Shropshire Community Health NHS
NHS Trust

Title	**Guidelines for the transition of young people moving to adult services who have ongoing health or nursing needs**
Trust Ref No	211-59861
Local Ref (optional)	
Main points the document covers	• An understanding of the importance of a safe effective transition from children's to adult services • Standards and process underpinning transition • Training resources to support practitioners • Transition care plan template.
Who is the document aimed at?	All children and adult services who support young people to transition to adult health services
Author	Kate Medhurst – Community Children's Nursing Service Manager Jane Hollins - Locality Manager
Approval process	
Approved by (Committee/Director)	Clinical Policy Subgroup
Approval Date	08/11/2021
Initial Equality Impact Screening	Y
Full Equality Impact Assessment	N
Lead Director	Claire Hobbs
Category	Clinical
Sub Category	
Review date	08/11/2024
Distribution	
Who the policy will be distributed to	All children and adult services who care for young people within our Trust
Method	Via Datix alert and SDG Quality and Safety meetings
Keywords	Transition, transfer, adults, children, health needs, complex
Document Links	
Required by CQC	Yes
Keywords	Young people, children, transition, adult services

Amendments History		
No	Date	Amendment
1	New Policy	Review in March 2019 to facilitate contribution from adult service delivery group.
2	V2 August 2022	Included full 10 steps to Transition pathway, included actions to meet NICE standards, updated appendices
3		
4		

Contents

1. Introduction

More young people with long-term and complex conditions are surviving into adulthood and a need to continue specialist care into adulthood. The process of moving children into adult services can be confusing and frustrating and often results in gaps in essential care because this has not been 'joined-up' or planned around the individual in a timely way.

Children with complex disabilities, learning disabilities, children and adolescent mental health service users, young people with palliative care needs/life limiting conditions and young people leaving residential care are all at particular risk of falling between service gaps.

Looked After Children are also a particular group of children with specific needs who require support to transition to adulthood including managing their healthcare needs in adult services.

A seamless transition for young people from children to adult health care services will be achieved through excellent communication channels and clear processes during this daunting time for both the young person and parent/carer as failure to achieve this and ensure effective transition can impact on the long-term health outcome of the individual.

The publication of the full Children's National Service Framework (NSF, 2004) highlighted the importance of well-planned transition of young people (12-19 yrs.) from child–centred to adult-oriented services. These are views mirrored by NICE (2016) 'Transition from children's to adult's services' guidelines and RCPCH (2018) 'Facing the Future: Standards for children with ongoing health needs'.

Development of Transition processes is also highlighted in the SEND code of practice (DfE 2015) and the NHS Long Term Plan (NHS, 2019) with selective move of services to a 0- 25 years model and NHS England have supported Quality Improvement initiatives and the development of transition networks supported by the Burdett Trust.

Transitional care is a multi-dimensional, multi-disciplinary process that addresses not only the medical needs of young people but also their psychosocial, educational and vocational needs. Transition is recognised as a gradual process of empowerment that equips young people with the skills necessary to manage their own healthcare as they move towards and into an adult lifestyle. It is a carefully planned process undertaken over time which includes (but is more than) a planned transfer to adult services.

Alongside potentially challenging moves from child to adult services there may be many other changes in a young person's life, including changes within education or employment; changes in self-identity and relationships; and, physical, emotional and cognitive changes that occur during the period of adolescence, all of such can result in uncertainty, anxiety and stress. It is important that any required transition process is managed sensitively and collaboratively to support continued engagement of the young person and their parents /carers and safe and effective service delivery. The involvement of the young person and their carers, collaborative working and effective communication between everyone involved is central to successful transition arrangements placing the young person's needs and aspirations at the centre of the transition process.

We know from widespread evidence that inadequate transitional care impacts on long-term health outcomes for children and young people. Professionals need to ensure transition planning is implemented in a coordinated way placing the young person's needs and aspirations at the centre of the transition process.

2. Purpose

The purpose of this guidance is to set out principles and guidance for effective and timely transition from children's to adult care services.

It provides a suite of resources for Professionals to access depending on the individual needs of the Young Person and their family/carers,

This guidance applies to all young people aged 14 and over, with long term conditions that are expected to continue through adolescence into adulthood. This guidance is also relevant to young people diagnosed with a long-term condition during the transition period.

This document has recognised current guidance:

- CQC from Pond into the Sea (2014)
- Stepping Up: Together for short Lives (2015)
- NICE (2016) Transition from children's to adult's services
- RCPCH (2018) Facing the Future: Standards for children with ongoing health needs

Consideration has also been given to examples of transition procedures from other organisations in establishing this guidance. It is recognised that staff working in both Children's and Adult Services will have very variable inputs into transition plans; this may range from taking the key transition lead to having a specialist advisory role only. However, it will be essential that all professionals continue to work in partnership with relevant statutory and voluntary organisations that are involved with the child and family in order that transition is as seamless as possible. Services identified for 'moving on to' will also vary dependant on individual needs

The aim of this guidance is to support staff to achieve a safe transition for Young People through:

- ✓ The provision of high quality, co-ordinated, healthcare that is patient-centred, age and developmentally appropriate and culturally competent, flexible, responsive and comprehensive with respect to all persons involved
- ✓ Promotion of skills in communication, decision-making, assertiveness and self-care, self-determination and self-advocacy;
- ✓ Enhancement of the young person's sense of control and move towards independence;
- ✓ Provision of support and signposting for the parents/carers of the young person during this process

3. Definitions

Term	Definition
Children (and Family) Service/Teams	All services provided to children and young people including the paediatric medical, nursing and therapy teams and any service provided by an adult clinician within a specific speciality e.g. ENT, Orthopaedics.
Education, Health and Care Plan	A document which sets out the education, healthcare and social care needs of a child or young person for whom extra support is needed in school, beyond that which the school can provide.
HCP	Health Care Professional

ICS	Integrated Care System
Key Worker	For the purpose of transition a key worker is the lead person / professional who role is to provide support and guidance to the young person, family and other professionals. They are responsible for co-ordinating the transition process across professions, services and agencies to ensure a seamless and successful transition into adult services for the young person and their family.
MDT	Multidisciplinary Team - is a group of health and care staff who are members of different organisations and professions (e.g. GPs, social workers, nurses), that work together to make decisions regarding the treatment of individual patients and service users.
NICE	National Institute of Clinical Excellence
NSPCC	The National Society for the Prevention of Cruelty to Children
Parent or Carer	Person identified by the young person who has been closely involved with caring for them, this may be a mother, father, close relative or close friend who are of adult age (older than 18 years). This policy is to be read in conjunction with the consent to treatment policy for details of who has parental responsibility for consent.
RCPCH	Royal College of Paediatricians and Child Health
SDG	Service Delivery Group
SEND	Special Educational Needs and Disabilities
SCHT	Shropshire Community Health Trust
Transition	Transition to adult services (transition) is defined as “a purposeful, planned process the address the medical, psychosocial and educational/vocation needs of adolescents and young people with (long term) condition as the move from child-centred to adult orientated health care systems” (DfES, 2006)
Young People	For the purpose of this policy, the term is used to describe young people between the ages of 13 – 19 years

4. Roles and responsibilities

The Medical Director is responsible for providing clinical leadership within our Trust for the provision of senior clinical advice. The Medical Director has the overall responsibility of ensuring that the Transition Guideline is implemented.

