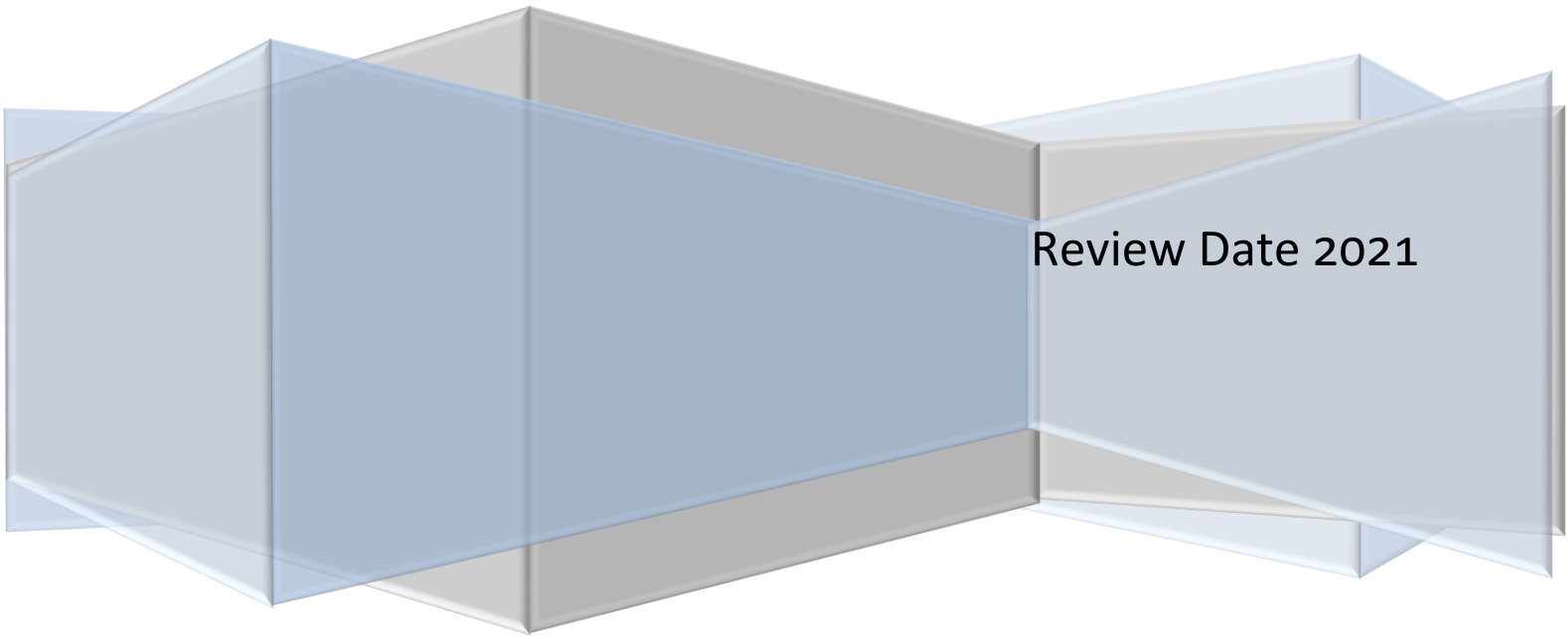
NHS
Manchester University
NHS Foundation Trust

Transition of Care for Young People Strategy



Review Date 2021

Transition of Care

Definitions

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, DH, RCH)

Transfer: is the event of leaving paediatrics and entering adult services within primary/secondary/tertiary care.

Our aims for Transition of Care

- **To provide safe, effective, developmentally appropriate transition process and transfer (handover) from children's services to adult services for all young people with long term conditions requiring on-going care**

- **To ensure young people and or carers experience a transition process that equips then with the required knowledge and skills to manage in adult services**

- **To care for young people and their families in adult services in a developmentally appropriate way without any loss in the quality of services provided, on-going engagement and a good patient 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 a long term and/or complex health condition are expected to move from paediatric to adult services. We know from evidence that good practice in 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 lessons learnt from other organisations, 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 Quality and Safety Committee will be responsible in monitoring progress against this strategy.

