Maidstone and Tunbridge Wells NHS Trust

Ref: FOI/GS/ID 4812

Please reply to:
FOI Administrator
Trust Management
Maidstone Hospital
Hermitage Lane
Maidstone
Kent
ME16 9QQ
Email: mtw-tr.foiadmin@nhs.net

01 August 2018

Freedom of Information Act 2000

I am writing in response to your request for information made under the Freedom of Information Act 2000 in relation to the Transition from child to adult services.

You asked:
I would be grateful if you could provide me with any policy that the Trust has published or any other formal guidance that staff follow concerning transition from child to adult health services within your hospitals, in particular concerning complex and life-limiting health conditions.

Trust response:

The Trust follows the University Hospital Southampton NHS Foundation Trust model which is available in full on their website.

http://www.uhs.nhs.uk/OurServices/Childhealth/TransitiontoadultcareReadySteadyGo/Transitiontoadultcare.aspx

The Trust also has the following guideline regarding paediatrics.

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Transition from Children's to Adult Care Guideline

Target audience:	All Paediatric staff
Main author:	Paediatric Respiratory and Allergy Nurse Specialist/ CF Nurse Lead (CS)
Other contributors:	Paediatric Dietitian (SR)
Document lead:	Paediatric Matron **Contact details:** jackie.tyler1@nhs.net
Directorate:	Children's and Young Persons Directorate
Specialty:	Paediatric Nursing
Supersedes:	Transitional care from Children's to Adult Services (2011); Vs 1.0
Approved by:	Paediatric Directorate Meeting **Date:** 24 November 2017
Ratified by:	Paediatric Directorate Meeting **Date:** 24 November 2017
Review date:	November 2020

Document history

Requirement for document:	To ensure Maidstone and Tunbridge Wells NHS Trust compliance with nation guidance relating to the transition of children to adult care services: • NSF (DOH 2004) • Transition: getting it right for young people (DOH 2006) • Aiming high for disabled children: delivering improved health services (NHS confederation 2009) • Independence: wellbeing and choice (DOH 2005) • Bridging the Gap: health care for adolescents (RCPCH 2003) • Care Quality Commission Core Standards
Cross references (external):	1. Department of Health (2004). *National Service Framework for children, young people and maternity services: Core standards*. London: HMSO 2. Department of Health (2006). *Transitions: Getting it right for young people*. London: HMSO 3. Department of Health (2007). *Your Welcome criteria*. London: NHSE. Bridging the gap: an integrated paediatric to adult clinical service for young adults with kidney failure', *BMJ* 2012; 344:e3718 4. Department of Health. (2008) *Transition - Moving on Well*. London: NHSE 5. National Institute for Clinical Excellence (NICE) No.43. (2016) *Transition from Children's to Adult Care*. Available at: https://www.nice.org.uk/guidance/ng43 6. NHS Confederation (2012). *Children and young people's health-Shaping the future and improving outcomes*. London: NHS confederation 7. Southampton website (2015). Ready Steady Go. Available at: http://www.uhs.nhs.uk/OurServices/Childhealth/TransitiontoadultcareReadySteadyGo/Transitiontoadultcare.aspx 8. Lewis, I (2012). *Report of the Children's and young Peoples Outcome Forum*. London: Department of Health 9. Royal College of Nursing (2008). *Adolescent Boundaries and Connections*. London: RCN 10. Royal College of Nursing (2013) Available at: https://my.rcn.org.uk/__data/assets/pdf_file/0011/78617/004510.pdf 11. Mental Capacity Act (2005) 12. South East Coast Strategic Clinical Network (2014). *Transition of children and young people to adult services. Best practice pathways guidance.*
Associated documents (internal):	• Safeguarding Children's Policy [RWF-OPPPCS-C-NUR6]