The Service Delivery Group Managers are responsible for ensuring that the guideline is implemented across the Children & Families and Adult SDG to support safe transition for young people.

The Heads of Nursing and Quality for both Children & Families and Adult SDG's are responsible for overseeing compliance of the guideline and quality of transition experienced by young people within our Trust.

Service and Clinical Managers for both children and adult services are responsible for implementation of this guidance within their areas of responsibility. They will monitor that all relevant staff are aware of the guidance and undertake training as appropriate. They will proactively identify and plan for young people with transition support needs in their respective areas.

Community Clinical Staff responsible for the care of young people must ensure they have access to this guideline for reference. All staff will work collaboratively with colleagues in Children & Family/Adult services to ensure that the transition needs of the young person are met. The young person will remain at the centre of the process with their thoughts and wishes considered at all times.

5. The Transition Process

5.1. Philosophy

The guiding principle of transition is to support the young person to reach individualised independence and facilitate a smooth transition to adult services. In facilitating the transition process, we need to consider the following points:

- Parallel to the key principles of safeguarding, supporting young people during transition is everyone's responsibility
- For transition to be effective we need to recognise that transition of health care is only one part of the wider transition from dependent child to independence.
- The needs of parents/carers should be acknowledged during transition as their role is evolving too.
- When moving from child to adult services young people will experience cultural as well as clinical change.
- A multi-disciplinary approach will support both children and adult services.
- Effective transition relies on the identification of a key worker to ensure a seamless transition.
- Transition is an active process which must begin early, be planned and reviewed regularly. Transition is not a single one-off event
- The timing of the move to adult services should be tailored to individual needs of the young person depending upon their emotional maturity, cognitive and physical development.
- Transition support will continue after the move until the young person is adequately settled/supported into adult services

5.2. Why is good transition to adult services important?

If young people are not adequately supported through transition, they may not engage with adult health care providers, and this increases the risk of deterioration of their long-term condition, and avoidable hospital admissions. Transition to adult services can be a traumatic period for

young people, who commonly fall between services or 'disappear' during transition, disengaging from services and becoming lost to follow up, only to present later in life with potentially avoidable complications. As a result, improving outcomes for young people's health and their transition to adult services is now a national priority.

5.3. Identification of Young People

Where transfer pathways are clear and simple between child and adult services, Children and Adult Service Manager counterparts should meet at least annually to review the number and needs of Young People transferring in the next 1 to 2 year in order to future plan for services and identify any capacity and skill set gaps as early as possible to aide commissioning discussions.

5.4. 10 Steps to transition

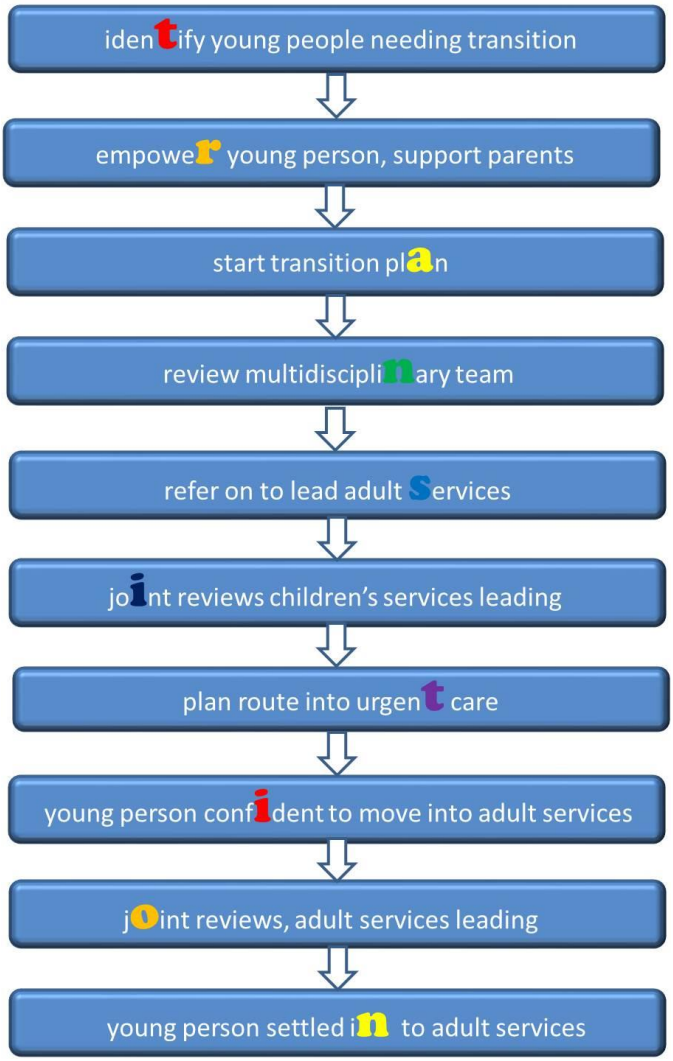
It is crucial that professionals work in partnership with young people and their families to ensure they receive the support they need for effective transition. The young person and their family should be kept informed every step of the way and understand what is happening, feel confident and in control.

Some young people will have long term conditions (e.g. asthma, diabetes or epilepsy) and transition will be mainly concerned with moving on to Adult Health Services. They should be supported and encouraged to learn about their health needs and develop self-management skills as a normal and expected part of growing up.

Other young people may have learning disabilities and/or social care needs. Their transition will be more concerned with moving on to adult social or learning disability services. A small number of young people with complex long-term conditions will have support from health, social care and special education services. It is important that services work together to co-ordinate the different transition pathways.

There is evidence that well organised transition programmes have measurable benefits for Young People and their parents including improved follow-up and better disease control.

The 10 Steps to Transition Pathway (Brook, L. and Rogers, J 2021) ensures a safe, effective, developmentally appropriate and person-centred transition to adult services. Some of these steps will continue for a considerable period of time and one step does not necessarily need to be completed before the next step is started.



