South Thames Paediatric Network
Transforming Healthcare for Children and Young People

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

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

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Session 3

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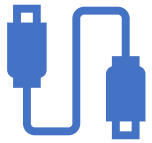
Session 3 : March 2023

Diagnostics & Solution Design

- Understanding the Current State
- Gathering good practice
- Benchmarking Services
- Defining the Future State

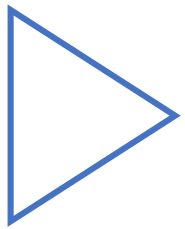


Diagnostics

Solution Design

Transition Toolkits

- Alder Hey - 10 Steps
- Together for Short Lives – An introduction to Stepping UP



Transition Toolkits

Slido

What challenges have you found trying to map your service?

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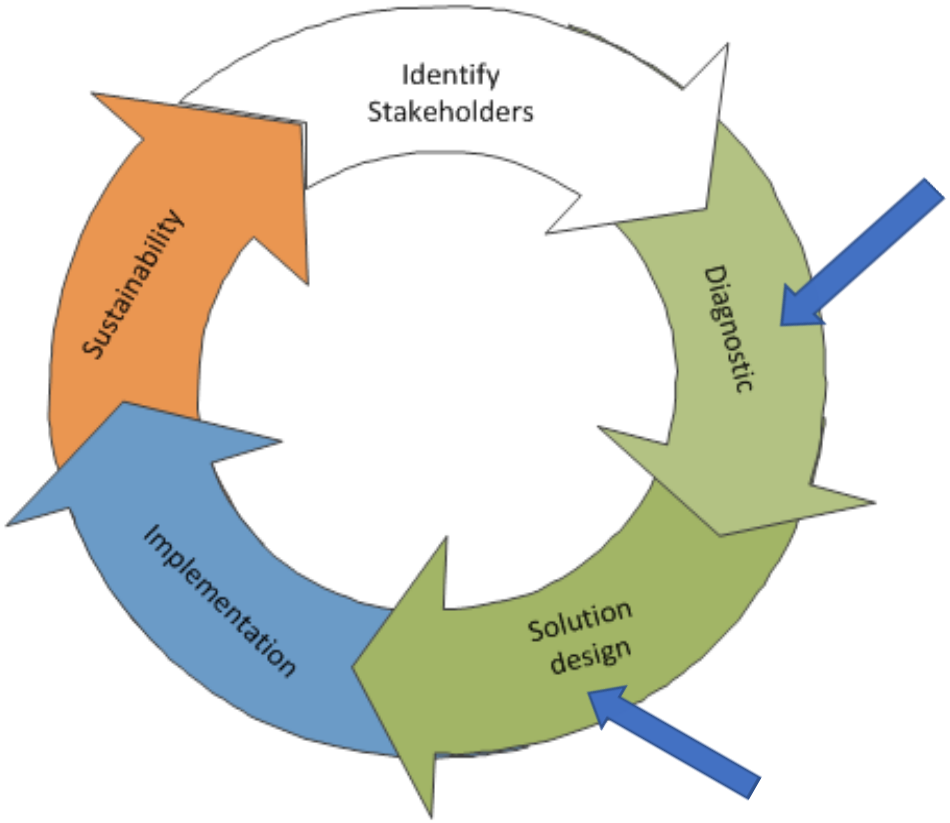
Mapping Your Service

Transition QI Model



Mapping Process

Current State
What does the Service look like now?

Mapping Your Service

Future State
What should the Service look like in the future?

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Understanding the current State of Transition Services

What does your Transition Service look like currently?	Who is involved in developing and delivering the service?	Where are patients currently seen, who by and how often?
Which other professionals will need to be involved and where will they be accommodated?	What policies and processes are in place ?	What documentation is to be used including a Transition Toolkit
Is the environment suitable for YP (You're Welcome Criteria)	Are there any risks, concerns or potential issues?	What is the follow up process?

Gathering Good Practice

Governance and Quality Assurance Standards

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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.

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.

Gathering Good Practice

- 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
- Look at other **service specific specialists centres** in the UK
- Consider **international experience** too; medical colleagues may have worldwide contacts.
- **Consider buddying up of services and organisations** and looking across stakeholders offering different services.
- Have **you looked at all outstanding practice**, not just within your own region but on a national front?

