

national transition support team

working together to improve transition
for disabled young people

Case Study: London Borough of Bromley

Introduction

Using health care plans to support young people from children's to adult health provision.

Overview

Transitional Healthcare Plans for young people with complex needs in Bromley are completed with them, their parents/carers and relevant professionals before they leave school, and provide agencies that will be supporting these young people, with high quality information on their health care needs.

A pathway has been developed to plan for and prioritise assessments for all young people within **special schools** in Bromley for physical disabilities and complex needs. This will form a template for healthcare planning for all young people within **mainstream schools** who have a disability.

The Transition Healthcare Plan:

- a) clearly outlines the healthcare needs and equipment that the young person is likely to need during transition into adult life
- b) incorporates the young person's and parents'/carers' views of current and future needs
- c) includes consent from the young person and parent/carer to share this information with key partner agencies that plan for and commission services in the local area
- d) provides a compilation of professional assessments of the needs of the young person to inform those who will be meeting these needs in adult services.

Main transferable learning points

- A structure for multi-agency planning – e.g. Transition Partnership Strategy forums; A Transition team; Health Transition Operational Group etc can support positive health planning
- Key drivers for change include: a) Consultant paediatrician b) Transition Nurse c) School Nurses (Children's Nursing Team) d) GPs e) Adult Learning Disability Team
- Portals for young people and their parents/carers to a) contribute to informal discussions on transition and the changes in their child's need as they mature e.g. nutritional care; reproductive health; sex education; activities of daily living b) be involved in planning with paediatric and adult services can support positive planning
- Flexibility around using existing resources can support continuity for young people
- A structure that supports easy communication between services/decision makers/budget holders and clients helps with planning
- Integrated data systems and information

management. Data sharing and information gathering requires compatibility across disciplines and regular updating and is crucial to strategic planning

- Regular evaluation of the usage of the Transitional Healthcare Plan and its impact, through feedback from young people; parents/carers and services can help with future development
- Someone to be identified at an early stage to have responsibility for monitoring and managing the Transitional Healthcare Plan ensures everyone knows who has responsibility to drive the plan forward and review any changes
- Ownership by the young person's and parents/carers of the Transitional Healthcare Plan throughout their transition ensures that the plan is truly person centred

Introduction

This case study describes how Bromley is developing health care plans and a supportive pathway for young people with complex health needs to move smoothly from paediatric to adult health services.

The London Borough of Bromley is the largest geographically of all the London boroughs. Whilst in general it is a prosperous borough, 6 of the 22 wards contain areas ranked amongst 20% of the most deprived in England. Healthcare planning during transition for young people with complex needs has been developed in Bromley to ensure that it involves a multi- agency team in a coordinated manner through partnership working between Bromley PCT, the Learning Disability Children's team and Oxleas Adult Learning Disability Services.

Transitional Healthcare Plans for young people with complex needs are completed when they are 17 years old to provide agencies who will be involved in their future support with high quality, up to date information from

assessments undertaken by health professionals. This should enable adult services to plan for the young person's medical and nursing needs and equipment required when they move on from school. Young people and their parents/carers are involved from the start of this process and contribute to the Transitional Healthcare Plan.

Background

Following a Joint Area Review of social care and health services in Bromley in 2007, in which transition was identified as a gap in services for adolescents with complex needs, Bromley PCT held a workshop in 2008 to identify key priorities for planning around transition. Difficulties in transition from support by paediatric teams to adult services for young people with a learning disability and complex health needs largely arose from the fact that there is not an equivalent to a paediatrician in the adult service. When the health care needs are no longer monitored and support co-ordinated by a paediatrician, a young person has to be referred on to specialists in the field which may mean they have many health professionals involved rather than just one to co-ordinate their healthcare needs. Whilst there were some good practice examples, overall it was felt that there needed to be better planning and multi-agency working with key partner agencies to enable information about the young person's needs to be shared, awareness of future support needs to be raised and planning to take place ahead of the transition. It was also essential that young people and their families were involved early in this healthcare planning so that they were aware of, and had more realistic expectations of services that would be available to them in adulthood.