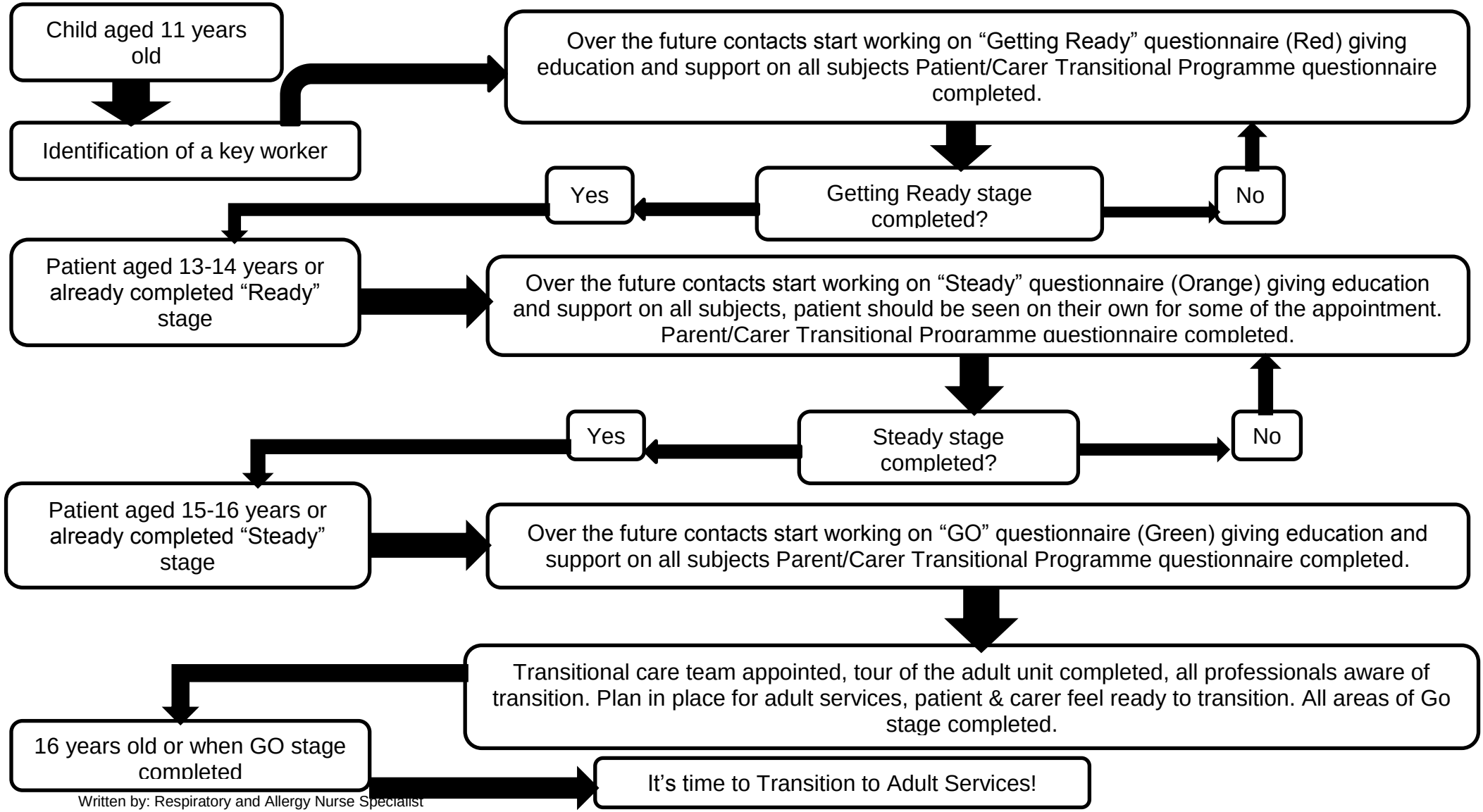
Version control:		
Issue:	**Description of changes:**	**Date:**
1.0	First iteration of this document	May – September 2017

Transition from Children's to Adult Care Guideline

Contents

OVERVIEW Maidstone and Tunbridge Wells Children's Service Ready – Steady – Go – Transitional Programme

Start transitional process – Watch video & Give leaflet – Transition: Moving into Adult Care
http://www.uhs.nhs.uk/OurServices/Childhealth/TransitiontoadultcareReadySteadyGo/Transitiontoadultcare.aspx



1.0 Introduction and scope

Scope

This guidance applies to:

- All paediatric specialities dealing with young persons.
- All children/patients from age 11 years with a long term condition until they are successfully transferred to adult services. The age of transfer is largely dependent on the progress made by each young person and where appropriate, the care giver.

The Purpose:

- To ensure a structured and co-ordinated transition to primary, secondary or tertiary adult health care services for young persons with on-going *health care needs.*

More children with long-term conditions now live into adulthood. There is a growing need for Specialised Care and services to ensure seamless transition of young people to adult health care services. This is achieved by maintaining good liaison between Paediatrician, Physician, GP and Allied Health Professionals (AHP). Inadequate transitional care impacts on long-term health outcomes for children and young people.

