

national transition support team

working together to improve transition
for disabled young people

Case Study: The Young People's Transition Task Group Appendix 1, 2, 3 and 4

Appendix 1.

Sheffield Teaching Hospitals NHS Foundation Trust

Caring for Children and Young People within Sheffield Teaching Hospitals

Audit Tool (2007 version)

2.7.2. All health care providers should plan, support and monitor adolescent services within GP and other primary care, school based and secondary services

		A
a. Does the organisation have a policy for, and identified lead professional for the provision of services for young people		
b. How are decisions made to transfer young people to adult services? Are they related to age or the needs of the young person?	Variable responses - some age related	
c. Is there a general policy on the transition of YP to adult services?		R
d. Do individual disciplines have good practice protocols on the transfer of adolescent from children's services? Is there an identified lead?		R

e. Is there a preparation period and education programme?		R
f. Is there a co-ordinated transfer process?		R
g. Is there administrative support for the transfer?		R
h. Is there primary health care and social care involvement?		A

**This section corresponds to Standard for Better Health C6.
C&YP NSF Standard 7 Hospital Services Growing up and moving to adult services 4.58-4.62
Bridging the Gaps: Health Care for adolescents (2003)**

Sheffield City Council, **Sheffield Children & Young People's Plan 2006-2009**

SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

TERMS OF REFERENCE FOR THE YOUNG PEOPLE'S TRANSITION TASK GROUP

THE PURPOSE OF THE GROUP

To oversee implementation of the Transition Guidance for all young people, including those with a learning or physical disability, transferring their care to adult services in the Sheffield Teaching Hospitals NHS Foundation Trust (STHFT).

TERMS OF REFERENCE

- 1 To ensure the implications of transition to adult services in STHFT in accordance with national guidance are clearly identified.
- 2 To ensure the appropriate engagement of and communication to key stakeholders. (All care groups in STHFT and referring services where possible).
- 3 To implement the agreed service model for STHFT to welcome and support young people and their families during transition
- 4 Identify training/education needs for clinicians to meet the needs of young people and their families during transition.

MEMBERSHIP (Core)

Lead Nurse, Children and Young People (Chair)	Consultant Renal Services
Sheffield Children's Hospital Transition Lead Consultant Clinician	Surgical Services representative
Sheffield Children's Hospital Nurse Consultant	Emergency Care Group representative
Sheffield Children's Hospital Youth Worker	Obstetrics and Gynaecology representative
Sheffield Health and Social Care Trust representative	Patient/Carer Representatives; SCH Parent/Governor
Matron Sheffield Children's Hospital	Professional Services Representative Operating Services
Head and Neck group representative – Nurse Director (Deputy Chair)	Patient Partnership
Specialised Cancer, Medicine; CNS Dermatology Consultant Rheumatology	Transition Liaison Nurse
Consultant Dermatology	Education/Social Care/0-19 Partnership
Lead Nurse Specialised Cancer, Medicine	Other people will be co-opted as required
South Yorkshire Regional Services representative	

MINUTES FOR INFORMATION

Deputy Medical Director

Consultant Spinal injuries

Nurse Director Critical Care

Clinical Audit and Effectiveness Representative

MEETINGS

To be held bi-monthly (3rd Tuesday);

SECRETARIAL SUPPORT

To be provided by Secretary to Medical Director's Office.

REPORTING

To the STHFT Children and Young Peoples Steering Group

REVIEW DATE 1 year; April 2011

Appendix 3

GUIDELINES FOR TRANSITION OF A YOUNG PERSON INTO ADULT SERVICES

<u>REFERENCE NUMBER</u>	<u>VERSION</u>	<u>STATUS</u>	<u>SPONSOR(S)/AUTHOR(S)</u> Mrs P. Scott Transition Task group
<u>AMENDMENTS</u>	New guideline		
<u>DOCUMENT OBJECTIVES</u> To provide guidelines for clinical specialities to facilitate the transitional care pathway from child to adult services for all young people with continuing health care needs.			
<u>INTENDED RECIPIENTS</u> All Staff with responsibilities for transitional care			
<u>GROUPS/PERSONS CONSULTED</u> Members of Children and Young People's Services Group and the Transition Task group; Matron's; Lead Nurses; Senior managers and clinicians at Sheffield Children's Hospital; Sheffield City wide Transitions Strategy Group.			
<u>MONITORING ARRANGEMENTS AND INDICATORS</u> The Guidelines for transition will be the subject of directorate (where relevant) clinical audits via the Annual Clinical Audit Programme			
<u>TRAINING/RESOURCE IMPLICATIONS</u> Further information will be accessible via the transition section on the CYP intranet page. It will be the responsibility of each directorate to ensure all staff are familiar with and have access to the Guidelines for transition of a young person to adult services.			
RATIFYING BODY AND DATE RATIFIED			
DATE OF ISSUE		June 2009	
DATE OF REVIEW		June 2012	

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Children and Young people

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Version history

Version	Date Issued	Brief Summary of change	Owner's Name:
1	16/06/2009	NA	Mrs P Scott

Document Imprint

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The Information Governance Department, Sheffield Teaching Hospitals.

