## Transition from Children’s to Adult Services Policy

<table>
<thead>
<tr>
<th>Category:</th>
<th>Policy</th>
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</thead>
<tbody>
<tr>
<td><strong>Summary:</strong></td>
<td>The aim of the policy is to provide the framework by which the Trust can ensure that young people receive a quality service when transitioning from child-centred services to services for adults. This includes all young people with long term conditions cared for in Oxford University Hospitals NHS Foundation Trust.</td>
</tr>
<tr>
<td><strong>Equality Analysis undertaken:</strong></td>
<td>May 2017</td>
</tr>
<tr>
<td><strong>Valid From:</strong></td>
<td>May 2017</td>
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<tr>
<td><strong>Date of Next Review:</strong></td>
<td>May 2020</td>
</tr>
<tr>
<td><strong>Approval Date/ Via:</strong></td>
<td>Safeguarding Committee, Clinical Policy Group</td>
</tr>
<tr>
<td><strong>Distribution:</strong></td>
<td>Clinical staff working in areas with patients between 12 and 25 years of age</td>
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</table>
| **Related Documents:** | Safeguarding Children Child Protection Policy  
Chaperone, Intimate Care and Examination Policy  
NICE Guidelines [NG43] Transition from children’s to adults’ services for young people using health or social care services |
| **Author(s):**  | Associate Director, Children’s Hospitals Network  
Children Safeguarding and Patient Experience Lead |
| **Further Information:** | Associate Director, Children’s Hospital Network |
| **This Document replaces:** | New document |

**Lead Director:** Chief Nurse  
**Issue Date:** May 2017
Document History

<table>
<thead>
<tr>
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<th>Version number</th>
<th>Author</th>
<th>Reason for review or update</th>
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<tbody>
<tr>
<td>February 2017</td>
<td>0</td>
<td></td>
<td>New document</td>
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Consultation Schedule

<table>
<thead>
<tr>
<th>Who?</th>
<th>Rationale and/or Method of Involvement</th>
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<tr>
<td>Trust's Young People's Executive (YiPpEe)</td>
<td>Allow patients currently using children’s services to express their needs for a successful transition to adult services. Discussion of ‘Ready, Steady, Go, Hello’ materials at group meeting.</td>
</tr>
<tr>
<td>Previously transitioned patient</td>
<td>Identify areas of strength and development of current process that exists in some specialities. Interviewed by representatives of Transition Working Group.</td>
</tr>
<tr>
<td>Parents of transitioned patients</td>
<td>Identify areas of strength and development of current process that exists in some specialities. Interviewed by representatives of Transition Working Group.</td>
</tr>
</tbody>
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Who should read this document?

1. This policy should be read by all clinical staff across the Trust who care for patients aged between 12 and 25 years old.

Key Messages

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

Every young person with any long term condition should have a planned transition of care, using the ‘Ready, Steady, Go, Hello, programme, evident within their health care records.

Background

2. A number of national publications, including NICE Guidelines, have highlighted the importance of transition in improving outcomes in care. It is clear that transition must be fully integrated into the care pathway for young people.

3. This document sets out the requirements to ensure that young people receive a seamless, quality service when transferring from child-centred to services orientated to adults. This includes all young people with a long term condition cared for across Oxford University Hospitals NHS Foundation Trust.

Scope

4. This policy applies to:

4.1. All specialties that provide treatment and care to children and young people between the ages of 12 and 25.

4.2. All young people, from age 12 years, with a long term condition, until they are transferred to adult services.

Aim

5. The aim of the policy is to outline the Trust’s arrangements for achieving and maintaining compliance with the NICE Guidelines on ‘Transition from children’s to adults’ services for young people using health or social care services’ (NG43, 2016)

6. The purpose of this policy is to ensure a structured and co-ordinated transition for young people, with on-going health care needs, to secondary or tertiary adult health care services where this is available, or to primary care, by:

   - ensuring a consistent approach is taken on transition by all clinical staff across the Trust
   - providing a clear framework for all staff on transition of patients from children’s to adult services