Professionals should give young people the opportunity to talk about how their health needs may impact on their future, including employment, independent living, sexuality and relationships. Young people should also have the opportunity to discuss risky behaviours like smoking, alcohol and substance misuse.

5.5. Shropshire Community Health Trust Standards for Transition

The following standards are underpinned by NICE Quality Standards QS140 Transition from children's to adults' services (NICE 2016) and RCPCH (2018) Facing the Future: Standards for children with ongoing health needs and are what teams should work towards achieving.

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

NICE Quality Statement 1: Young people who will move from children's to adults' services will start planning their transition with their key health practitioner by school year 9 (aged 13 to 14 years), or immediately if they enter children's services after school year 9.

ii) When a young person is known to a number of SCHT children's services, in agreement with the young person and their family, a member of the MDT will be identified as the young person's transition lead for SCHT and where appropriate will work with the key/lead practitioners from the other Organisations supporting the transition plan.

NICE Quality Statement 3: Young people who will move from children's to adults' services have a named worker to coordinate care and support before, during and after transfer

iii) A young person's Circle of Support is the group of people, professionals, friends and family, who are there to help them. It is important to list those professionals in children's services and identify the most appropriate service to take over when the young person transitions to adult services (Appendix 1)

The important role of the GP

The young person's GP is often the only source of continuity between children's and adult healthcare provision. The GP has a significant role in the ongoing management and co-ordination of care of many adult long term conditions. It is therefore essential that the GP is notified of transition planning and updated accordingly so that they can provide additional support in primary services, as required.

People with a learning disability often have poorer physical and mental health than other people and an annual health check can improve people's health by spotting problems earlier. Annual health checks are for adults and young people aged 14 or over with a learning disability and will be a fundamental part of the transition plan.

iv) The identified SCHT Transition Lead will work in partnership with the young person and their families to create a personal Transition Plan. This will be tailored to the young person's health needs as well as their developmental and cognitive needs. It will also be co-ordinated with other aspects of Transition, such as education, as necessary. Ideally, there will be one transition plan spanning across all Organisations involved with the young person.

These guidelines do not prescribe which Transition Plan is to be used within SCHT but provide a suite of resources that can be utilised by the MDT and identified SCHT Transition Lead, e.g:

- Ready Steady Go Transition Plan (also available in Easy-Read Format) (Appendix 2)
- Alderhey Transition Plan (Appendix 3)
- Planning Emergency Care Route (Appendix 4)

Young people will be given a copy of their Transition Plan, have the opportunity to read it and ask questions.

Young People with learning disabilities may also need additional advocacy support to safely access emergency and inpatient care, including a handheld Health Information Passport or similar document. At the time of writing this guidance, work is being undertaken to review the available health passports used within our local systems. Appendix 6 provides an example of a Patient Passport.

An alert on Rio will be recorded to inform HCP's that a young person has a transition plan in place.

Life threatening illness or Palliative Care

Diagnosis of a life threatening or life shortening condition does not automatically negate the requirement for transition to adult services, as increasingly these children are living into adulthood. A parallel planning approach is required. Active management with a view to achieving stability or improvement in the young person's condition, including transition to adult services, should continue alongside planning for a potential deterioration in the young person's condition and end of life care.

v) Transition planning for individual young people will be reviewed on an annual basis

The time and venue for the annual review of the transition plan will vary between each young person and will be considered and agreed within the initial planning process.

- For young people with a single long-term condition the annual review may take place as part of the medical annual review
- For young people with multiple and/or complex conditions the annual review may be organised as specific Transition Plan review appointment
- For young people with an Education, Health and Care Plan in place, the review of the Transition Plan will form part of the contribution of the annual review.

NICE Quality Statement 2: Young people who will move from children's to adults' services have an annual meeting to review transition planning.

vi) The young person will be introduced to the adult team prior to leaving children's services and ideally there should be a reasonable period of time where the young person's care is overseen jointly.

If this is unfeasible prior to transfer of care, the children's team should offer to support the young person and family/carer during the first appointment in adult services.

Young People may wish to continue developing independent knowledge and skills about their condition and Adult services may provide condition specific support tools. Alternatively, the Hello to Adult Services (Appendix 4.g) can be used.

It is recognised that from time to time there are no 'like for like' adult services to transition to and oversight of care is transferred to the GP. In the event there is an identified unmet need within the transition plan, service leads should escalate this through the relevant quality and safety meetings and involve the relevant ICS lead as necessary.

vii) Following transfer to adult services, if the young person is not engaging in adult services, where possible, the clinician will notify the professional from the relevant children's services. They will contact the young person to review the transition care plan and identify what help is required to enable them to use the service or discuss alternate ways to meet their needs. Shared decision making ensures that young person is supported to make decisions that are right for them. It is a collaborative process through which the professional (and the MDT) supports a young person to reach a decision about their care plan (NHSE&I, 2019) (See section 6)

NICE Quality Statement 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

6 Mental capacity and impact for obtaining Consent during Transition

Young people should be supported and empowered to take part in Shared Decision Making e.g. Ask three Questions (Appendix 2). Shared decision making ensures that young person is supported to make decisions that are right for them. It is a collaborative process through which the professional (and the MDT) supports a young person to reach a decision about their care plan (NHSE&I, 2019).

Children under the age of 16 can consent to their own care and treatment if they're believed to have capacity to make the decision. Capacity means the ability to use and understand information to make a decision, and communicate any decision made. This is known as being Gillick competent. Otherwise, someone with parental responsibility can consent for them. It is important that we consider capacity when working with a young person and their family to support effective transition. Capacity and competence can vary depending on the complexity and implications of each decision.

For further information see section 3 of the Reference guide to consent for examination or treatment, second edition 2009 and the NSPCC guidance A child's legal rights Gillick competency and Fraser guidelines

People aged 16 or over are entitled to consent to their own treatment/transition plan, and this can only be overruled in exceptional circumstances. Like adults, young people (aged 16 or 17) are presumed to have sufficient capacity to decide on their own medical treatment, unless there's significant evidence to suggest otherwise.

A young person may lack capacity if their mind is impaired or disturbed in some way meaning that they are unable to make a decision at that time e.g. a mental health condition or a severe learning disability. However, It is important to highlight, that most young people with mental health difficulties will still have capacity.

It is essential that young people and importantly parents/carers are explained to and understand the changes regarding consent and mental capacity as soon as transition planning commences.

