Burdett National Transition Nursing Network and the South Thames Paediatric Network Collaboration Events

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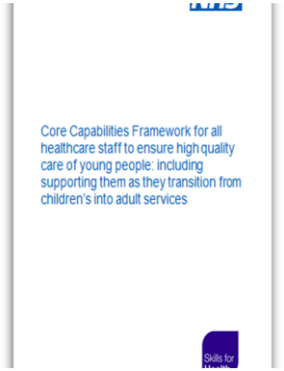
Session 2

Session 2: January 2023

- An overview of the key National Guidance and Frameworks informing the development of Transition Services - Understanding Transition and building an effective and sustainable Transition Service.
- An overview of the Transition Project Plan, including how to get started.
- Listening to and understanding Young People's development needs – using HEEADSSS, to support and guide conversations with young people.



Key Documents

Project Plan

How to get Started

Aim for Transition

Aim

- To improve the experience of young people age 11 to 25 years with a Long Term Condition (LTC) whilst also improving the experience of their families / carers, during the process of moving from children's services to being cared for and settled in adult services.
- In doing so having a positive impact on long term health outcomes, achievement of life aspirations and attainment of life goals.

Objectives for Transition Collaborative Events

Objectives

- To provide organisations with access to expert knowledge of Transition.
- Introduce an evidence based Nationally recognised QI process, to guide and support organisations in developing effective and sustainable Transition Services.
- To support the development of a Network of Transition contacts within organisations across the South Thames region as part of the wider Regional and National Transition Nursing Network.

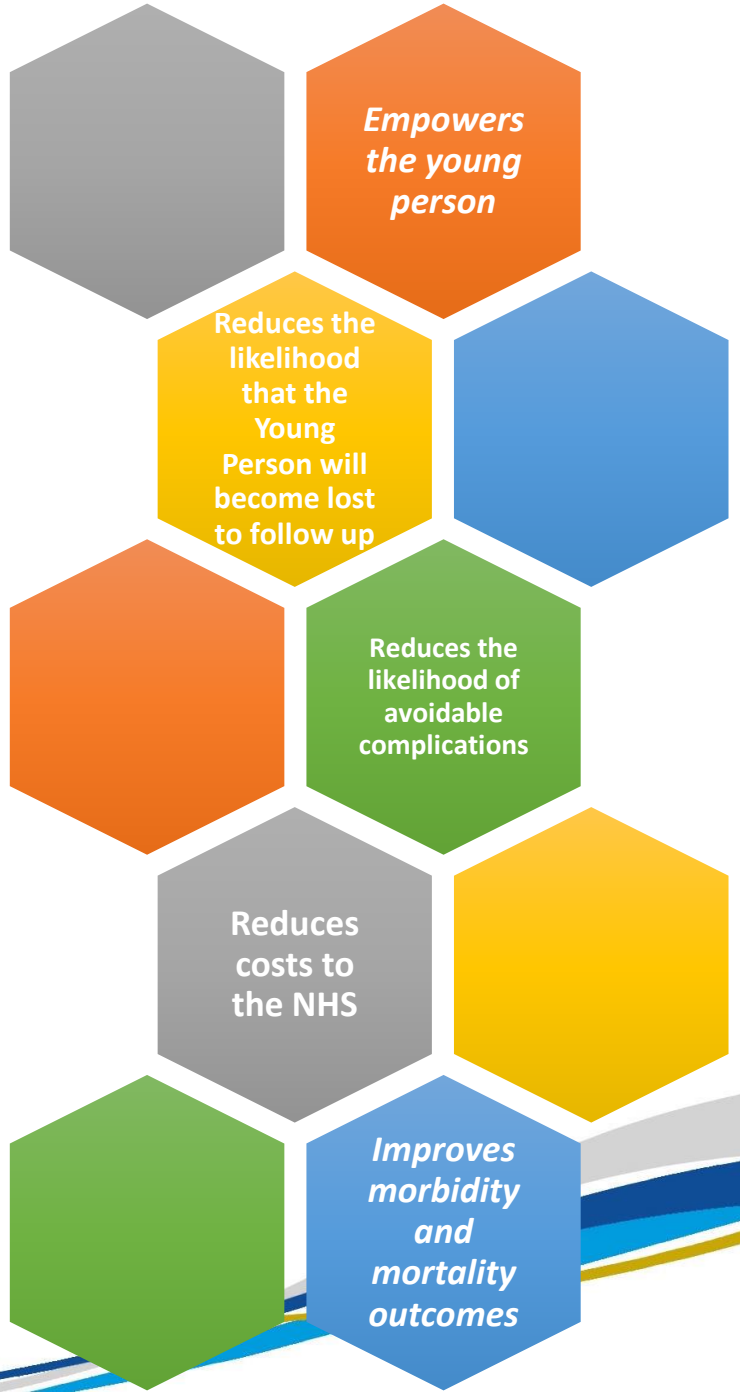
Transition – What it is and what it is not

- Blum et al (1993), stated that the aim is for Transition to be a planned, purposeful movement of a Young Person from a child centred to an adult orientated health care system.

- It is a process that evolves over a considerable amount of time and should NOT be considered a single event.

Transition

Effects & Benefits



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Effects of Poor Transition

The lack of co-ordinated care between child and adult services:

- Creates anxiety and unnecessary distress for young people, their families and carers
- Often results in poor compliance with treatments
- Frequent visits to hospital
- Poor engagement with Healthcare Services
- Poor social engagement and mental health

This contributes to increasing healthcare costs, but more importantly leads to poor health outcomes including poor mortality and morbidity.

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NHS Alder Hey Children's NHS Foundation Trust

NHS University Hospitals Birmingham NHS Foundation Trust

NHS Imperial College Healthcare NHS Trust

NHS Somerset NHS Foundation Trust

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Transition National Key Documents and Guidelines