Introduction to Transition

7. “Transition from children’s to adults’ services can be a complex process, spanning a range of agencies and specialisms. The absence of a coordinated approach to providing services across Transition from children’s to adults’ services for young
people using health or social care services health, education and social care can result in ineffective communication, poor engagement, discontinuity of care and staff feeling unclear about the process and their role in it. Adults' and children’s services need to come together to pool funding, addressing the structural and cultural barriers that prevent them from achieving this. Transitional care should become a shared priority, despite the current pressures on public funds."^1

8. There are an increasing number of young people with long-term conditions living into adulthood, leading to an impetus for a seamless pathway, from children’s to adult care. This can be achieved by maintaining liaison between the MDT i.e. Paediatricians, Physicians, GPs and AHP. Management of any illness is often complex and complicated, particularly so during adolescence. This can be due partly to pubertal changes, but also to psychosocial adjustments, which are well documented in the literature.

9. Transition to adult services can sometimes be traumatic for young people and there is a risk of non-compliance and morbidity associated with this.

10. Sometimes young people may be apprehensive about leaving their familiar healthcare team and the prospect of joining an unknown medical provider can cause undue stress and anxiety.

11. Concerns may be raised with the Child Protection Team or Safeguarding Teams where young people can be ‘lost’ to the system during transition. This needs to be closely monitored by the teams involved.

12. As a part of the transition process information is given to the young people and their families about the differences between children’s and adult services. The principles of good transition include ensuring that effective communication is maintained between families and providers.

13. The aim as a provider of services for this age group is to empower the young person and their parents/carers to actively participate in the transition process. This will be achieved by using the Ready Steady Go Hello model. It will equip the young person with the necessary skills and knowledge to manage their healthcare confidently and successfully in both children’s and adult services. It will also ensure that they are aware of important information such as days and time of clinics, location of resources, clinics, laboratories, wards, car parking, refreshments and other facilities available.

14. It is best practice to conclude the formal move of young people from Children’s to Adult services by the time they are 18 years of age, unless by exception this has been formally agreed between individual services and documented on EPR. Individuals can commence the Ready Steady Go Hello programme at 12 years of age, but their progression will be individually determined.

Principles

15. Transition should be a clear process over a defined period, starting from around 12 years and ending once the young person is successfully engaged in adult services. It is not a ‘one off transfer of care” from children’s to adult services.

16. There should be evidence in the health care record of the plan for transition of care for every young person with a long term condition.

^1 NICE Guidelines [NG43] Transition from children’s to adults' services for young people using health or social care services (2016)
17. The timing of the transfer should be tailored to the individual young person’s needs and will be dependent upon an assessment of their emotional maturity, and cognitive and physical development.

18. The recommendation is that this will occur between 16-18 years of age. Exceptions to this should be discussed with the young person and should always be in their best interests. These should be clearly documented in the young person's health care record and the outcome communicated to the young person and their family.

19. A clear management plan should be documented for the young person's care during the four phases of the transition period (Ready Steady Go Hello (RSGH)). The RSGH documentation should be used to structure this.

20. The Paediatrician/lead clinician or nurse specialist is responsible for ensuring the young person’s health care records are completed appropriately.

21. During transition the young person should be encouraged to keep a Personal Health Record, and should be provided with copies of key letters and summaries.

22. The transfer details from one service to another are on EPR, providing ongoing traceable data for each young person. The receiving department should ascertain that the details are entered and are correct.

23. In order to provide support during transition a named worker should be identified for each young person. The named worker can be any member of the MDT.

24. Young people should be given the opportunity of being seen without their parents/carers for a part of the consultation. This should be offered at an appropriate time, depending upon the cognitive ability of the young person to be engaged in the process, from around the age of 12 years. All young people being seen on their own should be chaperoned during the consultation, in line with Chaperone and Children’s Safeguarding Policies.

25. In some situations, especially if the care required is complex a MDT meeting, including the GP, may need to be instigated.