All staff supporting young people through Transition need to be aware of the Trust policy for Consent to Examination and Treatment Policy and children's services must ensure processes are adapted when supporting a young person aged 16 years and above (and below if deemed Gillick Competent).

a. Clinic Letters/Telephone Contacts

Young People with capacity have the legal right to access their own health records and can allow or prevent access by others, including their parents.

Health Professionals will make direct communications with the young person when booking appointments or undertaking health reviews. Young People should also be the recipient of any clinic letters.

The young person will be asked for consent to share a copy of the clinic letter with their parents and agree process for keeping parents up to date following other modes of contact. This decision should be noted on the Transition Plan and regularly reviewed.

7 Equality and Diversity

On 1st October 2010, the Government introduced the Equality Act. The Act makes it unlawful to discriminate either directly or indirectly because of a protected characteristic in relation to employment, supply of goods and services including healthcare, education etc. We have a legal responsibility to assess the services we provide and identify how we will protect people from discrimination based on the following 'protected' characteristics:

- ✓ Age
- ✓ Disability
- ✓ Gender reassignment
- ✓ Marriage and civil partnership
- ✓ Pregnancy and maternity
- ✓ Race
- ✓ Religion or belief
- ✓ Sex
- ✓ Sexual orientation

Children and young people must be protected from discrimination during the transition process. This includes discrimination in relation to protected characteristics under the Equality Act. There must be a focus on assessing the impact on children and young people with protected characteristics. This involves anticipating the impacts of transition on these groups and making sure that, as far as possible, any negative consequences are removed or minimised and opportunities for promoting equality are maximised.

8 Regional Nurse Advisor

SCHT is supported by the **Burdett Regional Nurse Advisor for Young People's Healthcare and Transition (Midlands & East of England).** This National Network aims to provide a coordinated and unified approach to transition and provides support and advice across both children's and adult services.

brochure-the-burdett-national-transition-nursing-network-final-july-2020.pdf (hct.nhs.uk)

9 Consultation

This guideline was distributed to the following group for consultation and comment:

Claire Horsfield Deputy Director of Allied Health Professions & Quality
Angela Cook Head of Nursing & Quality (Adult Service Delivery Group)
Mandee Worrall Head of Nursing and Operations (Adults)
Sharon Simkin Clinical Lead for Quality (Children and Families)
Vickie Clayton – Clinical Quality Lead (Adults)
Gill Richards – Information Governance Manager
Anthony Archambault - Nurse Specialist – Safeguarding Adults
Helen Unsworth – Consultant Community Paediatrician
Camilla Johns – Professional Lead and Consultant Clinical Psychologist
Sophie Burgess - Principal Clinical Psychologist
Iona James – Physiotherapist
Dyllis Kilby - Speech & Language Therapist
Karen Myles – Special School Nurse

Liz Vaughan – Specialist Nursery Nurse
Anne Griffiths – Family Nurse Practitioner
Adelle Astley - Specialist Public Health Nurse SEND 0-19
C&F's Operational Leaders Group

10 Dissemination and Implementation

This policy will be disseminated by the following methods:

- Notification through the Policies update alert via Datix
- Published on the Trust website and Staff Zone
- Awareness raising by managers and team leaders at local inductions and team meetings

11 Training

Training is recognised as an essential component to support delivery of a multi-disciplinary approach to the transition process within our Trust. Professionals need to consider further development of their knowledge and skills in working with young people, including the physiology and developmental process of adolescence; communication and consultation strategies; multi-disciplinary teamwork and an and understanding of how health impacts into adulthood. Training will be available for health care practitioners across children and adult services working with young people and their families. **It is recommended that at least one E-learning module is completed every two years.** Appendix 7 lists some training resources.

12 Monitoring

We will use the NICE NG43 Transition Standards to monitor the effectiveness through clinical audit and experience feedback from Young People, families/carers and wider stakeholders.

Teams should also monitor their compliance against the 10 Steps Transition Pathways auditable standards

Incidents and near misses relating to transition to adult services will be reported via Datix

13 References

Brook, L. and Rogers, J (2021) 10 Steps to Transition Pathway. Alder Hey Children's NHS Foundation Trust. https://10stepstransition.org.uk/10-steps-pathway/ (Accessed 27/09/2021)

Care Quality Commission (CQC 2014) From the Pond into the Sea; Children's Transition into Adult Health Services. https://www.cqc.org.uk/sites/default/files/CQC_Transition%20Report_Summary_lores.pdf (accessed 27/09/2021)

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NHS England & improvement (2019) Shared Decision Making Summary guide https://www.england.nhs.uk/wp-content/uploads/2019/01/shared-decision-making-summary-guide-v1.pdf (accessed 25/08/2022)

RCPCH (2018) Facing the Future: Standards for children with ongoing health needs https://www.rcpch.ac.uk/sites/default/files/2018-04/facing_the_future_standards_for_children_with_ongoing_health_needs_2018-03.pdf (Accessed 27/09/2021)

Together for Short Live (2015) A guide to enabling a good transition to adulthood for young people with life-limiting and life-threatening conditions. https://www.togetherforshortlives.org.uk/wp-content/uploads/2018/02/ProRes-Stepping-Up-Transition-Care-Pathway.pdf (Accessed 27/09/2021)

14 Related Policies

Consent to Examination and Treatment Policy

Information Governance Policy

Safeguarding Adults Policy

15 Appendices

Appendix 1 – Circle of Support		10-Steps-circle-of-support-checklist-2017-; Circle-of-support-contacts-list-2017-02-17.p
Appendix 2 – Ready Steady Go	a) Transition: moving into adult care	transition_moving_into_adult_care.docx
	b) Getting Ready	transition_the_ready_steady_go_transitio; Easy Read ready to fill READY QUESTIONI
	c) Steady	transition_the_ready_steady_go_transitio; Easy Read ready to fill STEADY QUESTION
	d) Go	transition_the_ready_steady_go_transitio; EASY READ Ready to Fill GO QUESTIONNAI
	e) Parent/carer's transition questionnaire	transition_parent_carers_transition_plan.(
	f) Transition plan (this is available on Rio editable letters – CS Transition Plan – Ready, Steady, Go)	Transition Plan v1.1.docx
	g) Hello	Hello Questionnaire.pdf
Appendix 3 - Alderhey Transition Plan		Transition-plan-template-complex-and-mul
Appendix 4 Planning Emergency Care Route		Route-into-urgent-care-2017-02-10.pdf
Appendix 5 The Patient Passport		PATIENT PASSPORT FINAL.pdf
Appendix 6 – Ask 3 Questions		NHS-Ask-three-questions.pdf
Appendix 7 – E-Learning Resources		NHS-Ask-three-questions.pdf