Self-management of any illness is often difficult and complex, particularly so during adolescence. This is due in part to pubertal changes, but also due to psychosocial changes such as erratic eating and exercise patterns, poor adherence to medication regimes, risk taking/antisocial behaviours, family stressors, psychological and self-image problems, frequently missed appointments, as well as binge drinking, smoking and eating disorders in a small minority.

Transition to adult services can be a traumatic period for young people, who commonly fall between services. In some cases there is a risk, non-concordance and morbidity associated with this transition.

There is a perception of a lack of appreciation of young people's needs and issues, the worry that they will not receive adequate information, the fear about leaving their familiar health care team for an unknown medical provider, and the desire for autonomy and involvement in decision-making.

Concerns may be raised with the Child Protection Team or Safeguarding Adult Teams where young people 'disappear' during transition and this will need to be monitored by individual teams to which the young people have been referred.

Part of the transition process is to educate the families and children about the differences between adult and children's services and find out their expectations. The principles of good transition are to ensure that effective communication is maintained between the child, families and providers.

Our aim is to empower the young person and their parents/carers. This is achieved by using the University of Southampton's Ready Steady Go programme to equip the young person with the necessary skills and knowledge to manage their healthcare confidently and successfully in both paediatric and adult services. Clearly this will include ensuring they are aware of basic information such as days and time of clinics, location of resources, clinics, laboratories, wards, car parking and refreshments.

Young people formally move from Children's Services to Adult Services ideally between 16 and 17 years.

2.0 Definitions / glossary

Transition: "a purposeful, planned process to firstly prepare young people moving from a child-centred to adult-orientated service and secondly addresses the medical, psychological and educational/vocational needs of adolescents and young adults with chronic physical and medical conditions as they move from Child-centred to adult-oriented health care systems."

Clinician: the professional responsible for the young person's care i.e. doctor or nurse specialist.

Key Worker: a professional who has the responsibility for collaborating with professionals from their own and from other services and developing good working relationships with many professionals to ensure co-ordination of care for the young person.

Parents/carers: a mother, father, close relative or close friend who are adults (older than 17 years) and who have been closely involved in caring for children prior to admission to hospital.

Child /Young Person: anyone not yet reached their 18th birthday.

3.0 Duties

Transition needs to address the medical, psychological and educational/vocational needs of the young person and the needs of their parents/carers.

Young people and their carers start the Ready Steady Go transition programme at around 11 years of age, if developmentally appropriate. Available at:
http://www.uhs.nhs.uk/OurServices/Childhealth/TransitiontoadultcareReadySteadyGo/Transitiontoadultcare.aspx

Please access all the DOWNLOADS available on this website.

Young people and carers are introduced to Ready Steady Go through the 'Transition: moving into adult care' information leaflet.

At the next consultation the young person completes a 'Getting Ready' questionnaire which, through a series of structured questions, is designed to establish what needs to be done for a successful move to adult services. The issues are addressed over the following 1- 2 years and not in a single consultation.

In due course, the young person completes the 'Steady' questionnaire which covers the topics in greater depth and is used to confirm progress and address any on-going issues or concerns.

Finally, a 'Go' questionnaire is completed to ensure that the young person has all the skills and knowledge in place to "Go" to adult services.

The young person should be introduced to the adult team – ideally at least a year prior to transfer.

The carer completes a separate questionnaire which follows the same format as the Ready Steady Go questionnaires, alongside the young person to ensure that they are also supported through the transition process.

The actual timing of the move to adult services is one that is mutually agreed by the YP, parents or carers and medical professionals.

Any issues / concerns and progress are documented in the transition plan by the healthcare team/keyworker.

- On transfer to adult services they should commence the "Hello to Adult Services" programme and a 'Hello' questionnaire be completed.

- Periodically the Hello questionnaire should be re-used to ensure they maintain knowledge and skill levels and that any new or on-going concerns or problems are addressed.

- Those young people or adults whose first presentation with a long term condition is in adult services should be started on the 'Hello to Adult Services' programme - this follows the same format as Ready Steady Go. It can be used for all young people and adults regardless of age or sub-specialty.