26. Before the young person is transferred, the Paediatrician / lead clinician should ensure that the following information has been shared with the clinician in adult services:
   - Blood and investigation results for at least 12 months
   - Current medication
   - Current treatment regime
   - Planned future treatments

Using ‘Ready Steady Go Hello’

27. All young people moving from children’s to adult services will undergo a transition programme - ‘Ready Steady Go Hello’. This will be initiated in children’s services and completed after a successful transition to adult services. Transition should address the medical, psychological and educational/vocational needs of the young person, and acknowledge those of their parents/carers.

28. Young people and their parents/carers start the RSGH transition programme, around 12 years of age. Other condition specific programmes may be used in conjunction with Ready Steady Go.

2 See Appendix 6 for examples of the ‘Ready Steady Go Hello’ materials mentioned.
29. Young people and carers are introduced to RSGH through the ‘Transition: moving into adult care’ information leaflet, in addition to any service specific information.

30. During consultation the young person completes a Ready questionnaire, designed to establish what needs to be in place for a move to adult services. This is monitored during each outpatient appointment until the young person is deemed ready to move to the Steady questionnaire i.e. The issues are addressed over the following year, not during a single consultation.

31. In due course the young person completes the Steady questionnaire which explores topics in greater depth and is used to confirm progress as well as addressing any on-going issues or concerns.

32. The Go questionnaire is completed to ensure that the young person has all the skills and knowledge in place to Go to adult services. Any gaps identified in skills or knowledge must be referred onto the adult services.

33. The young person will be introduced to the adult team within the year prior to the planned transfer. At this stage a named worker should be identified in the adult team.

34. Where is has not been possible to transfer a young person to adult services, it is important to ensure the GP is involved and fully informed that care is being transferred from secondary/tertiary care back to Primary Care. Therefore the Lead Clinician from the specialist team in children’s Services must write to the GP to ensure they are aware of their on-going responsibilities.

35. The Young Person and parents or carers must know who is responsible for any on-going care prior to discharge from Children’s Services.

36. The actual timing of the move to adult services is one that should be mutually agreed by the Young Person, parents or carers and health care professionals.

37. Any issues / concerns and progress should be documented in the RSGH questionnaires by the healthcare team or keyworker. On transfer to adult services the Hello to Adult Services programme and Hello questionnaire would be completed by the adult service.

38. The Hello questionnaire should be monitored annually by the healthcare team, until completed, to ensure that the knowledge and skill levels or new/on-going concerns and problems are addressed.

39. Clinical Directors and Operational Service Managers must ensure there are appropriate services for children, young people and adults to support transition with age-banded clinics.

Transition for parents/carers

40. In conjunction with the young person there is an option for the parent/carer to complete a separate questionnaire. This follows the same format as the RSGH questionnaires, and may assist in supporting them throughout the process.

Young People new to OUH

41. Any young person who first presents to adult services with a long term condition should start the Hello to Adult Services programme, at a time considered appropriate to the health care team – this follows the same format as RSGH and it is designed for use for all young people regardless of age or sub-specialty.

Young People with Learning Disabilities

42. Where the young person has learning disabilities the parent/carer should work through the RSGH programme with them, engaging them as much as possible. If deemed appropriate, carers with a young person who has a severe disability can also
start RSGH, so that they too are prepared for the move to adult services; allowing all concerns/issues to be carefully addressed and progress monitored prior to transfer.

43. A referral to the Learning Disability Liaison Nurse should be made and the information is provided on the Learning Disability Intranet Site. A referral may also be appropriate if it is predicted that the person will have complex needs to be addressed in the future when admitted to the adult ward or for general support. A ‘Hospital Passport’ should also be offered to anyone who has a learning disability for use on admissions. These can be found on the Learning Disability Intranet Site or OUH Easy Read website.