Benchmarking Services

London South Bank University

orchid
Centre For Outcomes And Experience Research In Children's Health, Illness And Disability

Great Ormond Street Hospital for Children NHS
NHS Foundation Trust

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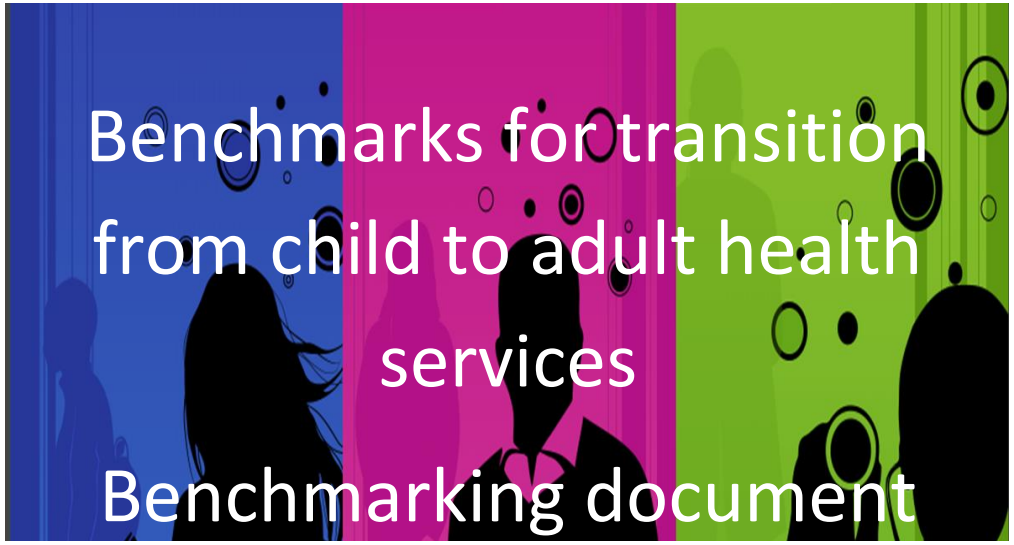

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Benchmarking Services

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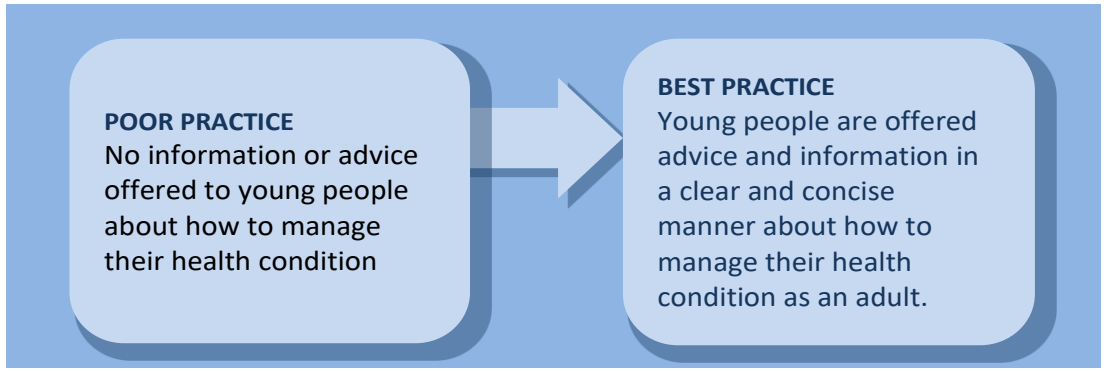
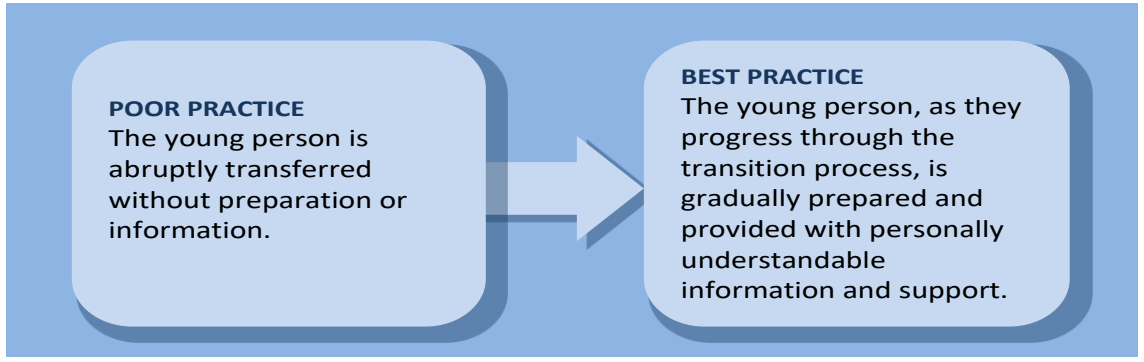
Factor 1