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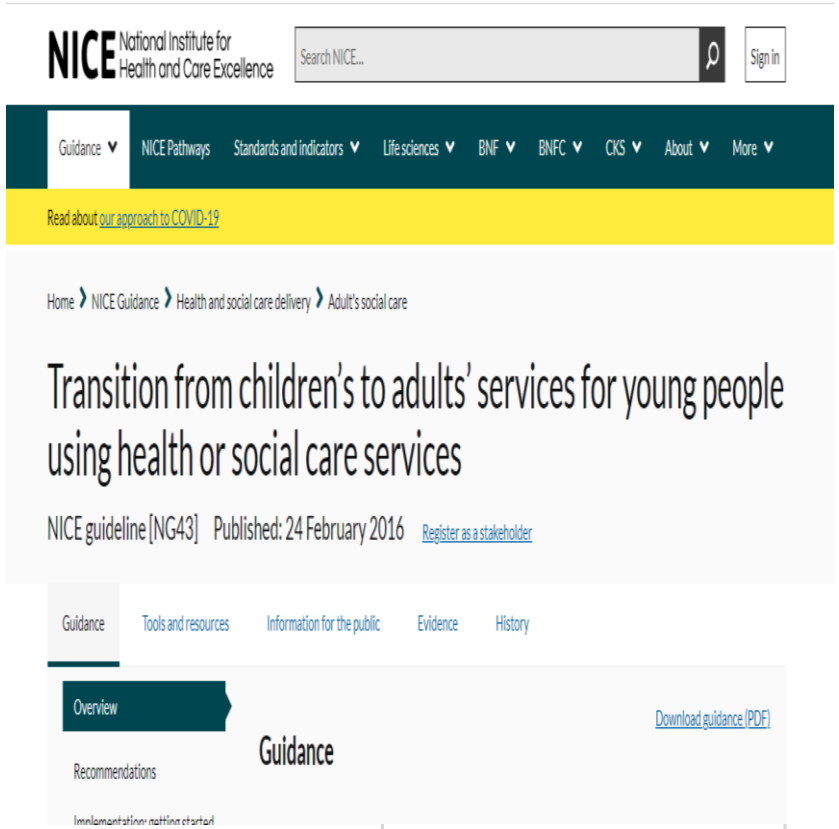
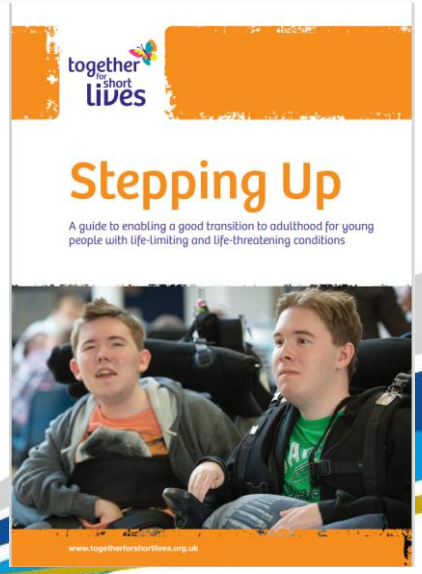
Current Guidance

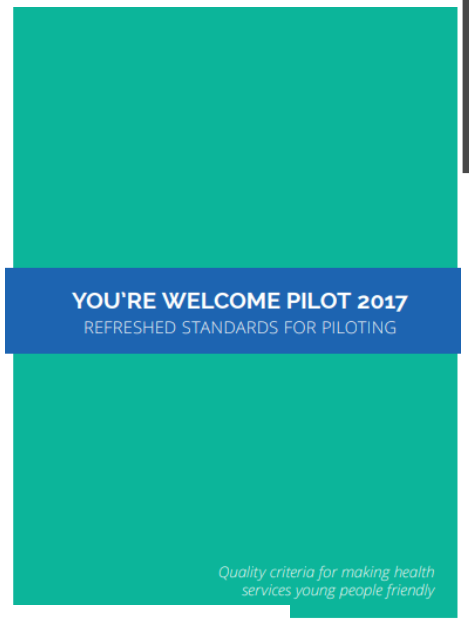
- NICE Guidance 2016
- NICE Standard 2016
- You're welcome 2017
- SEND code of practice
- TFSL Guide to stepping up 2016
- Northumbria tool kit for transition 2018

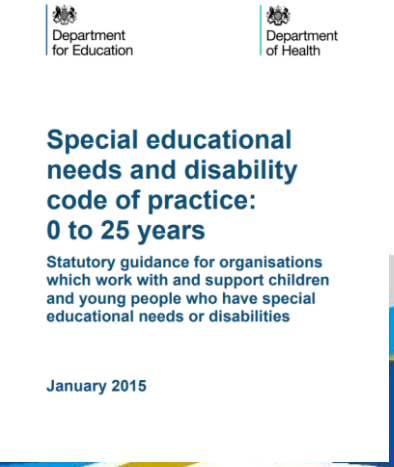
Transition Tools

- HEEADDESSS
- RSG
- GUGI
- 10 steps









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NICE Transition Guidelines NG43 (2016)

- 'covers the period before, during and after a young person moves from children's to adults' services.'
- 'help young people and their carers have a better experience of transition by improving the way it's planned and carried out. '
- 'covers both health and social care.'

56 recommendations

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NICE Transition Guidelines NG43 (2016) – Overarching Principles

It is estimated that up to 15% of young people aged 11 – 15 have a long term condition that requires ongoing specialist care

Transition into adult services can take up to seven years to complete

- Managers in **Children's and Adult services need to work together** to enable a smooth Transition
- Examples of good practice include having a **joint mission statement and information sharing protocols**
- Transition plans need to **reflect the individuals capabilities and preferences,** and young people should be asked regularly about parent or carer involvement
- Before Transfer, they should be able to **meet with someone from adult services** and **choose a named worker** to help them navigate the Transition Process.

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NICE Quality Standards

1) Young people who will move from children's to adults' services **start planning their transition** with health and social care practitioners by school year 9 (**aged 13 to 14 years**), or immediately if they enter children's services after school year 9.

2) Young people who will move from children's to adults' services have an **annual meeting to review transition planning.**

3) Young people who are moving from children's to adults' services have a **named worker to coordinate care and support before, during and after transfer.**

4) Young people who will move from children's to adults' services **meet a practitioner from each adults' service** they will move to before they transfer.

5) 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.**

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You're Welcome Pilot 2017 (Update commissioned)

- **The Department for Health's Quality Criteria for Young People friendly health services**

Includes:

Accessibility

Publicity

Confidentiality and consent

Environment

Staff training, skills attitudes and values

Joined up working

Young people's involvement in monitoring and evaluation of patient experience

Health issues for young people

Sexual and reproductive health

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Northumbria Developmentally Appropriate Healthcare

- **The toolkit is designed to support all 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.**

Supports:

- Understanding biopsychosocial development and holistic care
- The acknowledgement of young people as a distinct group
- Adjustment of care as the young person develops
- Empowerment of the young person by embedding health education and health promotion in consultations n Working across teams and organisations.