A Health Transition working group was formed which focused on the development of a Transitional Healthcare Plan to outline the healthcare needs and equipment that a young person is likely to require during and after transition and which could inform professionals responding to these needs. An experienced Learning Disabilities Transition Nurse, co-ordinates the healthcare plan and ensures that young people and their parents/carers are

involved throughout the transition from pediatric to adult health services

Aims and Objectives

1. To develop a co-ordinated process for transition for young people with learning disabilities and complex health needs from support by paediatric services to support in adult services
2. To inform strategic planners and commissioners, through co-ordinated high quality assessments, of the adult health services required and equipment needed in the local area – and in turn help to reduce the need for expensive out of borough placements
3. To promote multi-agency communication and enhance partnership working
4. To enable young people with complex healthcare needs to improve their confidence, access appropriate further education, be included in social experiences and achieve their goals
5. To establish the use and ownership of a Transitional Healthcare Plan that will provide information on the current health needs of a young person with complex learning disabilities and possible future support they may require
6. A Personal Health profile from the GP, if he/she is part of the Direct Enhanced Service scheme, attached to the Transitional Healthcare Plan.

Approach

Key people

A Health Transition Operation Group was formed with representatives from children's therapies, special school nursing, community paediatrics and Dietetics. The Transition Nurse from the Learning Disabilities Team is crucial to this panel as she forms the conduit between health professionals, schools and families.

More recently, other representatives from the Learning Disabilities Children's Team and Education have also joined the panel.

Target group of young people

The panel meets twice a year to discuss the young people attending two special schools in Bromley. One school is for children and young people with physical disabilities and moderate learning difficulties and the other is for children and young people with complex health needs and learning disabilities.

All young people aged 16+ are discussed, and a decision is made about those who will need a detailed Transitional Healthcare Plan.

Management of the Project

The project has developed out of close working arrangements between the Consultant Paediatrician in Bromley PCT, and the Transition Nurse from Oxleas NHS Foundation Trust who works as part of Bromley's Learning Disabilities Transition Team. It has benefited from being driven by both these people.

Development of processes

The Transition Nurse from the Learning Disabilities Transition Team liaises with the school nurse to contact the family to obtain permission to complete the plan. She then meets with them to seek their views and their consent to sharing this information with other services. The school nurse will share the plan at the school's Transition Review so that other key agencies are informed and can contribute. In the pilot phase, school leavers were prioritised to have a Transitional Healthcare Plan, but this has now been rolled out to include Year 11 students. It is acknowledged that the healthcare needs of this group may change before they require support from adult services, which reinforces the need to keep the Transitional Healthcare Plan as a 'live' document.

For those young people whose healthcare needs do not warrant a detailed plan, their GP is contacted to make them aware of the young person's needs and so that they can arrange to complete an Annual Health Check.

Once the Transitional Healthcare Plan has been completed, the Transition Nurse will forward this

to the young person and their parent/carer for approval. If amendments are required, the Transition Nurse will make another home visit to seek approval for the final plan and to obtain signatures.

The Transitional Healthcare Plan is then shared with agreed professionals.

A flow chart has been piloted and revised as an aide memoire for the process leading to the drawing up of a Transition Healthcare Plan (see end of case study)

Challenges

1. Gathering information to complete a Transitional Healthcare Plan – health professionals can take time to forward the information requested or have to be contacted to clarify their input. Bromley has found that this is particularly so around physiotherapy and orthotics (especially the provision of Peidro boots and Callipers post 19 years.)
2. Ownership of the plan – to ensure the monitoring and management of the plan so that it can be relied upon to provide up to date clinical information. It is important to identify an equivalent to the Learning Disabilities Transition Nurse in the Adult Community Nursing team to ensure this.
3. Data gathering and sharing of information across services – Oxleas NHS and Bromley PCT (RiO) computer systems are not compatible, and data gathering of information is proving difficult. This is being investigated.
4. Manpower – It is proving to be a considerable amount of work for one Transition Nurse to undertake. This may be due to the initial groundwork required to set up the process and could be alleviated to a certain extent by sharing the management with school nurses.
5. Limited use of Personal Health Profiles which is the document the GP needs to

attach to the Transitional Healthcare Plan - this could be improved by promoting this within an informative DVD on Transition.