Moving to manage a health condition as an adult



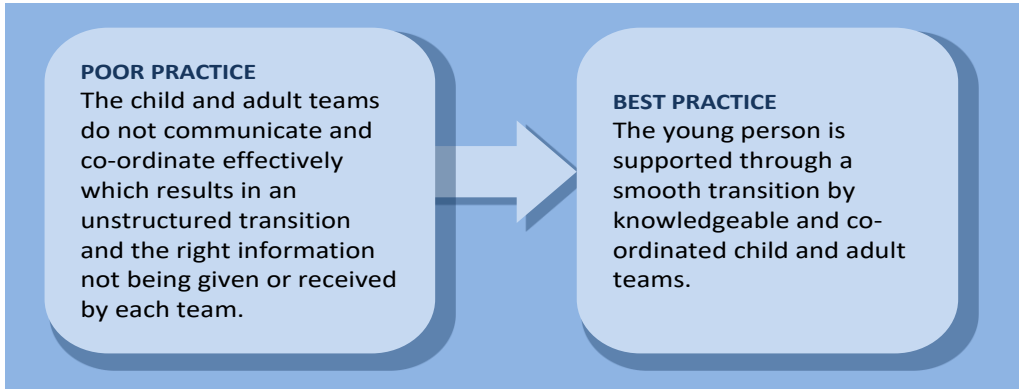
Factor 2

Support for gradual transition



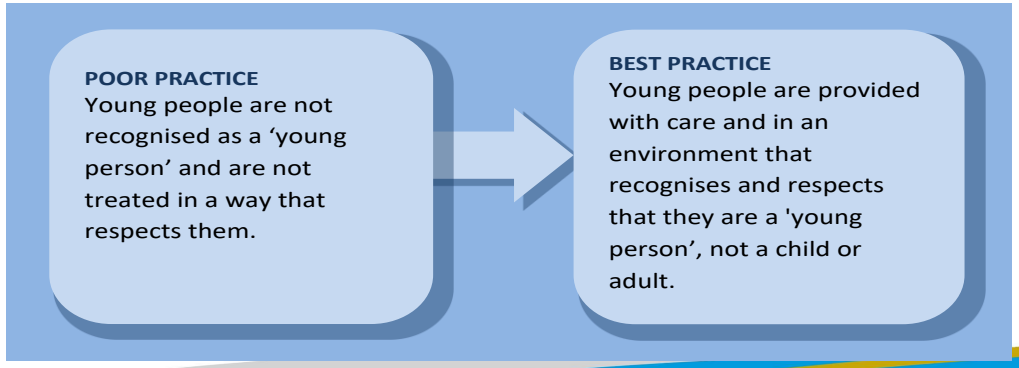
Factor 3

Co-ordinated child and adult teams



Factor 4

Services 'young people friendly'