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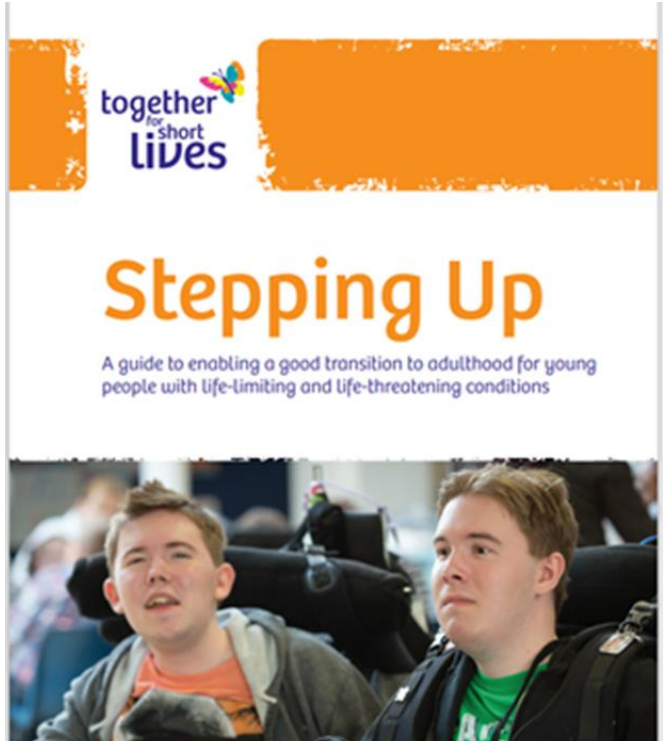
Together for Short Lives - Stepping Up



- A guide to enabling a good transition to adulthood for young people with a life-limiting and life-threatening conditions

- *Currently being updated*

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SEND Guidelines

- Provides statutory guidance on duties, policies and procedures relating to Part 3 of the Children and Families Act 2014 and associated regulations and applies to England.
- It relates to children and young people with special educational needs (SEN) and disabled children and young people.
- A ‘young person’ in this context is a person over compulsory school age and under 25.

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Burdett Partnership working with NHS England

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Future Frameworks and Guidelines

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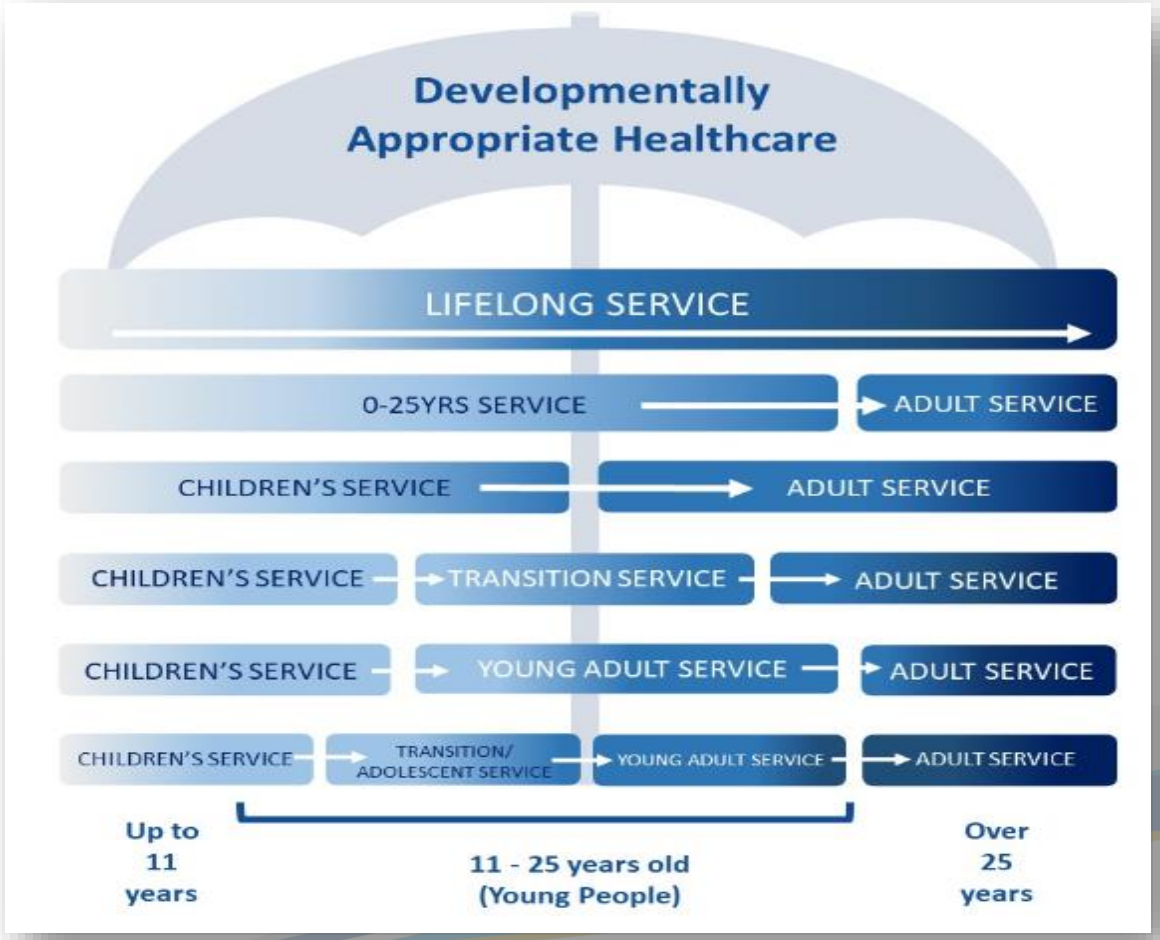
Burdett Partnership working with NHS England – Future Frameworks and Guidelines

- National framework for transition (0-25 years models of care)
- Core capability Framework for the Care of Young People and Transition
- National training package for the care of young people and transition
- Community Currencies for Transition
- CQC – inspection criteria
- Data collection (transition code)