Circle of Support

10stepstransition.org.uk

10 Steps: transition to adult services for young people with long term conditions
Circle of support checklist

☐ Nutrition and Dietetics

☐ Psychology

☐ Speech and Language Therapist (SALT)

Physiotherapy
☐ Respiratory
☐ Neuromuscular

Name
DoB
Transition keyworker
Lead Consultant

NHS

☐ Pharmacy and medicines

☐ Specialist Nurse Practitioners

☐ Medical consultants

☑ GP

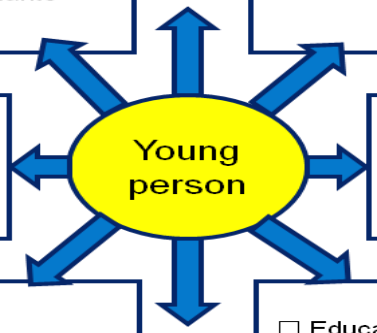
☐ Community Nurses

☐ Dental care

☐ Respite

☐ Continuing care

☐ Family &Friends



☐ Learning disability MDT

☐ School Nurse

☐ Equipment servicing and maintenance

☐ Wheelchair Services

☐ Finance and benefits

☐ Social Care (social work)

☐ Education and employment

☐ Hearing and vision support

☐ Adult care centres

☐ Transport

☐ Support for parents and carers

☐ Housing

☐ Independent living

☐ Volunteers & community support

☐ Legal and advocacy

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10 Steps: transition to adult services for young people with long term conditions Step 4: circle of support contacts list

Name: **DoB:**

Unit No: **NHS No:**

Updated:

Children's services				Adult services			
Professional role	**Name**	**Telephone**	**Email**	**Professional role**	**Name**	**Telephone**	**Email**
Multidisciplinary community services							
General Practitioner							
Community nurses							
Specialist health services							
Consultants							
Nurse specialists							
Nutrition and dietetics							

www.10stepstransition.org.uk

10 Steps: transition to adult services for young people with long term conditions

Step 4: circle of support contacts list

Children's services				Adult services			
Professional role	**Name**	**Telephone**	**Email**	**Professional role**	**Name**	**Telephone**	**Email**
Allied health professionals							
Dentist							
Hearing and vision							
Wheelchair services							
Pharmacy and medicines management							
Continuing care, hospice and short breaks							

Social care							
Social worker							
Transport							
Finance and benefits							
Housing and independent living							
Education and employment							
School							

Alder Hey Children's NHS
NHS Foundation Trust

Ready Steady Go

This is only a start

This leaflet is designed to get you to start thinking about adult services and the transition process.

For every person, this process will be slightly different but your healthcare team should be able to provide you and your family with information about it.

By talking about transition early, you should have plenty of time for discussions and questions, ensuring that you are fully prepared when the time comes to make the move to adult services.

Ask your healthcare team about the Ready Steady Go programme

You may like to use this section to jot down any questions you have about your transition.

My key worker is:

Contact details:

Ready Steady Go is based on the work of: 1. S Whitehouse and MC Vyas. Contemporary Paediatrics; 1998, 13-16. 2. Vyas MC, Wade M, Vyas E. Prog Transplant 2006; 16:291-302. 3. Janet E McDonagh et al, J Child Health 2006; 10(1):22-43.

Further information at www.uhs.nhs.uk/readysteadygo

NHS

Transition: moving into adult care

Information for young people and families

What is transition?

In healthcare, we use the word "transition" to describe the process of preparing, planning and moving from children's to adult services.

Transition is a gradual process that gives you, and everyone involved in your care, time to get you ready to move to adult services and discuss what healthcare needs you will require as an adult.

This includes deciding which services are best for you and where you will receive that care.

Transition is about making plans with you - and not about you.

We understand that moving away from a team of doctors and nurses that you have been with for many years can be scary but hopefully, by getting involved in the transition process, you will feel more confident and happier about the move.

Why do I have to move?

As you get older, you will find that some of the things you want to discuss or some of the care you might need is not properly provided by our children's services.

Adult services are used to dealing with all sorts of issues that may arise, such as higher education, travelling, careers and sex.

You may also find that you would prefer to be seen in a more grown-up environment, rather than the usual children's departments or wards.

When do I have to move?

There is no exact time that is right for everyone.

The purpose of this leaflet is to get you thinking about moving on and preparing for it.

Your doctors and nurses may have an idea about when they feel that you might be ready but it is important that you are involved in that decision.

Can I choose where I move to?

Part of the transition process should be helping you to look at where your ongoing healthcare needs can best be met and how this will fit in with your future plans.

Your consultant or family doctor (GP) will be able to give you information to help you make the best decision.

If there is a choice of places, it is a good idea to visit all of them and then decide which is best for you.

Who can help me get ready?

Your healthcare team will be able to give you information and support about moving on.

They can help you get ready for adult services by:

- Teaching you about your condition or illness, its treatment and any possible side effects
- When you are ready, seeing you on your own for part of the clinic appointment and working towards seeing you on your own for the whole clinic appointment
- Making sure you know when to get help and who to contact in an emergency
- Helping you understand how your condition or illness might affect your future education and career plans
- Making sure you know about the support networks available
- Making sure you understand the importance of a healthy lifestyle, including exercise, diet, smoking and sex.

Your family

Your parents or carers have been really important in looking after your health and will be able to give you lots of helpful advice.

While you are in the process of transitioning, your parents will still be very involved in your care and their role is still important.

Try to talk to them and your health care team about how you feel about moving on to adult care and any questions or concerns you might have.

Also try to discuss practical issues relating to your health, such as getting to appointments, obtaining repeat prescriptions and asking questions in clinic.

While transition is all about you, it is important to realise that your parents may also be finding the process difficult as now they are handing over the responsibility to you.

This can be hard for many parents and they may have worries of their own.

You may find talking to them about your feelings, and allowing them a chance to tell you how they feel, will help you all through the process.

Questions you may like to discuss with your healthcare team:

- What is the plan for my transition?
- When am I moving to adult services?
- Can I choose which adult service I move to?
- What is different about the adult service?
- Can I meet the adult staff before I leave children's services?
- Can I visit the adult service to look around?
- Are there any young people I can talk to about moving to adult services?
- What do I need to know before I move to the adult service?
- When can I start getting more involved in my health care?
- How will my condition affect my future, such as my education and employment prospects?

The Ready Steady Go transition programme - Getting Ready

The medical and nursing team aim to support you as you get older and help you gradually develop the confidence and skills to take charge of your own healthcare.

Filling in this questionnaire will help the team create a programme to suit you.
Please answer all questions that are relevant to you and ask if you are unsure.