- Where the young person has learning difficulties the carer works through the Ready Steady Go programme with the young person engaging as much as possible. Carers with a severely disabled young person also start Ready Steady Go so that they too are prepared for the move to adult services; the programme allowing all concerns/issues to be carefully addressed and progress monitored prior to transfer**.**

3.1 Principles

- Every young person with any long term condition should have a planned transition of care evident within their health care records and transition should be a clear process over a defined period starting from around 11 years and ending by 18 years of age. It is not just a “one off transfer of care” from children’s to adult services.

- The timing of actual transfer should be tailored to individual patient’s needs depending upon their emotional maturity and cognitive and physical development but would usually be recommended between 16- 17 years.

- A clear management plan is recommended for patient care during the three phases of the transition period (Ready, Steady, Go) and a suggested format is in the Ready Steady Go documentation.

- The paediatrician/ lead clinician or nurse specialist is responsible for ensuring the patient’s clinical notes are up-to-date.

- Copies of key letters and summaries should be given to the young person during transition to keep in a Personal Health Record.

- A transition clinic between both paediatric and adult teams should take place, and if an identified adult ward has been designated, The Nurse in Charge should receive a comprehensive handover from the paediatric ward sister or paediatric specialist nurse.

- A named **key worker** who offers support around the transition should be agreed with each young person and identified to them.

- Young people should be given the opportunity of being seen on their own at least during part of the consultation. This can be offered at an appropriate time depending upon the emotional maturity of the young person from around the age of 12 years. All children being seen on their own should be offered a chaperoned during the consultation, in line with children safeguarding policies.

- Under the Mental Capacity Act children over the age of 16 years are within their right to choose whether they have treatment or not.

- Some young people will require MDT meetings, which may include the GP in complex care cases. The key worker can be any member of the multi-disciplinary team (MDT).

3.2 Roles and Responsibilities:

Director of Nursing: has responsibility for ensuring that appropriate processes are in place for the transition of young people (12-19yrs) from child-centred to adult orientated services policy.

Matron and Head of Nursing Children's Services: have responsibility for taking action on any non-compliance from the identified measurement tools that monitor compliance against this guidance.

Paediatric Validation Committee: Has responsibility to ensure standards are met, actions are carried out and areas of concern are raised and escalated appropriately.

Children's Hospital Governance: is responsible for receiving reports from the Paediatric Validation Committee.

4.0 Training / competency requirements

Professionals may 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 and multiagency teamwork
- An understanding of the relevant individual conditions and disorders and their evolution and consequences in adult life

An E-Leaning package developed by Royal College of Paediatrics and Child Health (RCPCH), Royal College of General Practitioners (RCGP), Royal College of Nursing (RCN) and other Royal Colleges is available to all staff so they can develop the necessary skills to help young patients make necessary changes to lead a healthier and more active life:

- It is an interactive online sessions and can be accessed via: www.rcpch.ac.uk/AHP
- It is easy to register and is free

Professionals within the Maidstone and Tunbridge Wells NHS Trust can be a resource for practitioners; particularly in respect of communication, team working and understanding conditions and disorders and their evolution, as now many children and young people survive into adult hood with complex conditions that previously would have been lethal in infancy.

5.0 Procedures for the transition of a child to adult care

Refer to:

- OVERVIEW See Maidstone and Tunbridge Wells Children's Service Ready – Steady – Go – Transitional Programme (page 4)

APPENDIX ONE

Process Requirements

1.0 Implementation and awareness

- Once approved this guideline will be published on the Trust intranet by the Maternity Compliance and Safety Co-ordinator.
- On publication of any Paediatric document, the Maternity Compliance Co-ordinator will ensure that an email is sent to all Paediatric staff and other stakeholders, as appropriate.
- On receipt of notification, all managers/team leads should ensure that their staff members are aware of the new publications.

2.0 Monitoring compliance with this document

Monitoring and Audit of this guideline will be identified with issues raised via Clinical Risk/Governance.

The purpose of monitoring is to provide assurance that the agreed approach is being followed – this ensures we get things right for patients, use resources well and protect our reputation. Our monitoring will therefore be proportionate, achievable and deal with specifics that can be assessed or measured.