National Framework for Transition

Delivery models/pathways of care for a 0-25 service



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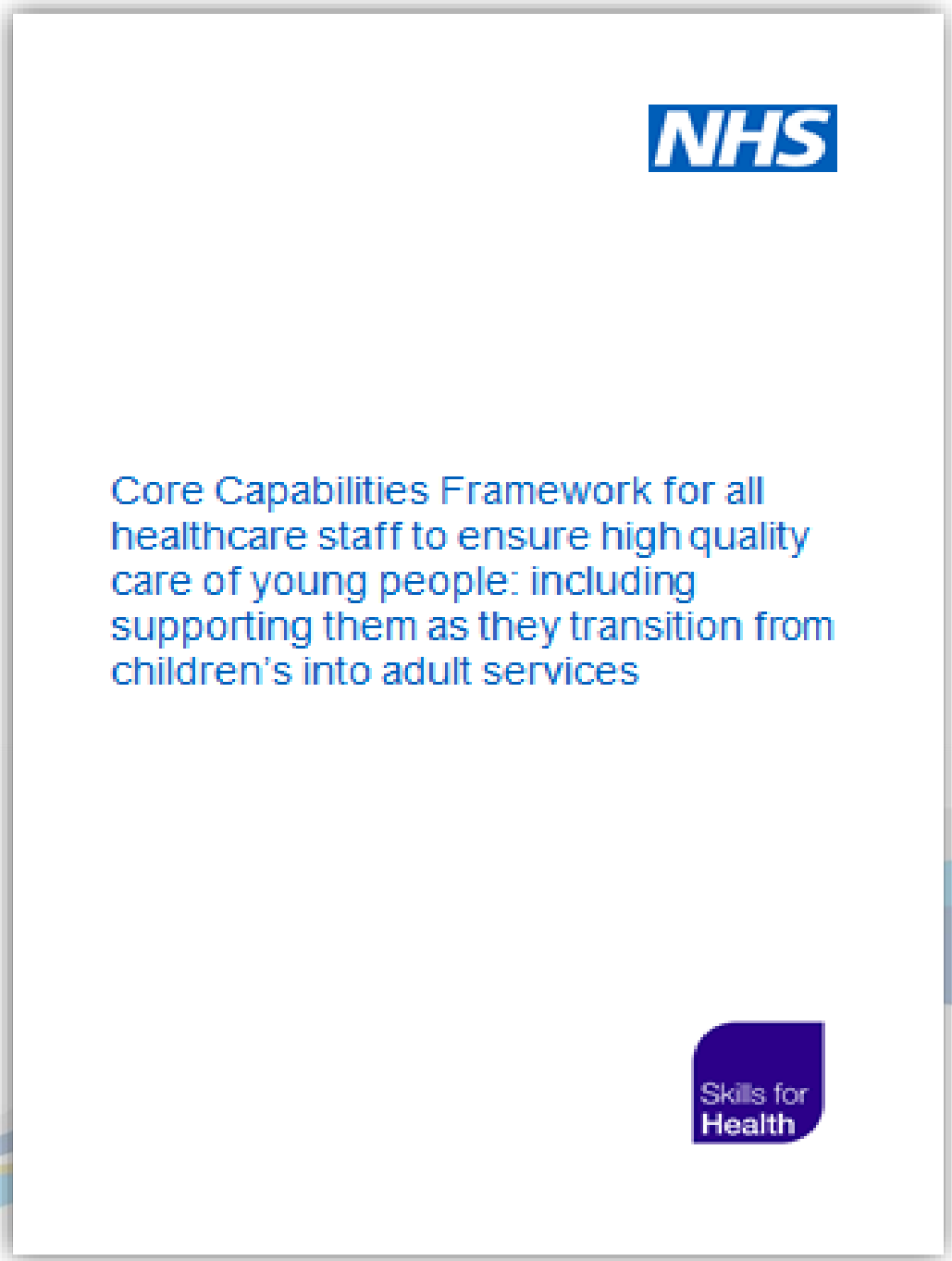
Core Capabilities



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Core Capabilities Framework for all staff to ensure high quality care of young people: including supporting them as they transition from children's into adult services

Aim

The Core Capabilities Framework for the care of all young people including Transition aims to identify and describe the **knowledge, skills, behaviours and attitudes that the healthcare workforce needs** to apply in order to deliver high quality, compassionate, personalised care to young people. It will provide a single, consistent, comprehensive, and explicit framework on which to base review and development of all relevant staff across clinical services.

The framework will determine standards for transition education and training and will assist in measuring if education and training satisfies these standards.

Currently there is no national framework that addresses the core skills and knowledge required to equip the workforce to provide personalised, high quality care for young people transitioning between services

Scope

The framework will be applicable to all healthcare employers and also to educational organisations who train students who will subsequently be employed in the healthcare workforce.

Consistent with other frameworks, the capabilities described in the framework are defined in tiers.

Structure

14 capability headings – capability statements in each

Tier 1 – Those who care for young people aged 11-25yrs

Tier 2 – Health and social care staff and others who regularly work with young people transitioning between services

Tier 3 - Health, social care, and other professionals with a role in leading and or transforming transition

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Capability	Capability Heading
1	Young people's development
2	Communicating with young people
3	Preparing for adulthood
4	The role of parents carers and significant others
5	Challenges for and influences on young people
6	Providing accessible high quality developmentally appropriate healthcare for young people and engaging them in their care
7	Confidentiality
8	Consent
9	Safeguarding
10	Multi-disciplinary working in partnership and collaboration across organisational boundaries
11	Involving young people in improving and developing services
12	Hospice and palliative care support
13	Complex needs transition
14	Leadership and transformation in transition

Tier 1 **The knowledge, skills, attitudes and behaviours for all staff working with young people aged 11 to 25 years in healthcare settings**

Tier 2 **Knowledge, skills and attitudes and behaviours of all staff who work directly with young people aged 11 to 25 years who are in, or require, healthcare transition from children's into adult services. This includes support for young people to be settled and engaged within adult services.**

Tier 3 **Enhancing the knowledge, skills, attitudes and behaviours of all healthcare staff who are responsible for the leadership, transformation and monitoring of transition services.**

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Best Practice

Aiming for Outstanding

Developmentally appropriate healthcare for all	Transition preparation and Support 11 – 25 years (For those moving into adult care)	Appropriate care for newly presenting Adolescents and Young Adults

- NICE Guidance and Standard 2016
- Benchmarks for transition
- Core Capabilities for Care of YP &Transition
- National Framework for Transition
- National Training Package for care of YP &Transition

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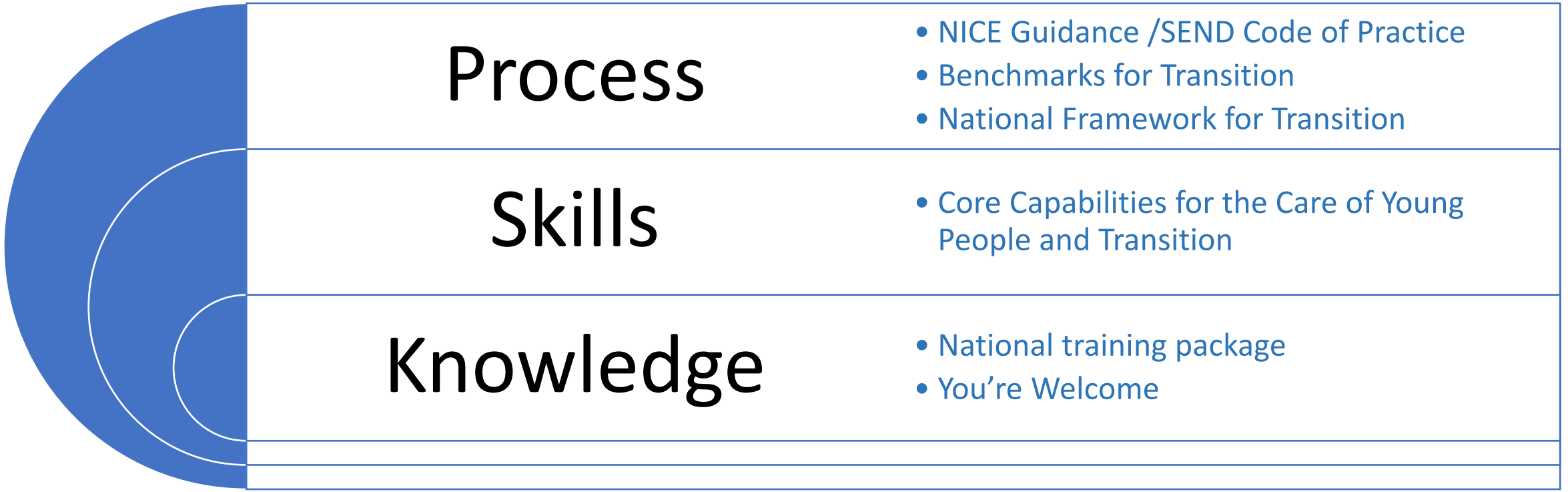
Why so many documents?