Key Documents

44. **Ready Steady Go Hello User Guide** – this is the main tool to be used to identify the extent the young person is ready for transition to adult services and the skill sets / knowledge base which will need to be developed further to enable successful transfer to adult services (see appendix 6)

45. **Flow chart** demonstrating how to use Ready Steady Go Hello (see Appendix 7)

46. **Key worker document** – this document supports the key worker, for CYP with complex health needs, by providing additional guidance on how to assess the young person at each stage (see Appendix 8)


48. Original copies of the RSGH documents must be stored in the young person’s health care record on EPR. Copies should be offered to the young person.

Review

49. This policy will be reviewed every 3 years, as set out in the Policy for the Development and Implementation of Procedural Documents.

50. This policy may need to be revised before this date if there are changes to NICE Guidelines, or if any individuals, or the OUH Transition Policy Working Group, consider an earlier review is necessary.

References

51. NICE Guidelines [NG43] Transition from children’s to adults’ services for young people using health or social care services (2016)

52. Care Quality Commission (2014) From the pond into the sea: Children’s transition to adult health services


54. The Health Foundation (2014) Ideas into action: person-centred care in practice


62. Bridging the gap: an integrated paediatric to adult clinical service for young adults with kidney failure BMJ2012; 344:e3718


Appendix 1: Responsibilities

67. The Chief Executive has overall responsibility for ensuring that appropriate processes are in place for the transition of young people (12-25 years) from child-centred to adult orientated services.

68. The Medical Director and Chief Nurse have delegated responsibility for ensuring that appropriate processes are in place for the transition of young people (12-25 years) from child-centred to adult orientated services.

69. Divisional Directors and Clinical Directors have a responsibility to ensure this Policy is championed by Paediatricians and Clinicians in relevant adult services and that it is followed robustly when transitioning children to adult services within a specialist service framework. They also have responsibility for taking appropriate action when non-compliance is reported.

70. Divisional Nurses have responsibility for co-ordinating reports of non-compliance through the Trust Children’s Safeguarding Strategy Group.

71. Lead Nurse Safeguarding & Patient Experience have responsibility for monitoring compliance through the Transition Working Group and reporting non-compliance to Trust Children’s Safeguarding Strategy Group.

72. Matrons and Operational Service Managers have responsibility for providing a process for recording non-compliance, and taking appropriate action when non-compliance is reported.

73. Clinical medical, nursing and AHP staff have a responsibility to ensure this Policy is championed and followed robustly when transitioning children to adult services within a specialist service framework.

74. The Transition Working Group is responsible for developing the transition service, ensuring that this Policy is followed accurately, and that it is revised as practice evolves.

Appendix 2: Definitions

75. The terms in use in this document are defined as follows:

Transition: a purposeful, planned process to prepare young people moving from a child-centred to adult-orientated service and to address the medical, psychological and educational/vocational needs of young people 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 e.g. doctor, nurse specialist or AHP.

Named Worker: a professional who has the responsibility for collaborating with professionals from their own service, and from other services, 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 (minimum of 18 years old) and who have been closely involved in caring for the child/young person prior to admission to hospital.

<table>
<thead>
<tr>
<th>Word, Phrase or Abbreviation</th>
<th>Definition</th>
</tr>
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<tbody>
<tr>
<td>OUH</td>
<td>Oxford University Hospitals NHS Foundation Trust</td>
</tr>
<tr>
<td>RSGH</td>
<td>Ready Steady Go Hello</td>
</tr>
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<td>Word, Phrase or Abbreviation</td>
<td>Definition</td>
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<tr>
<td>-----------------------------</td>
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<tr>
<td>NICE</td>
<td>National Institute for Health and Care Excellence</td>
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<tr>
<td>MDT</td>
<td>Multi-Disciplinary Team</td>
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<tr>
<td>EPR</td>
<td>Electronic Patient Record</td>
</tr>
<tr>
<td>AHP</td>
<td>Allied Health Professionals</td>
</tr>
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<td>CYP</td>
<td>Children and Young People</td>
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<td>RCPCH</td>
<td>Royal College of Paediatrics and Child Health</td>
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<td>RCGP</td>
<td>Royal College of General Practitioners</td>
</tr>
<tr>
<td>RCN</td>
<td>Royal College of Nursing</td>
</tr>
</tbody>
</table>
Appendix 3: Training

76. There is no mandatory training associated with this policy.

77. 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 multi-agency teamwork; and an understanding of the relevant individual conditions and disorders and their evolution and consequences in adult life.