Name: Date:

Knowledge and skills	Yes	I would like some extra advice/help with this	Comment
KNOWLEDGE			
I can describe my condition			
I know when to take my medications, names, doses, how often, etc			
I know who's who in the medical and nursing team			
I understand the differences between children's and adult health care			
I know about resources that offer support for young people with my condition			
SELF ADVOCACY (speaking up for yourself)			
I feel ready to start preparing to be seen alone for part of the clinic visit in the future			
I ask my own questions in clinic			
I have heard and know about 'Ask 3 Questions'			
HEALTH AND LIFESTYLE			
I understand it is important to exercise for my general health and condition			
I understand the risks of alcohol, drugs and smoking to my health			
I understand what appropriate eating means for my general health			
I am aware that my condition can affect how I develop e.g. puberty			
I know where and how I can access reliable information about sexual health			

Knowledge and skills	Yes	I would like some extra advice/help with this	Comment
DAILY LIVING			
I can look after myself at home in terms of dressing and bathing/showering etc			
I can make my own snacks/meals			
I am able to be away from home overnight			
SCHOOL AND YOUR FUTURE			
I am managing at school e.g. getting to and around school, school work, PE, friends, etc			
I know what I want to do when I leave school			
LEISURE			
I can use public transport and access my local community, e.g. shops, leisure centre, cinema			
I see my friends outside school			
MANAGING YOUR EMOTIONS			
I know how to deal with unwelcome comments/ bullying			
I know someone I can talk to when I feel sad/ fed-up			
I know how to deal with emotions such as anger or anxiety			
I am comfortable with the way I look			
I am happy with life			
TRANSFER TO ADULT CARE			
I understand the meaning of 'transition' and transfer of information about me			

Please list anything else you would like help or advice with:

Thank you

The Ready Steady Go transition programme - Steady

The medical and nursing team aim to support you as you get older and help you gradually develop the confidence and skills to take charge of your own healthcare.

Filling in this questionnaire will help the team create a programme to suit you.
Please answer all questions that are relevant to you and ask if you are unsure.

Name: Date:

Knowledge and skills	Yes	I would like some extra advice/help with this	Comment
KNOWLEDGE			
I understand the medical terms/words and procedures relevant to my condition			
I understand what each of my medications are for and their side effects			
I am responsible for my own medication at home			
I order and collect my repeat prescriptions and book my own appointments			
I call the hospital myself if there is a query about my condition and/or therapy			
I know what each member of the medical team can do for me			
I understand the differences between children's and adult health care			
I know about resources that offer support for young people with my condition			
SELF ADVOCACY (speaking up for yourself)			
I feel confident to be seen on my own for some/all of each clinic visit and to ask my own questions			
I understand my right to confidentiality			
I understand my role in shared decision making with the healthcare team e.g. Ask 3 Questions*			
HEALTH AND LIFESTYLE			
I exercise regularly/have an active lifestyle			
I understand the risks of drugs, alcohol and smoking to my health			
I understand what appropriate eating means for my general health			
I am aware that my condition can affect how I develop e.g. puberty			
I know where and how I can access reliable information about sexual health			
I understand the implications of my condition and medications on pregnancy/parenting (if applicable)			

*See www.uhs.nhs.uk/Media/UHS-website-2019/Patientinformation/Childhealth/ReadySteadyGo/Printready/Ready-Steady-Go-postcard-print-ready.pdf

Knowledge and Skills	Yes	I would like some extra advice/help with this	Comment
DAILY LIVING			
I can look after myself at home in terms of dressing and bathing/showering etc			
I can make my own snacks/meals			
I know how to plan ahead for being away from home, overseas, trips, e.g. storage of medicines and vaccinations			
EDUCATION AND YOUR FUTURE			
I am managing at school/college (getting to and from the site, coping with work, friends and PE, for example)			
I know what I want to do when I leave school			
I have had work/volunteering experience			
I am aware of any potential impact of my condition to my education and/or work opportunities			
I know who to contact for careers advice			
LEISURE			
I can use public transport and access my local community, e.g. shops, leisure centre, cinema			
I see my friends outside school/college			
MANAGING YOUR EMOTIONS			
I know how to deal with unwelcome comments/ bullying			
I know someone I can talk to when I feel sad/fed up			
I know how to deal with emotions such as anger or anxiety			
I am comfortable with the way I look			
I am happy with life			
TRANSFER TO ADULT CARE			
I understand the meaning of 'transition'			
I am aware of the plan for my medical care when I am an adult			
I have all of the information I need about the adult team who will be looking after me			

Please list anything else you would like help or advice with:

Thank you

The Ready Steady Go transition programme - Go

The medical and nursing team aim to support you as you get older and help you gradually develop the confidence and skills to take charge of your own healthcare.

Filling in this questionnaire will help the team create a programme to suit you.
Please answer all questions that are relevant to you and ask if you are unsure.

Name: Date:

Knowledge and skills	Yes	I would like some extra advice/help with this	Comment
KNOWLEDGE			
I am confident in my knowledge about my condition and its management			
I understand what is likely to happen with my condition when I am an adult			
I look after my own medication			
I order and collect my repeat prescriptions and book my own appointments			
I call the hospital myself if there is a query about my condition and/or therapy			
SELF ADVOCACY (speaking up for yourself)			
I feel confident to be seen on my own in clinic			
I understand my right to confidentiality			
I understand my role in shared decision making with the healthcare team e.g. Ask 3 questions*			
HEALTH AND LIFESTYLE			
I exercise regularly/have an active lifestyle			
I understand the risks of drugs, alcohol and smoking on my condition and general health			
I understand what appropriate eating means for my general health			
I know where and how I can access reliable information about sexual health			
I understand the implications of my condition and medications on pregnancy/parenting (if applicable)			
DAILY LIVING			
I am independent at home – dressing, bathing, showering, preparing meals, etc			
I can or am learning to drive			

*See www.uhs.nhs.uk/Media/UHS-website-2019/Patientinformation/Childhealth/ReadySteadyGo/Printready/Ready-Steady-Go-postcard-print-ready.pdf