Our Strategy:

This strategy aligns with our Trust values of compassion, empathy, consideration, dignity, pride and respect.

The work plan that underpins this strategy outlines our plans over the next three years to deliver transition of care 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 close partnership working with our commissioners, schools and colleges, voluntary sector organisations, local networks, general practitioners other health and social care providers, Greater Manchester Health and Social Care Partnerships and Manchester Local Care Organisation.

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 decision making will be involved in discussions and make informed decisions about their own care

What we will do:

- We will involve young people and their families in the development of transition policies and supporting documents and treat them as equal partners in the process
- We will utilise the Youth Forum at RMCH 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
- 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 and their parents/carers
- Transition and transfer processes will be developmentally appropriate taking into account their maturity, cognitive abilities, need in respect of, long term conditions, social and personal circumstances and psychological status
- Transition planning will start early in each young person's clinical journey and be reviewed with the young person on a regular basis (at least annually)

Objective two: There will be a Named Worker to support the 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 single named worker to coordinate their transition care and support
- The named worker will be a doctor, nurse, health or social care practitioner with whom the young person has a meaningful relationship
- 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 when appropriate
- 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 disability and in education, the named worker should be integral to the educational health care plan process for those young people who have one.
- If the young person does not consent or is not in education, a full summary will be provided to primary care
- The named worker will ensure relevant information such as any safeguarding concerns are shared with other organisations, in line with local information-sharing and confidential policies

- The named worker will support the young person and their family for a minimum of 6 months after the transfer of care, the exact time will be negotiated with the young person
- In clinical areas where large numbers of young people transfer to adult services (for example those caring for young people with long term conditions) there will be a lead individual in that specialty with responsibility for transition

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

What we will do:

- We will develop, in consultation with young people and parents/carers where appropriate, transition documentation including passports and plans
- These plans will address all relevant outcomes including those related to education/training/ employment, community inclusion, health and well-being including emotional health and independent living
- We will set up a Trust database of young people in transition to ensure accurate shared records are maintained
- 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 risk 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
- Where the young person's social circumstances are unsettled, and no adult service has been identified, a comprehensive letter and plan will be provided to primary care. This will enable primary care to refer to adult services when the young adult is experiencing greater stability

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 engage with 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 support young people to maximise clinical appointments and consultations
- We will ensure the support we provide focuses on what is positive and possible for the young person rather than on a pre-determined set of transition options
- We will identify the support available to the young person, which includes but is not limited to their family or carers
- We will work with families and carers and talk to them about what to expect during and after transition
- We will signpost e-learning resources for young people, their families, carers and health care profesionals
- We will establish peer support mechanisms to prepare young people for transition

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 not be based on a rigid age threshold and will take place at a time of relative stability for the young person in late adolescence but before the end of adolescence
- 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 and respond to the needs of young people who have been receiving support from children's services, including child and adolescent mental health services, but who are not able to get support from adult services

Objective six: Responsibility for funding will be agreed early in the transition process and clearly communicated to the young person and their family in order to minimise distress or worry

What we will do:

- We will work closely with commissioners and other care providers to ensure arrangements are made in a timely way and communicated clearly to young people and their families and carers

Objective seven: All staff involved in transition and transfer of care will have 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 develop and deliver a training package on developmentally appropriate transitional care
- We will ensure all staff involved in transition have access to training (face to face and 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 confidentiality, competency, 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 champions across all clinical areas

Objective eight: The organisation will have up to date guidance that supports a young person friendly transition service which will have measurable outcomes for monitoring

What we will do:

- We will maintain a suite of transition documentation based on local and national guidance on the intranet
- We will continuously review our transition and transfer services and processes against national and local guidance
- 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 departments and hospitals will implement the You're Welcome Standards

Objective nine: The organisation will work closely with primary care colleagues; commissioners, schools and colleges, voluntary sector organisations, local networks, general practitioners other health and social care providers, Greater Manchester Health and Social Care partnership and Manchester Local Care 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 change 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:

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

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

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*

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:

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

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

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

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