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The National Confidential Enquiry into Patient Outcome and Death – NCPOD Transition Study

Aim

To explore the barriers and facilitators in the process of Transition of Young People with chronic conditions from child to adult health services.

Study Population

- 13 – 24 years
- Chronic condition
- Data returns: 1st of October 2019 to 31st March 2021

- Included 227 organisations with 176 organisations returning questionnaires

Explored:

- Organisational data
- Peer review data (Clinical questionnaires and case note reviews)
- Primary care (Organisational and clinical questionnaires)
- Surveys and focus groups (including Health and Social Care, YP and parent Carer Surveys and focus groups)

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NCEPOD – Transition Study

What happens next?

- A full report of the findings is being produced.
- There will be a total of the three drafts of the report circulated to the advisory group for comments, which will be considered and included as appropriate.
- Publication expected on the 8th of June 2023
- Development of QI Tools

Summary

NICE Guidance & Standard for transition NG43 QS 140 (2016)
Gold standard principles for transition, help to design transition process
National framework for transition (coming soon)
Principles for delivering and commissioning transition including minimum standard for care outlined
Capability framework (coming soon)
Assessment document for the skills, knowledge and behaviours staff require when caring for young people, including transition
National training package (coming soon)
Training for the care of young people and transition
You're Welcome 2017 & 2011
To be use to assess if healthcare services are young person friendly
Benchmarks for transition 2016
Assessing services against best practice for transition identifying areas of good and poor practice tool for process improvement
Northumbria Tool kit for transition
Recommendations for effective transition processes
Together for Short Lives Guide to Stepping up
A guide for transition of complex needs patients
tools for Young people and families as well as professionals

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Links

Transition

NICE Guidance for Transition 2016
https://www.nice.org.uk/guidance/ng43
NICE Standard for Transition 2016
https://www.nice.org.uk/guidance/qs140
SEND Code of Practice
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/398815/SEND_Code_of_Practice_January_2015.pdf
Northumbria Tool Kit for Transition 2018
https://www.northumbria.nhs.uk/quality-and-safety/clinical-trials/for-healthcare-professionals/#0fc61122

Young Person Friendly

Your Welcome criteria 2011
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216350/dh_127632.pdf

Complex needs

Together For Short Lives (TFSL) Guide to stepping up
https://www.togetherforshortlives.org.uk/resource/transition-adult-services-pathway/

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NHS The Leeds Teaching Hospitals NHS Trust

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NHS Somerset NHS Foundation Trust

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Transition Project Plan for Services

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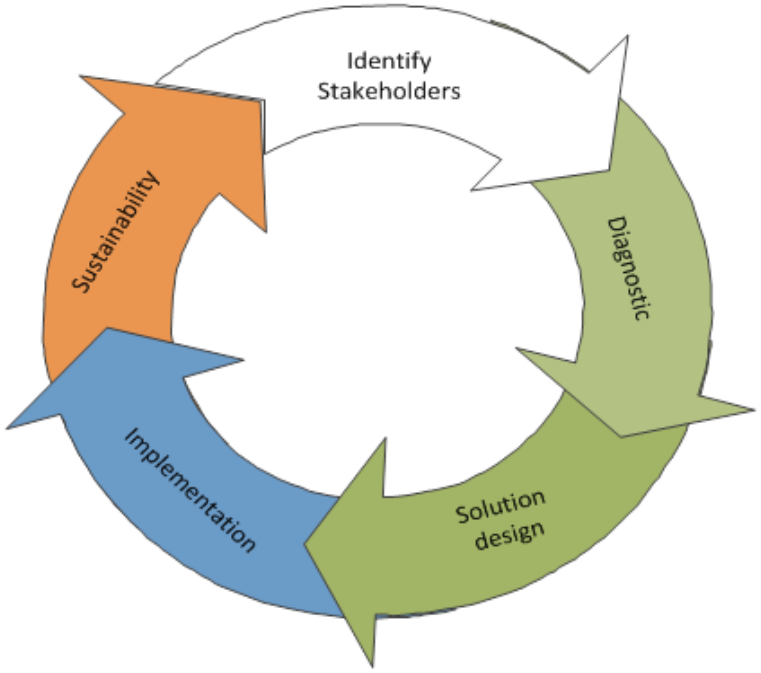
The Burdett Process for Improvement



- Stakeholders
- Diagnostic
- Solution design
- Implementation
- Sustainability

A structured way of approaching improvement

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Project Plan for Services

Service project plan	Identify key stakeholders	Identify key stakeholders for transition in the service
		Create delivery group for the transition project work-stream (e.g. service Renal, Diabetes, Allergy etc.)
		Create Stakeholder list and perform stakeholder analysis (use stakeholder analysis grid)
		Create focus groups to assist the delivery group (if required e.g. patient / youth forum for feedback)
	Understand current state	Understand the current transition process and who is involved (use mapping sheet)
		Understand current documentation used
		Identify where patients are currently seen by medical / nursing staff when in transition
		Identify where patients are currently seen by other professionals when in transition
		Understand what information patients are currently given when in transition
		Identify concerns and potential risks and issues in the transition pathway
	Gather good practice from elsewhere	Look at other service specific centres in the UK
		Look at other specialities within your organisation providing good practice for transition
		Look at other specialities outside of your organisation providing good practice for transition
	Define future state (Including You're welcome criteria)	Benchmark service against best practice using the University of Surrey's benchmarking tool
		Define best practice for your service including the use of the 'you're Welcome Criteria'
		Use a transition programme documentation tool, e.g. Ready Steady Go, GUGI, Alder Hey 10 Steps etc.
		Develop best practice future state patient pathway for transition
		Identify gaps between current state of transition pathway and future desired state pathway
		Identify and agree new roles and responsibilities
	Training needs analysis and gap analysis	Identify skills / knowledge required to deliver the future state transition programme to patients and families
		Identify gaps between current skills and desired skills and knowledge
		Identify staff groups / individuals to be trained and level /package of training required
	Communicate	Feedback the defined current state transition pathway
		Feedback any good practice gathered from elsewhere
		Communicate future state
		Communicate new roles and responsibilities
		Communicate work within the project to wider stakeholders
	Train and educate align new R&R's	Create training programme
		Identify trainers / methods of training: face to face, e-learning, practical, shadowing etc.
		Implement training programme (clear aims, objectives, methods of assessment & timescales)
		Ensure time allocated for training
	Implement	Roll out use of the new transition patient pathway
		Delivery group to support staff in use of the new transition pathway
		Consider formal start / launch date for new roles & responsibilities for better impact
		Agree how, when and who will collect measurement data and set a date to review of findings and pathway

Slido

- Best Practice

➢ What systems do you have in place to gain information from young people in terms of patient experience?