6. Lack of support for young people without Learning disabilities/difficulties but with complex health needs. At present this is patchy and fragmented. The Health Transition Operational Group has been raising awareness with strategic partners about the needs of this group and how to provide a more holistic approach to providing services, as many healthcare needs for both groups overlap.

Successes

- Enhanced partnership working at an operational level
- The development of a joint clinic between community paediatrics and a psychiatrist for adolescents with Learning Disabilities who are attending a special school for young people with severe learning difficulties and challenging behaviour
- Better understanding of a young person's healthcare needs
- GP involvement in the provision of an annual health check for young people with complex health needs and learning disabilities
- Earlier engagement by adult services in meeting the complex needs of young people
- Smoother transition from being supported by paediatric to adult services
- Increased quality of life for young people with complex health needs who are now surviving into adulthood.
- Better tracking of young people's ongoing complex health needs
- More co-ordinated approach to meeting

the needs of young people

- More effective use of limited resources
- More realistic expectations of support from adult health services by parents/carers
- Useful information about young person's healthcare needs which can inform strategic planning and commissioning in the local area
- Action by 'drivers' to enable joined up thinking, planning and response between the Health Transition Operational Group, the Transition Operational Group and the Transition Strategy Group to ensure multi-agency co-ordination in all aspects of transition planning.

Conclusion

The work of the Health Transition Operational Group and the 'drivers' within it, have provided strategic partners with information about the healthcare needs of disabled young people in an environment where response to these needs has frequently been driven by education and residential placement issues. Bromley, as with many other local authorities, is recognising the growing number of young people with complex health needs surviving into adulthood and has developed the Transitional Healthcare Plan to improve the life chances of these disabled young people. The future of this approach is dependent upon multi-agency continuity of healthcare support for nursing care, equipment and medical supervision, and recognition of the value of forward planning to meet the economic challenges within borough.

Contributors

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Bromley's Transitional Health Care Plan Flow Chart

H.T.O.G panel meeting (eligibility decision) Yes or No to completion of T.H.C.P

If yes start process of completing T.H.C.P / If No; no further action

Identify G.P / D.E.S = Yes – No

If yes write to G.P re: P.H.P/ Complete T.H.C.P work in conjunction with GP/possibly attach the T.H.C.P to back of P.H.P

If no complete T.H.C.P

T.H.C.P procedure

Write to client/carer informing them the client has been selected for a T.H.C.P /If they agree; complete T.H.C.P; If Not (no further action)

If yes make appointment with client/carer

Complete H/V / information gathering

Complete T.H.C.P

Forward to client/carer to go over

Make any amendments and obtain client/carer signature

Plan completed / Share with agreed health professionals

Abbreviation Key:

H.T.O.G = Health Transition Operational Group

T.H.C.P = Transition Health Care Plan (plan)

D.E.S = Direct Enhanced Service

G.P = General Practitioner

H/V = Home Visit

PHP = Personal Health Profile

Bromley's Transitional Health Care Plan Flow Chart for Young People with a Learning Disability

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National Transition Support Team (NTST)

NTST is working alongside the National Strategies and the Child Health and Maternity Partnership to coordinate the delivery of the Transition Support Programme.

NTST is based at the Council for Disabled Children (CDC), the umbrella body for the disabled children's sector in England. CDC is hosted by NCB. www.ncb.org.uk/cdc

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