78. An E-learning package developed by the RCPCH, RCGP, RCN and others, is available to all staff so that they can develop the necessary skills to help young people make necessary changes to lead a healthier and more active life. It is an interactive online session. This can be found on www.rcpch.ac.uk/AHP. It is easy to register and is free.

79. This E-learning is recommended for all OUH staff working with Young People, between the ages of 12 and 25.

80. Professionals within OUH can be a resource for practitioners, particularly in respect of communication, team working and understanding conditions. Many young people now survive into adulthood with complex conditions that previously would have been fatal in infancy.

81. Information for staff on how to use RSGH is available on the Trust’s intranet page on Transition.

Appendix 4: Monitoring Compliance

82. Compliance with the document will be monitored in the following ways.

<table>
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<th>By who, and when:</th>
<th>Minimum standard</th>
<th>Reporting to:</th>
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<td>Audit sample, per clinic of 5 patients aged 12-25</td>
<td>Transition Working Group biennially</td>
<td>80% compliance per clinic</td>
<td>Children’s Quality Committee</td>
</tr>
<tr>
<td>CYP satisfaction of transition provision</td>
<td>Audit sample, per clinic of 5 patients aged 12-25</td>
<td>Transition Working Group biennially</td>
<td>80% of patients, per clinic, are satisfied with transition provision</td>
<td>Children’s Quality Committee</td>
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Appendix 5: Equality Analysis

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<th>Have you considered how the Policy will affect people:</th>
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<td>Of different ages?</td>
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<tr>
<td>With different racial heritages?</td>
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<td>With different sexual orientations?</td>
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<td>Who are pregnant or recently had a baby?</td>
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<td>With different religions or beliefs?</td>
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<td>Who are going through gender re-assignment or have transitioned?</td>
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<td>Of different marital/partnership status?</td>
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Summary of Analysis

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<td>The advancement of equality of opportunity?</td>
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Appendix 6: Ready Steady Go Hello User Guide

Introduction

Ready Steady Go (RSGH) is a generic programme for (CYP) with a long term condition aged 12+ years. It can be used across all sub-specialties. RSGH is a structured, but where necessary adaptable, transition programme. A key principle throughout RSGH is ‘empowering’ the CYP to take control of their lives and equipping them with the necessary skills and knowledge to manage their own healthcare confidently and successfully in both paediatric and adult services. This is initiated through the completion of a series of questionnaires.

There are 3 main questionnaires and each one can be completed over a period of 2 years, gradually increasing the young person’s knowledge and skills:

Questionnaire 1: Age 12-14 – Ready
Questionnaire 2 Ages 14-16 – Steady
Questionnaire 3 Ages 16-18 - Go

The questions are deliberately broad providing the opportunity for the healthcare professional to ask targeted questions specific to their condition. The answers are used as a basis for starting discussion which reveals whether the extent of the patient’s perception of their own knowledge and skills is justified. Some are prone to misrepresentation—accidentally or otherwise, this is readily identified through discussion and the underlying issues can then be addressed. The questionnaires also prompt appropriate engagement over potentially difficult issues such as sex and psychosocial concerns. Any issues which may arise are carefully addressed prior to transfer to adult services.

The intent of RSGH is that the YP will be able to manage their healthcare successfully not just in their local adult service but in any adult service across the country - whether or not they have previously met the adult physician or GP to whom their care is transferred. Where the YP has learning difficulties the carer works through the RSGH programme with the YP engaging as much as possible. Carers with a severely disabled YP also start RSGH 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.