Tel: 0114 226 5151. E-mail: infogov@sth.nhs.uk

Appendix 4.

SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

Guidelines for Transition of a Young Person into Adult Hospital Services

These guidelines are based on guidance and legislation from the National Service Framework for Children and Young People (DH, 2004) and Transition; moving on well (DH, 2008). These policies outline the framework for health, education and social care staff to provide a seamless pathway for transition from child to adult services.

This guidance is relevant to young people up to the age of 18 years and for a young person with a learning or physical disability up to the age of 19 years. This guidance should be implemented in accordance with the STHFT Nursing Care Guidelines for Transition.

1. Each clinical service across STH NHS FT will identify a lead person to support the transition of care of young people to adult hospital services e.g. Clinical Lead and Clinical Nurse Specialist or other appropriate professional.
2. As young people are identified to transfer to adult services which may be from the age of 13 onwards there needs to be a full assessment undertaken by the Clinical Lead or Clinical Nurse Specialist in partnership with the adult hospital services clinical team. The formal assessment will be the first part of the joint transition plan to support the young person entering into adult hospital services.
3. In accordance with the wishes of the young person their specific needs in the transition of their clinical care will include their domestic arrangements, their health needs, their social and educational needs. Consideration has to be given to the young person with regard to any formal consent that is required and the young person may need help and advice from an appropriate and informed professional or their legal guardian/next of kin.
4. Following assessment of the young person STHFT will participate in and support a joint clinic for the purpose of transition of care which should be held on the appropriate hospital site.
5. Where appropriate during the last year of transition the clinical appointment should be held in the adult Trust to ensure the young person has an awareness of the adult hospital service they have been referred to. As part of their appointment a transitional care plan will be completed and copies will be retained by the referring Trust, the receiving Trust, their GP and the young person.
6. For a young person with multiple clinical diagnosis and profound learning disability, the Lead Clinician receiving the referral and the Clinical Nurse Specialist or Allied Health Professional needs to link in with the other professionals involved in the management of care of the young person to support a co-ordinated approach in the planning of care of the young person.
7. Each Clinical Lead, Clinical Nurse Specialist or Allied Health Professional will provide appropriate written communication to support the young person, welcoming them to the new service, whilst providing relevant information for their specialist services. The young person should also be provided with information about the Trust's Patient Advice and Liaison Service.
8. If a young person does not attend for their appointment, this needs to be followed up by contacting the young person, if appropriate, or their guardian/next of kin. The follow up can be by letter, phone call, text or email and the follow up and outcome should be recorded in the young person's clinical record. Each service needs to establish their own robust systems of

checking and follow up arrangements in line with Trust guidance for young people that do not attend.

9. On arrival at the appointment a record of who accompanies the young person needs to be recorded in the patient's medical records.
10. All aspects of confidentiality (section 10 STH CYP policy) and consent to treatment for a young person will be adhered too throughout transition in accordance with legislation, trust policy and the wishes of the patient.
11. Any concerns in respect of safeguarding a young person should be raised through following trust guidance and South Yorkshire Child Protection Procedures 2007.

References and legislation

Department of Health (2004) 'The National Service Framework For Children, Young People & Maternity Services'. HMSO, London. www.dh.gov.uk

Department of Health (2008) Transition: Moving on Well. London. DH London www.dh.gov.uk

RCN (2008) Adolescence: boundaries and connections. RCN London. www.rcn.org.uk

RCN (2008) Lost in transition; Moving on well; moving young people between child and adult services. RCN London. www.rcn.org.uk

Bridging the Gaps: Health Care for adolescents (2003)

All health care providers should plan, support and monitor adolescent services within GP and other primary care, school based and secondary services

This section corresponds to Standard for Better Health C6.

C&YP NSF Standard 7 Hospital Services Growing up and moving to adult services 4.58-4.62

Cross Reference

Children and Young People within Sheffield Teaching Hospitals NHS Foundation Trust – Guidance for the Care of. June 2008

STH FT Nursing Care Guideline Transition from Child to Adult Services (June 2009)

Safeguarding Children intranet site

<http://www.sth.nhs.uk/NHS/SafeguardingPatients/SafeguardingChildren/>

Consent to examination or treatment policy

http://www.sth.nhs.uk/STHcontDocs/STH_Pol/ClinicalGovernance/Consent/ConsentPolicy.htm

Acknowledgements

The National Transition Support Team would like to thank the staff who assisted with this case study.

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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