Knowledge and Skills	Yes	I would like some extra advice/help with this	Comment
DAILY LIVING (CONTINUED)			
I know how to plan ahead for being away from home, overseas, trips e.g. storage of medicines, vaccinations			
I understand my eligibility for benefits (if applicable)			
EDUCATION/WORK AND YOUR FUTURE			
I have had work/volunteering experience			
I have a Career Plan (please specify)			
I am aware of the potential impact (if any) of my condition on my future career plans			
I know how and what to tell a potential employer about my condition (if applicable)			
I know who to contact for careers advice			
LEISURE			
I can use public transport and access my local community, e.g. shops, leisure centre, cinema			
I see my friends outside school/college/work			
MANAGING YOUR EMOTIONS			
I know how to deal with unwelcome comments/ bullying			
I know someone I can talk to when I feel sad/fed-up			
I know how to cope with emotions such as anger or anxiety			
I know where I can get help to deal with my emotions if needed			
I am comfortable with the way I look			
I am happy with life			
TRANSFER TO ADULT CARE			
I understand the meaning of 'transition' and transfer of information about me			
I know the plan for my care when I am an adult			
I have all of the information I need about the adult team who will be looking after me			

Please list anything else you would like help or advice with:

Thank you

Parent/carer's transition programme

Name of parent:

Name of patient:

Date: Review (1) Review (2) Review (3)

Internet access: YES/NO

This transition plan is designed to help parents and carers feel confident about their knowledge and skills during the period of transition. Over the next few years we aim to equip your son/daughter and you with the necessary skills to manage their condition and hopefully increase your confidence and that of your son/daughter to transfer to adult services

.

Knowledge and skills	Yes	No	N/A
I understand the meaning of transition	☐	☐	☐
I know who's in the team and their respective roles	☐	☐	☐
I know about resources that offer support for parents/carers of young people with my son/daughter's condition.	☐	☐	☐
I understand what is likely to happen in the future regarding my son/daughter's condition.	☐	☐	☐
I understand the changes (physical and emotional) which occur during adolescence and how their condition potentially affects and is affected by this development.	☐	☐	☐
I am confident my son/daughter is knowledgeable about their condition and its therapy.	☐	☐	☐
I encourage my child to regularly exercise. I am aware of any restrictions my son/daughter may have.	☐	☐	☐
I feel confident in teaching my son/daughter to become responsible for their own medication at home.	☐	☐	☐

Parent/carers transition programme

Encouraging independence

	Yes	No	N/A
Is your son/daughter independent at home - dressing, bathing, preparing meals, doing chores, etc?	☐	☐	☐
I feel confident for my son/daughter to be seen on their own in clinic for part or all of clinic visits	☐	☐	☐
I understand my son/daughter's rights to information, privacy and confidentiality	☐	☐	☐
I know how to advise my son/daughter about financial help and other support	☐	☐	☐

Healthy lifestyle

I understand the importance of an appropriate healthy diet for young people	☐	☐	☐
I understand the effect of smoking, drugs and/or alcohol on my son/daughter's condition and general health	☐	☐	☐
I know where to access reliable sexual health information for young people and their parents	☐	☐	☐

Preparation for adult services

I feel confident in teaching my son/daughter how to contact the hospital themselves and to organise their repeat prescriptions	☐	☐	☐
I understand the differences between paediatric and adult medical care	☐	☐	☐
I know the plan for my son/daughter's medical care when he/she is an adult	☐	☐	☐

Please list any other things you have concerns about or would like extra help/advice with:

Thank you

The Ready Steady Go transition programme - Hello

The medical and nursing team aim to support and help you develop the confidence and skills to take charge of your own healthcare.

Filling in this questionnaire will help the team create a programme to suit you.
Please answer all questions that are relevant to you and ask if you are unsure.

Name: Date:

Knowledge and skills	Yes	I would like some extra advice/help with this	Comment
KNowleDge			
I am confident in my knowledge about my condition and its management.			
I understand what is likely to happen with my condition in the future			
I understand what each of my medication/ treatment is for and their side effects			
I order and collect my repeat prescriptions and book my own appointments			
I know who to contact if I have any concerns about my health			
I call the hospital myself if there is a query about my condition or treatment			
I know about resources for young people or adults with my condition			
SelF ADVoCACY (speaking up for yourself)			
I feel confident to be seen on my own in clinic			
I understand my right to confidentiality			
I understand my role in shared decision making with the healthcare team e.g. Ask 3 Questions*			
HeAlTH AND lIFeSTYle			
I exercise regularly/have an active lifestyle			
I understand the effect of smoking, drugs and alcohol on my condition and general health			
I understand what appropriate eating means for my general health			
I am aware that my condition can affect how I feel and function e.g fatigue, sexual function, fertility			
I know where and how I can access providers for accurate information about sexual health			
I understand the implications of my condition and drugs on pregnancy/parenting			

*See leaflet or www.advancingqualityalliance.nhs.uk/wp-content/uploads/2013/04/BrochureFinal25.10.12.pdf

The Ready Steady Go transition programme - Hello

Knowledge and Skills	Yes	I would like some extra advice/help with this	Comment
DAIlY lIVINg			
I am independent at home – dressing, bathing, preparing meals etc			
I know how to plan ahead for being away from home, overseas trips e.g. storage of medicine and vaccinations			
I can or am learning to drive			
I understand my eligibility for benefits (if applicable)			
College, woRK AND YoUR FUTURe			
I am managing at college/work e.g getting to and around, nature of work, friends etc			
I have had experience of working/volunteering			
I have a career plan - please specify			
I am aware of the potential impact (if any) of my condition on my future plans			
I know how and what to tell a potential employer about my condition (if applicable)			
I know who to contact for careers advice			
leISURe			
I can use public transport and access my local community e.g shops, leisure centre,cinema			
I have friends and see them socially			
MANAgINg YoUR eMoTIoNS			
I feel confident in telling people about my condition e.g. friends, family, employers			
I know someone I can talk to if I feel sad/fed-up			
I know how to cope with emotions such as anger or anxiety			
I would like more information about where I can get help to deal with my emotions			
I am comfortable with the way I look to others			
I am happy with life			

Please list anything else you would like help or advice with:

Thank you

10 Steps: Transition Plan

Transition 10 Steps to Adult Services: Transition Plan

Update at each clinic visit. Scan/ upload/file in medical record, copy to young person. Master copy held by Lead Speciality team

Young person's details				
Name		**Date of birth**		
Address		**Unit number**		
		NHS number		
		Home telephone		
Postcode		**Mobile**		
Email				
Main diagnosis				
Other important diagnoses				
Planning the Transition Journey				
Expected level of self-management after transition		☐ Independent	☐ Assisted	☐ Fully supported
Main professionals *(more information in Circle of Support)*				
GP		**Telephone**		
		Email		
Level of GP involvement	**Children's services**	☐ GP led	☐ Shared Care	☐ Speciality led
	Adult services	☐ GP led	☐ Shared Care	☐ Speciality led
Circle of support commenced (date)				
Children's services				
Lead Consultant		**Telephone**		
		Email		
Keyworker		**Telephone**		
		Email		
Other key professionals		**Telephone**		
		Email		
		Telephone		
		Email		
Adult services *(See Transition Map for more information on usual target adult services)*				
Lead Consultant		**Telephone**		
		Email		
Keyworker		**Telephone**		
		Email		
Other key professionals		**Telephone**		
		Email		
		Telephone		
		Email		
Transition plan supporting information				
☐ **Consent for sharing healthcare record with adult professionals**		**Date**		
Special Transition Register	**From (date)**	**Review date(s)**		
	To (date)			
Education Health and Care Plan (EHCP)		**Date**		☐ Not applicable
Advance Care Plan (ACP)		**Date**		☐ Not applicable
Health Information Passport (HIP)		**Date**		☐ Not applicable
Other Care plan (specify)				