Key aspects of the procedural document that will be monitored:

What aspects of compliance with the document will be monitored?	**What will be reviewed to evidence this?**	**How and how often will this be done?**	**Detail sample size (if applicable)**	**Who will coordinate and report findings (1)?**	**Which group or report will receive findings?**
Compliance with Transitional plans	Transitional plan completion	Ideally annually, but as directed by service needs	Approx 50 sets of notes	Transition steering group	Child Health Governance
Satisfaction survey	Engagement with –young people	Ideally annually, but as directed by	Approx 50 young people	Transition steering group	Child Health Governance

		service needs			

Where monitoring identifies deficiencies actions plans will be developed to address them.

3.0 Review

3.1 It is essential that Trust Policy/procedural documents remain accurate and up to date; this policy/procedural document will be reviewed three years after approval, or sooner if there are changes in practice, new equipment, law, national and local standards that would require an urgent review of the policy/procedure. It is the responsibility of the Document Lead for this policy/procedure to ensure this review is undertaken in a timely manner.

3.2 The Document Lead should review the policy/procedure and, even when alterations have not been made, undertake the consultation process as detailed in **Section 5.5 Consultation** of MTW Policy and Procedure '*Production, Approval and Implementation of Policies and Procedures*'.

4.0 Archiving

4.1 The Trust intranet retains all superseded files in an archive directory in order to maintain document history

4.2 Old paper guideline copies pre-dating Datix Guidelines are stored at:

Chatham Archive & Storage Document Co.
Anchor Wharf
Chatham
ME4 4TZ
Telephone: 01634826665

APPENDIX TWO

CONSULTATION ON: Transition from Children's to Adult Care Guideline

Consultation process – Use this form to ensure your consultation has been adequate for the purpose.

Please return comments to: Carol Smallman, Respiratory and Allergy Nurse Specialist (email: carol.smallman@nhs.net)

By date: 3rd October 2017 (all documents must undergo a minimum of two weeks consultation)

Job title:	**Date sent dd/mm/yy**	**Date reply received**	**Modification suggested? Y/N**	**Modification made? Y/N**
Paediatric Consultants including Clinical Director	18/09/17	22/11/17 x2	N	N
Paediatric Matron	18/09/17	01/10/17	Y	Y
Paediatric Ward Managers	18/09/17			
Paediatric Nurses	18/09/17	01/10/17 x4	Y	Y
Junior paediatric medical staff	18/09/17			
Paediatric Dietitians (including diabetes young person dietitians) and Paediatric Physiotherapists	18/09/17	Initial consultation	Y	Y
Paediatric Speech and Language Therapists	18/09/17			
Play Therapists	18/09/17			
Adult Diabetes Consultant	18/09/17			
Chief Nurse	10/11/17	10/11/17	N	N
Chief Operating Officer	10/11/17			
Adult Respiratory Nurse	17/11/17	17/11/17	Y	N

The following staff have given consent for their name to appear in this guideline and its appendices: Jackie Tyler Carol Smallman				
The role of those staff being consulted upon as above is to ensure that they have shared the policy for comments with all staff within their sphere of responsibility who would be able to contribute to the development of the policy.				

APPENDIX THREE

Equality impact assessment

This policy includes everyone protected by the Equality Act 2010. People who share protected characteristics will not receive less favourable treatment on the grounds of their age, disability, gender, gender identity, marital or civil partnership status, maternity or pregnancy status, race, religion or sexual orientation. The completion of the following table is therefore mandatory and should be undertaken as part of the policy development and approval process. **Please note that completion is mandatory for all policy and procedure development exercises.**

Title of policy or practice	Transition from Children's to Adult Care Guideline
What are the aims of the policy or practice?	To ensure best practice care for young person's in transition to adult care
Is there any evidence that some groups are affected differently and what is/are the evidence sources?	Refer to page 2 of this guidance
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	**Is there an adverse impact or potential discrimination (yes/no).** **If yes give details.**
Gender identity	No
People of different ages	Context of young person in transition to adult care
People of different ethnic groups	No
People of different religions and beliefs	No
People who do not speak English as a first language	The Trust offers a Translator service
People who have a physical or mental disability or care for people with disabilities	No
People who are pregnant or on maternity leave	No
Sexual orientation (LGB)	No
Marriage and civil partnership	No
Gender reassignment	No
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	Context of young person in transition to adult care
When will you monitor and review your EqIA?	Alongside this policy/procedure when it is reviewed.
Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix 3 of this policy/procedure on the Trust approved document management database on the intranet, under 'Trust policies, procedures and leaflets'.