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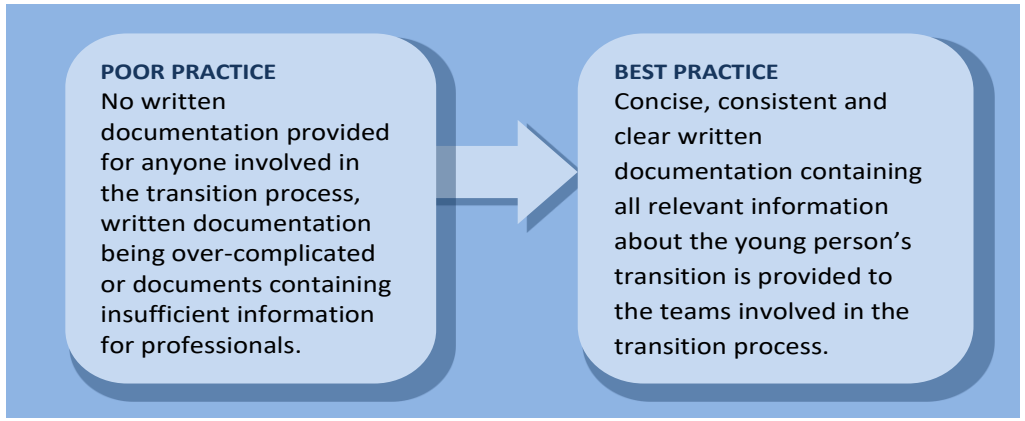
Benchmarking Services