Successful transition also needs carers to be part of the transition process. This is achieved by engaging with the carer over issues that are raised during the completion of the parent/carer questionnaire. RSGH actively involves and supports them through the process thus making it easier for them to “let go” and allowing the YP to gain independence.

Guide to using the Ready Steady Go Questionnaires

Age 12: Ready Steady Go Leaflet given to CYP and Parents
CYP and their carers are introduced to the Ready Steady Go programme at around 12 years of age, if developmentally appropriate. They are introduced to ‘Ready Steady Go’ through the ‘Transition: moving into adult care’ information leaflet (figure 1).
Age 12-14: Getting Ready questionnaire given to CYP

At the next consultation the young person completes the ‘Getting Ready’ questionnaire (figure 2) which, through a series of structured questions, is designed to establish what needs to be done for a successful move to adult services. Goals are agreed with the YP and carer.

The issues are not addressed in a single consultation but over the following 1-2 years in ‘bite sized pieces’ at a pace appropriate for the CYP and carer.

Progress and goals are documented on EPR and can also be completed in the transition plan (figure 3) by the healthcare professional which remains in the patient notes.

The carer completes a separate questionnaire (figure 4) which follows the same format as the Ready Steady Go questionnaires, alongside the CYP, to ensure that they are also supported through the transition process.

Age 14-16: Ready questionnaire given to YP

In due course, around age 14 years, the CYP completes the ‘Steady’ questionnaire (figure 5) which covers the topics in greater depth. It is used to monitor progress on existing issues and ensure that any new issues that may arise are also identified and tackled at an appropriate pace over the following two years, again with agreed targets and goal setting.

If necessary the carer may also fill in the parent/carer questionnaire again to ensure issues are addressed.
Age 16-18: Go questionnaire given to CYP

This is followed by the ‘Go’ questionnaire (figure 6), at around 16 years of age, to ensure that they have all the skills and knowledge in place to “Go” to adult services. Any issues are highlighted and once again goals are agreed and over the following years actions in preparation for the move to adult services.

It is at the ‘Go’ stage that the CYP is introduced to the adult team, at least a year prior to transfer; ideally this should happen earlier in the programme if resources permit. The number of joint clinics with the adult team will be dependent on the needs of the CYP and carer.

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

Arrival in adult services: Hello

For a seamless transfer to adult services the CYP completes a ‘Hello to Adult Services’ (figure 7) their first clinic appointment in adult services. The questionnaire follow the same format as the Go questionnaire for familiarity and to support the continued delivery of holistic care, self-management and shared decision making in adult services. Any issues raised are addressed, goals set and progress monitored and recorded in the Hello to adult services transition plan.

Periodically the ‘Hello’ questionnaire is re-used to ensure they maintain knowledge and skill levels and that any new or on-going concerns or problems are addressed in ‘bite size pieces. Goals are set. Progress and goals are documented on EPR and can also be completed in
the transition plan (figure 8) by the healthcare professional which remains in the patient notes.

The carer can complete a separate questionnaire (figure 9) if considered necessary and they wish to do so.

There is a discrete ‘Hello’ to Adult Services’ programme that follows the same format as Ready Steady Go. This is used for CYP and adults whose first presentation with a long-term condition is in adult services. Age and sub-specialty is not a barrier to using the programme.

Ready Steady Go documents

The full list of the RSGH documents are as follows:

- Information leaflet
- Young person's transition plan
- Parent's transition plan
- Ready Questionnaire
- Steady Questionnaire
- Go Questionnaire
- Hello to adult services transition plan
- Hello to adult services parent plan
- RSGH clinicians user guide
- RSO quick guide
- ‘Easy Ready’ RSGH questionnaire
Appendix 7: Flow chart for using RSGH programme

**GENERIC HEALTH TRANSITION PATHWAY**
(for ‘Ready Steady Go’ users and non-users)

### ‘Ready Steady Go’ specific actions

**EARLY STAGE TRANSITION**
('READY')
AGE 11-13

- Complete ‘Ready’ Questionnaire with Young Person over 2 years.
- Note any actions / areas for development on Transition Plan.
- Store questionnaire and transition plan in hospital / handheld notes. Copy to Young Person +/- if appropriate.