Please go to slido.com to enter your answer using enter code:

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Stakeholders

Identify key stakeholders	• Identify key stakeholders for transition in the service • Create delivery group for the project work-stream • Perform stakeholder analysis • Create focus groups to assist the delivery group	➢ Anyone who has interest in or influence over transition ➢ Look at every aspect of transition eg. Heads of Nursing, Chief Exec, parents, adult services, LD Lead also LA colleagues, primary care, commissioners etc. Think about representation at all levels eg. HCAs, admin, MDT coordinator etc. People who are going to deliver are part of the design process. ➢ Delivery Group is term we use but could be focus group, steering group, project group etc. Need representatives from who is delivering transition eg. Both adult and children's services, therapies etc. ➢ Look at contacting the transformation teams, consider QI training. Involve from beginning. Also comms team (will be more involved later on but think about involving from the start). Patient Experience team (may manage volunteers/YP forum etc.) and Audit team too. ➢ Create a stakeholder list, put together as examples above. Look at Power and Influence of stakeholders. ➢ Identify who might be barriers and will be levers. Put into categories and work out communication plan ➢ Consider meeting face to face if possible with flip charts and post-it notes. NB. Take photo to type up before moving!

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Understand the Current State

Understand current state	• Understand the current transition process and who is involved • Understand current documentation used Identify where patients are currently seen by medical / nursing staff when in transition • Identify where patients are currently seen by other professionals when in transition • Understand what information patients are currently given when in transition • Identify concerns and potential risks and issues	➢ Understanding the process: Patients from 11-25yrs, who is involved etc. Put self in patient's shoes and walk through the process. ➢ Clinics, adults or childrens setting? Who will they see? Where is it? How long are the appts? Are there enough clinic rooms? Consider having 3-5 consultation rooms for transition clinics. ➢ Consider full MDT in a room; could be intimidating for YP and might not get equity of allotted. ➢ Is there an opportunity to speak separately from parents ➢ Do they need to get changed? Are there facilities? ➢ Is the information available age appropriate/YP friendly ➢ Identify who is responsible for making referrals etc? ➢ Do YP have an opportunity to visit adult setting? ➢ At what point is confidentiality/consent discussed? Needs to be built into the process. Consider time and level of information needed for informed consent. Look at process of change in role of parent. ➢ Ensure level of information YP has about their condition is understood and any deficits addressed eg. Genetic conditions, not having used the word cancer etc. ➢ If using a transition tool, think about what time this starts and at what point the GP will be notified that the YP is in transition. ➢ Who do clinic letters go to? At what point do they start being addressed to YP. ➢ ALL OF THE ABOVE needs to be mapped out on both adult and Children's services ➢ Point of transition needs to be agreed by both settings. ➢ Consider risk and issue boxes when mapping out current state eg. Succession planning, environment/clinic rooms etc. Might not be able to resolve all but look to mitigate.

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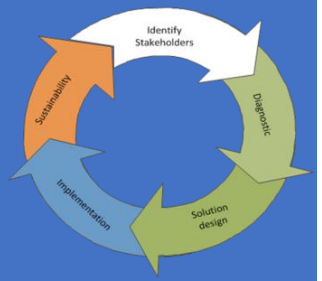
Gather Good Practice from Elsewhere



Gather good practice from elsewhere	• Look at other service specific centres in the UK • Look at other specialities within your organisation providing good practice for transition • Look at other specialities outside of your organisation providing good practice for transition	➢ Have you looked at all outstanding practice, not just within your own region but on a national front? Also consider other countries in UK ➢ Consider international experience too; medics may have worldwide contacts. May just be from children's side though rather than including adults too because of way that health services are set up (not cradle to grave model) ➢ Consider buddying up of services and organisations and looking across stakeholders offering different services.

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Define Future State

Define future state (Including You're Welcome criteria)	• Benchmark service against best practice using the University of Surrey's benchmarking tool	➢ Benchmarking where you're at may affect your stake holder list ➢ What should the service look like regardless of financial constraints, staffing etc..Think of an ideal pathway based on what the patient needs ➢ Roles and responsibilities-agree who is doing what don't just assume ➢ ? SOP for clinic; everyone to follow the same process
	• Define best practice for your service including the use of the 'you're welcome criteria'	➢ Make sure that that gap then doesn't exist in the future state pathway by going through all the benchmarks. If it meets the benchmarks it will meet the NICE guidance standards and the You're Welcome criteria. ➢ Consider clinic observations and assessment against You're Welcome criteria. Will highlight gaps too which then can be closed. ➢ Consider services that might not review annually eg. Cardiac services. Can build in a specific transition appt which may be nurse led.
	• Use documentation transition programme documentation tool, for example; 'Ready Steady Go'	➢ Needs to follow guidelines and deliver best practice but needs to be locally defined to support buy in from staff in addition to making it fit for specific service. ➢ Be specific about age of transition to ensure that this happens rather than saying it will happen across a range of ages. Take into account the needs and wishes of patients rather than just staff assessment of readiness to transition. ➢ Think about how service would like to document transition eg. GUGI, 10 Steps, RSG but some services will have their own where transition may be built into lifelong document. Is any current documentation robust enough if external staff were to review?
	• Develop best practice future state patient pathway for transition	➢ How is this being measured eg. Number of patients/where pts are in transition etc. Normal databases can be adjusted to incorporate new measures rather than replicating work. eg. DNA rates in adult services; ➢ Thinking about pathway, who needs to do what and when? Needs to be agreed otherwise might not happen eg. Transition events, comms, measures etc. ➢ Make sure all people needed to make the changes are involved eg. Business managers, service managers, administrative staff. Think creatively eg. Education settings may be supporters of transition processes.
	• Identify and agree new roles and responsibilities	

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Training Needs and Gap Analysis

Training needs analysis and gap analysis	• Identify gaps between current state of transition pathway and future desired state pathway • Identify skills / knowledge required to deliver the future state transition programme to patients and families • Identify gaps between current skills and desired skills and knowledge	➢ May be around communication/documentation/SOPs align roles and responsibilities ➢ Knowledge and understanding of the process in addition to specific skills ➢ Consider patients and parents. Look at stakeholders and find suitable way to disseminate information around new process ➢ Need to elicit agreement from staff to take on new roles and responsibilities, use motivational interviewing/coaching skills ➢ Consider attitude in addition to skills and knowledge; do staff understand why YP need something different to adults ➢ Consider HEADSSS assessment ➢ Document action plan which is time bound. Ensure governance around this, who has overall responsibility for this? Regular scrutiny and reporting.