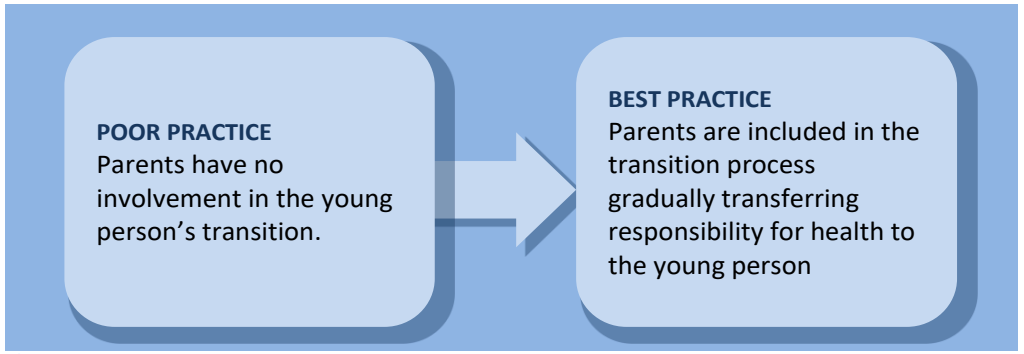
Factor 5

Written documentation



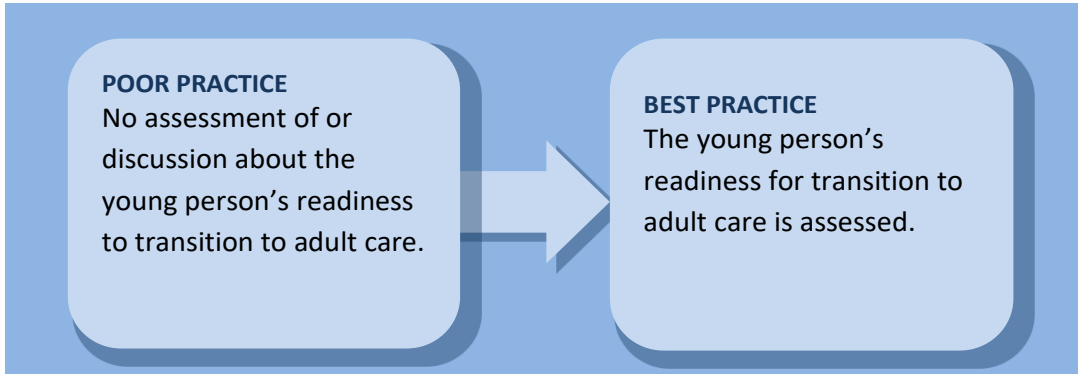
Factor 6

Parents



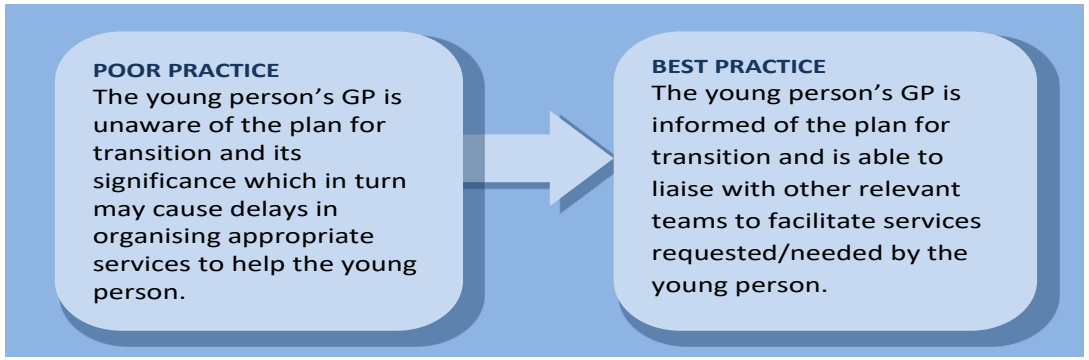
Factor 7

Assessment of 'readiness'



Factor 8

Involvement of the GP.



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Benchmarks for Transition from child to adult services

Indicators of Best Practice for Factor 1	Evidence
a) Health professionals have good interpersonal and communication skills, good knowledge of the young person's condition and the ability to signpost appropriately.	Designated Clinical Nurse Specialist with role in transition. Attended courses and training about transition and young people. Patient feedback. Close working relationship between paediatric and adult teams.
b) Ensure the young person understands their health condition (including information about their treatment when they were younger and how it may affect them now and in the future).	Regular clinic visits where young person is seen by a consultant, nurse and physiotherapist. - Discussions in clinic and with youth worker. - Give young person opportunity to ask questions at each clinic. Document in patient transition record. - Two way conversations with young people about their understanding, record it. - Check verbally and written summary given. - Report given to young person detailing health history. - Use questionnaires to access knowledge and gaps in knowledge.
c) Information on life as an adult with their health condition is given in an appropriate format.	Use of checklists. Given leaflets, dialogue with nurse and youth worker. Signposted to websites. Verbal information given. DVD on adult service is provided.
d) Information about their treatments and medications is given in an appropriate format.	Copies of clinic letters. - Give leaflets. - Discussed in clinic. - information sheets are given on specific drugs and information on how to access the pharmacist.
e) Information on how to order, collect prescriptions and book, rearrange and cancel appointments is given in an appropriate format.	Given information and leaflets about prescriptions and contact details. - Contact numbers in patient held record. - Done as part of our 'moving to high school' programme to increase independence. - Keyworker/school nurse show where to go.
f) 'Lifestyle' advice is given (e.g. about healthy diet, alcohol, smoking, recreational drugs, exercise, sexual health, staying well).	

Gap Analysis and Defining the Future State

Governance and Quality Assurance Standards

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What transition pathways are you aware of within your organisation?

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Gap Analysis

Comparing current state and what your 'GOLD STANDARD future state pathways should look like, including gaps identified in benchmarking.

Future state mapping: the future state is what you want your transition service to look going forward…..this is the '*best practice*' pathway.

Implementation can be a stepped / staged process – if a service can't meet the future state / best practice pathway immediately.

From experience we know…..

……most services have delivered future state / best practice pathways as staged implementation.

It can take anything from 6 months to 10 years to achieve best practice

The Future State – Developing best Practice Pathways

Define best practice for your service including the You're Welcome Criteria

Use Transition Documentation Tools e.g. Ready Steady Go

Identify and agree new roles and responsibilities

Identify skills / knowledge required to deliver the Future State Pathways

Identify the gaps between current skills and desired skills & knowledge

Create and implement training programs and ensure time is allocated to education

Communicate Good Practice evidence gathered, new roles and responsibilities and Future State Pathways

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We Know….

One size does not fit all!

All organisations work in different ways. This approach aims to support organisations to work in collaboration with the Young People and other professionals.

Goal - to provide preparation for adulthood for all young people and improve long term outcomes and life chances.

Next Steps

Transition: - A call to action

- Identify your current state for Transition.
- Map what Transition Pathways are needed within your Service / organization.
- Explore what your Future State for Transition needs to look like.
- Explore which Transition Toolkit you will use in your service.

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What’s the most significant aspect of transition that you’ve learned today?

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Thank You

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Slido

How do you currently capture the ‘circle of contacts’ involved in a young person’s care and transition?

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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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