**MIDDLE STAGE TRANSITION**
('STEADY')
AGE 14-16

- Complete ‘Steady’ Questionnaire with Young Person over 2 years.
- Note any actions / areas for development on Transition Plan.
- Store questionnaire and transition plan in hospital / handheld notes. Copy to Young Person +/- if appropriate.

**LATE STAGE TRANSITION**
('GO')
AGE 16-18

- Complete ‘Go’ Questionnaire with Young Person over 2 years.
- Note any actions / areas for development on Transition Plan.
- Store questionnaire and transition plan in hospital / handheld notes. Copy to Young Person +/- if appropriate.

### General actions

**TRANSITION CLINIC**
AGE 16-18

- Consider DNA f/u for patient (GP / Adult safeguarding lead).
- Consultant to review DNACPR / ACP forms and add their own name.
- Remove ‘in transition’ flag on EPR.
- Consider the need for IMCA involvement when making decisions.

**GP TRANSFER LETTER**
AGE 16-18

- OR

**DISCHARGE LETTER**
AGE 16-18

- OR

**ADULT SERVICES**
('Hello')
AGE 16+

- Consider DNA f/u for patient (GP / Adult safeguarding lead).
- Consultant to review DNACPR / ACP forms and add their own name.
- Remove ‘in transition’ flag on EPR.
- Consider the need for IMCA involvement when making decisions.
Appendix 8: Key worker document for CYP with complex needs

<table>
<thead>
<tr>
<th>NAME</th>
<th>NHS NO.</th>
<th>HOSPITAL NO.</th>
<th>DATE OF BIRTH</th>
<th>ADDRESS</th>
<th>SCHOOL</th>
<th>GP (NAME AND ADDRESS)</th>
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<table>
<thead>
<tr>
<th>NEXT OF KIN (NAME AND CONTACT NO.)</th>
<th>KEY WORKERS (NAME AND CONTACT NO.) e.g. school/residential home</th>
<th>LOOKED AFTER CHILD? please add details of section if known</th>
<th>SOCIAL WORKER (NAME AND CONTACT NO.)</th>
<th>YES / NO</th>
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**Annual GP Health Check Needed?** Yes / No

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## Ongoing Management of Healthcare

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<thead>
<tr>
<th>Role</th>
<th>Name</th>
<th>Transferring Care To</th>
<th>Role</th>
<th>Contact Name</th>
<th>Further Actions Needed</th>
<th>Action Owner</th>
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<td>Paediatric Ep CNS</td>
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<td>Children’s Community Nurse</td>
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<td>Paediatric Continuing Healthcare</td>
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<tr>
<td>Other (LD community nurse, wheelchair clinic etc.)</td>
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<tr>
<td>Tertiary Centre</td>
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## Ongoing Management of Therapies

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<th>Contact Name</th>
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<th>Further Needed</th>
<th>Actions</th>
<th>Action Owner</th>
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<td><strong>Speech And Language</strong></td>
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<tr>
<td><strong>Other (Dietician, Psychology Etc.)</strong></td>
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<th>Current School</th>
<th>Key Worker (Name And Contact No.)</th>
<th>Transition Arrangements</th>
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<th>Social Worker (Name And Contact No.)</th>
<th>Transition Arrangements</th>
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### Health History

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<td>Notable Previous Medications</td>
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<td>Drug Allergies</td>
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**Known Plans**
- ACP [ ]
- DNACPR [ ]

**Epilepsy (if applicable)**
- Description of Seizures:
  - Seizure type:
  - Emergency management:

**Gross motor**

**Respiratory**

**Communication**

**Feeding**

**Equipment**

**Vision**

**Hearing**

**Activities of Daily Living**

**Other**

**Carers**
- Mental Capacity Act information given (if applicable) [ ]

**ED / Ward admissions arrangements**

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*transition from children’s to adult services policy*

*version 1.0 – may 2017*