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Communicate

Communicate	• Feedback any good practice gathered from elsewhere	➢ Who are the people that need communicating with? ➢ Consider achieving 'buy-in' from relevant parties
	• Communicate future state	➢ Think about methods of communication for different groups eg. Present paper to exec board, newsletter for families, staff intranet articles etc.
	• Communicate new roles and responsibilities	➢ May be wider stakeholders that need communicating with but are not an immediate part of the process but who will be able to support eg. Charities ➢ Which influential staff are around you to help achieve what you need eg. Buy in from certain staff groups.
	• Communicate work within the project to wider stakeholders	➢ Transformation/Improvement, Patient Experience/PALS and Digital teams can support communication ➢ Consider parent/parent forums teams which might not be directly involved with transition but work with YP. Private healthcare providers eg. LD and autism residential settings.

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Educate and align new roles and responsibilities

Educate and align new Roles and Responsibilities	• Utilise upcoming National Training Programme for Transition when available • Identify trainers / methods of training: face to face, e-learning, practical, shadowing etc.	➢ Ensure education is in line with Core Capabilities for Transition ➢ Implement training programme (clear aims objectives, methods of assessment & timescales) ➢ Ensure time allocated for training

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Implement

Implement	• Roll out use of the new patient pathway • Delivery group to support staff in use of the new transition pathway	➢ Build communication strategy around start date and roll out • Consider formal start date for new roles and responsibilities and gian authority for better impact

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Assurance governance and sustainability

Create audit mechanism (measure of success) and review	• Identify Key Performance Indicators to be used • Agree how, when and who will collect measurement data and set a date to review of findings and pathway • Update and refine pathway if required following audit	➢ Patient experience questionnaires ➢ Need baseline to work from ➢ Consider DNA rates as indicator of success ➢ Look at local measures eg. Diabetes and HB1C; is it affected ➢ Review measures annually at a minimum ➢ PDSA cycle – PLAN>DO>STUDY>ACT ➢ Who is collecting measures? Has this been agreed and are staff members aware (as discussed in Training above) ➢ Further examples of KPI's…….

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Transition KPI – Mind Map

National Benchmarks / KPIs

- Standard 1 = Transition planning from 13 years

How many age appropriate YP have started Transition?

- Standard 2 = Annual Health Meeting

How many YP require annual meeting versus how many have been completed?

- Standard 3 = Named Worker

Number of YP who have a named worker identified.
What is there level of engagement?

- Standard 4 = Meeting Adult Practitioner

Have individual services been identified / has an adult physician been identified?
Has the YP had a joint Paediatric / Adult service meeting?

- Standard 5 DNA Process

Measure DNA rate
Has the YP been followed up and offered further appointment?
What is the re-engagement rate?

Whole Organisation Aims / Measures

- Transition Lead Nurse in Post
- Executive Lead Identified
- Transition QI process utilised including regular re-evaluation to ensure sustainability.
- Number of individual service pathways in use versus number required.
- Transition Youth worker in post.
- Patient Experience process in place to allow regular YP feedback (Youth Forum?)
- Governance process – Steering Group, Transition Board etc.

Overall / Generic KPIs for Organisation

- System Wide approach in use. (Are all services using an agreed and consistent process, Care plans, and Communication Tool).
- Is there a program of support in use? (RSG, GUGI, 10 Steps etc)
- How many Young People have a Transition Plan?
- How many YP have joint involvement with paediatric AND adult services?
- How many pathways are required for the YP versus how many are actually in use?
- Has the YP got a named worker?
- What is the DNA rate?
- What is the number of unplanned admissions to ED / inpatient units.

Service Specific KPIs

Examples:

- Diabetes – HBA1C, admission to ED / Ward/ DKA episodes
- CF – Lung Function, infection rates
- Renal / Liver – Graft retention, Transplant fails, Function tests.

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NHS
The Leeds Teaching Hospitals
NHS Trust

NHS
Alder Hey Children's
NHS Foundation Trust

NHS
University Hospitals Birmingham
NHS Foundation Trust

NHS
Imperial College Healthcare
NHS Trust

NHS
Somerset
NHS Foundation Trust

An introduction to HEEADDESSS

Nigel Mills

Burdett Regional Nurse Advisor (London)

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Slido

Transition / Communication Tools

- What tool do you currently use to gain an holistic over-view of a young person? If you don't use anything, or are unsure, please state that.

Please go to slido.com to enter your answer using enter code:

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HEEADESSS-what is it?

Tool for:

- Communication
  - An interview prompt
  - An opportunity to develop a relationship and rapport
- Holistic assessment
- Psych-social assessment
  - Risks and strengths
- A guide to possible future interventions

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HEEADSSS-why and where?

Designed mid 1980s by General Practitioner in US

- Standard clinic assessment wasn't working for YP

Flexible tool with +++ variations

Can be used anywhere

- ED, clinic, ward, GP etc
- In person, questionnaire in advance

Paeds and adult environments

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HEEADSSS

Home
Education and employment
Eating
Activities
Drugs
Sexuality
Suicide and depression
Safety (savagery)

(Originally Goldenring & Rosen, 2004)

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HEEADSSS interview tips

- See young person on their own
- Check understanding of confidentiality
- Interactive rather than interrogative
  - Be interested!
- Listen carefully and check language usage
- For sensitive issues take ‘third person’ approach
- Respect the young person’s concerns & points of view

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HEEADSSS

- Open-ended questions
- No ‘standard’ questions
- Avoid assumptions
- Not superficial-takes time
- Doesn’t have to be ‘completed’ in 1 session

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HEEADSSS interview tips

- Go with the flow and follow their lead-doesn't have to be done strictly in order. If they want to talk about something, if they raise a concern, explore it-just remember to cover all areas
- Doesn't have to be done in one sitting
- Can be part of an MDT assessment
- Practice!
  - Find the language you're comfortable with

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HEEADSSS - Home

- Who lives with YP ? Where? What is neighbourhood like?
- Own room or shared?
- What are relationships like at home?
- What do parents/carers do for living?
- Any recent moves?
- New people in home environment?
- Ever run away/thought of running away? (What stopped you?)
- Is there someone you would talk to at home if you were worried about something? (Who?)

Education

- Likes/dislikes school ? Performance?
- Favourite subjects, worst subjects?
- Likes/doesn’t like teachers ?
- Suspensions/dropping out of lessons?
- Changes in school?
- Further education/career goals?

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Eating

- How much exercise in an average week?
- Anything you do you like and not like about your body?
- Any recent changes in weight?
- Worries about weight? How often?
- Dieted in the last year? How / how often?
- Anything else to manage weight?

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- Does it ever seem as though your eating is out of control?
- Have you ever made yourself throw up on purpose to control your weight?
- Have you ever taken diet pills?
- What would it be like if you gained (lost) 4 kg?

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Activities

- Fun with peers? When/ where?
- Activities with clubs or family?
- Sports-regular exercise?
- Hobbies –other home activities?
- Reading for fun/TV/Computer games?

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Drugs

- Use by peers?
- Use by young person (tobacco, vaping, alcohol)?
- Amounts, frequency, patterns?

Sexuality

- Degree and types of sexual experience?
- Orientation?
- Number of partners?
- Contraception and knowledge of STDs
- Comfort with sexual activity

- *'Are you aware if any of your friends are sexually active? Is this something that you're interested in?'*

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Suicide and depression

- Sleep disorders?
- Appetite/eating behaviour changes?
- Hopeless/helpless feelings?
- Self harm/suicide attempts?
- Suicidal ideation?
- Affect in interview?

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Safety

- Is there violence in your school or neighbourhood?
- Are you aware of anyone who has been picked on / bullied?
- Have you ever been seriously injured? How?
- Do you always wear a seatbelt in the car?
- Have you ever ridden with a driver who was drunk / high?
- Do you use safety equipment for sports and activities?
- Is there any violence in your home? Does this ever get physical?

Safety

- Is there violence in your school or neighbourhood?
- Have you ever been picked on / bullied?
- Have you ever been physically or sexually abused?
- Have you ever been in a car / motorcycle accident?
- Involved in physical fights?
- Do you ever carry a knife or gun or other weapon to protect yourself?

- *'Are you aware of any bullying in your school?'*

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Closing

- Discuss how you will follow up any issues
  - Actions
  - Next time
- Revisit some of the positive things you've identified
- Thank them

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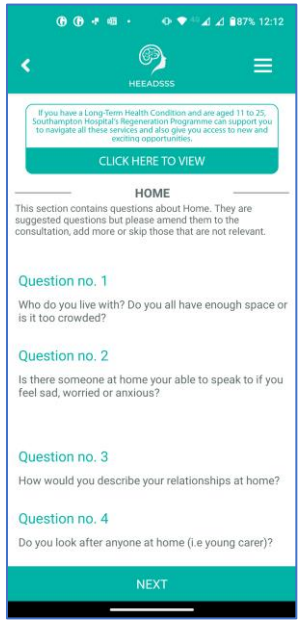
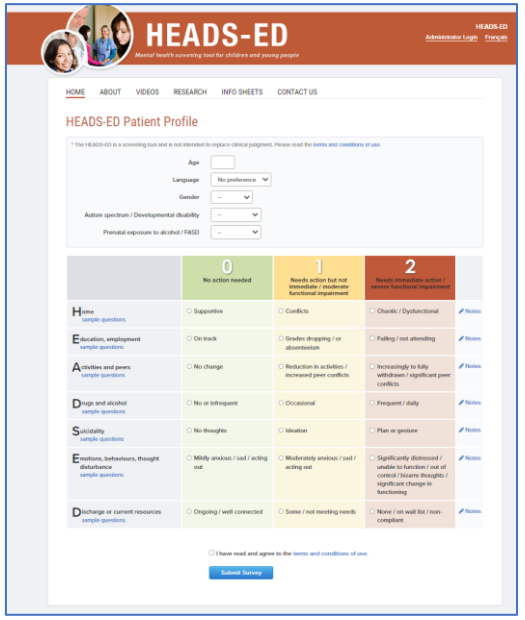
Truth or lie?

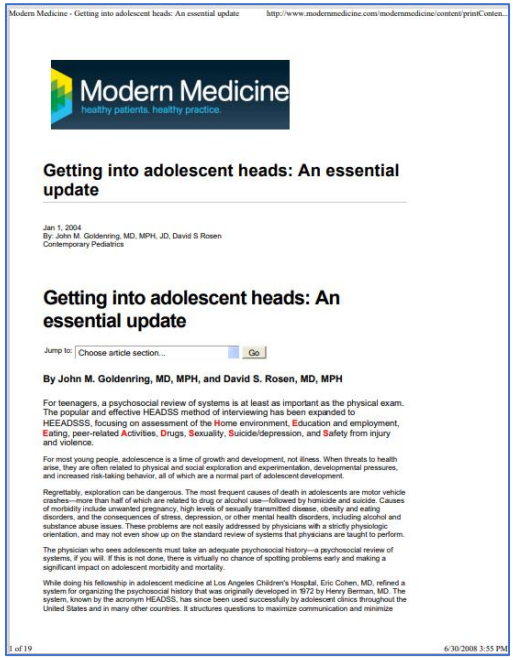
We are often asked: "How can we trust what teenagers say about drug use or sexual activity? Aren't they lying?" Certainly, youths as well as adults are known to underestimate or misreport alcohol and drug use. Occasionally, teens even overreport (if you are going to be "bad," be the "baddest"!). In the end, it does not matter. In our experience, if we establish good rapport, we can get a good idea of which teens are having psychosocial difficulty. It does not matter if we ascertain and precisely quantify every risky activity. HEEADSSS is a screening tool. We fully expect to follow up over time, which will clarify the situation. The important point is to establish communication and demonstrate your willingness to discuss sensitive issues.

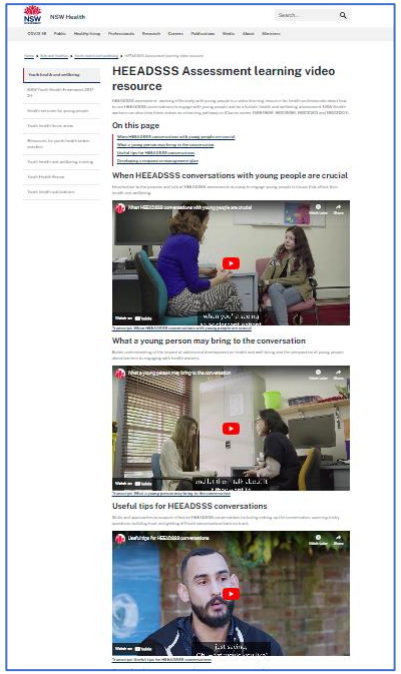
Resources

- RCPCH Young People's Health Special Interest Group (YPSIG) app – free to download here: https://app.appinstitute.com/heeadsss
- HEADS-ED assessment tool: http://www.heads-ed.com/en/headsed/HEADSED_Tool_p3751.html
- Goldenring JM, Rosen DS (2004) Getting into adolescent heads: An essential update Contemporary Pediatrics 21:64
- HEEADSSS Assessment learning video resource - Youth health and wellbeing (nsw.gov.au)









Next Steps

- Transition: Things to do to get started

  - A call to action

- Identify who the Key Stakeholders are within your own organization and the wider health and social care arena.
- Consider those who possess and engender enthusiasm and those who hold the power in the change management process.
- Explore and identify which Transition Tool you will use to support conversations with young people.

Future Sessions

- Future sessions will cover 1 or 2 aspects of the Burdett Transition QI process.
- Each will include practical examples throughout, including an overview of the Transition Tools available, Transition Lead Roles and the Lived experiences of young people
- Final session will include an overall summary, next steps and future planning as call to action.

	Session 2	Stakeholder Analysis Transition Toolkit 1 & 2
	Session 3	Diagnostic / Solution design Transition Toolkits 3 & 4
	Session 4	Implementation The Role of The Transition Lead
	Session 5	Sustainability Summary of Transition events and learning
	***Next steps and future planning - call to action.***	

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South Thames Paediatric Network
Transforming Healthcare for Children and Young People

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Thank You

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