Transition 10 Steps to Adult Services: Transition Plan

Update at each clinic visit. Scan/ upload/file in medical record, copy to young person. Master copy held by Lead Specialty team

Young person's details					
Name	**Date of birth**				
Mark topics discussed – add detail overleaf **Transition progress review (T)**	**Parents leading** *Detail overleaf*	**Planning transition (1 – 4)**	**Starting out (5&6)**	**Moving on (7&8)**	**Settling in (9&10)**
1. Understands concept of transition	☐	☐	☐	☐	☐
2. Review multidisciplinary team	☐	☐	☐	☐	☐
3. Review Education Health and Care Plan	☐	☐	☐	☐	☐
4. Review Advance Care Plan	☐	☐	☐	☐	☐
5. Review Health Information Passport	☐	☐	☐	☐	☐
Long term condition management (L)					
1. Describes condition, effects and prognosis	☐	☐	☐	☐	☐
2. Understands medication/treatment purpose &	☐	☐	☐	☐	☐
3. Takes some/complete responsibility for medication/other treatment e.g. physiotherapy	☐	☐	☐	☐	☐
4. Uses self-management plan	☐	☐	☐	☐	☐
5. Orders repeat prescriptions	☐	☐	☐	☐	☐
6. Knows how to make/alter appointments	☐	☐	☐	☐	☐
Self advocacy (S)					
1. Part/whole clinic appointment on their own	☐	☐	☐	☐	☐
2. Sees GP independently	☐	☐	☐	☐	☐
3. Understanding of confidentiality	☐	☐	☐	☐	☐
4. Understands their role in shared decision-making with the healthcare team e.g. Ask 3 Questions*	☐	☐	☐	☐	☐
5. Role of Advocate/ concept of Best Interests	☐	☐	☐	☐	☐
Moving into adulthood					
Health and lifestyle (H)					
1. Understands importance of diet/exercise/dental care	☐	☐	☐	☐	☐
2. Understands impact of smoking/alcohol/substance	☐	☐	☐	☐	☐
3. Understands how their condition can affect how they feel and function e.g. sexual function, fertility,	☐	☐	☐	☐	☐
4. Understands sexual health issues/ pregnancy/sexually transmitted infections/ parenting	☐	☐	☐	☐	☐
Activities of daily living (A)					
1. Self care/meal preparation	☐	☐	☐	☐	☐
2. Independent travel/mobility	☐	☐	☐	☐	☐
3. Trips/overnight stays away from home	☐	☐	☐	☐	☐
4. Benefits	☐	☐	☐	☐	☐
Vocational (V)					
1. Current education/work, impact of condition on	☐	☐	☐	☐	☐
2. College/university/work attendance and	☐	☐	☐	☐	☐
3. Work/volunteering experience, careers advice	☐	☐	☐	☐	☐
4. Outside activities and interests	☐	☐	☐	☐	☐
5. Disclosure to college/university/employer	☐	☐	☐	☐	☐
Psychosocial (P)					
1. Self esteem/self confidence	☐	☐	☐	☐	☐
2. Body/self image	☐	☐	☐	☐	☐
3. Peer relationships	☐	☐	☐	☐	☐
4. Support networks/family/disclosure to friends	☐	☐	☐	☐	☐
5. Coping strategies	☐	☐	☐	☐	☐
Co-ordination and continuity of care (C)					
1. Knows key team members and their roles	☐	☐	☐	☐	☐
2. Uses Health Information Passport and/or ACP	☐	☐	☐	☐	☐
3. Knows where to get help	☐	☐	☐	☐	☐
4. Accesses urgent care including A&E and ward visit	☐	☐	☐	☐	☐
5. Understands role of Lead Consultant	☐	☐	☐	☐	☐
6. Understands changing role of GP	☐	☐	☐	☐	☐
7. Understands role of Keyworker	☐	☐	☐	☐	☐
Planning transition (1-	**Signature**		**Date**		
Starting out (5&6)	**Signature**		**Date**		
Moving on (7&8)	**Signature**		**Date**		
Settling in (9&10)	**Signature**		**Date**		

Transition 10 Steps to Adult Services: Transition Plan

Update at each clinic visit. Scan/ upload/file in medical record, copy to young person. Master copy held by Lead Specialty team

Young person's details			
Name		**Date of birth**	
Transition discussion notes *(e.g. goals, exceptions, discussion points, signposting & to whom)*			
Section	**Notes**	**Date**	**Initial**
Resources (please specify)		**Date**	**Initial**
Offer copy of clinic letters			
Multidisciplinary Transition Planning meeting			

Route into Urgent Care

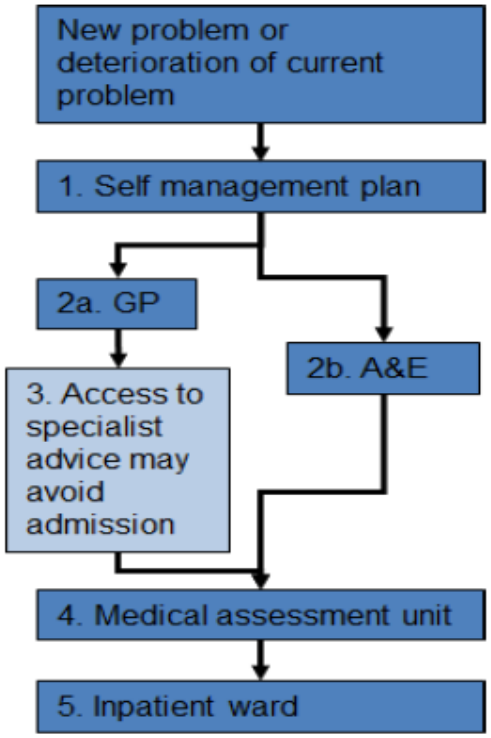
to adult services for young people with long term conditions

Step 7: planning your route into urgent care

Name: **DoB:**

Unit Number: **NHS No:**

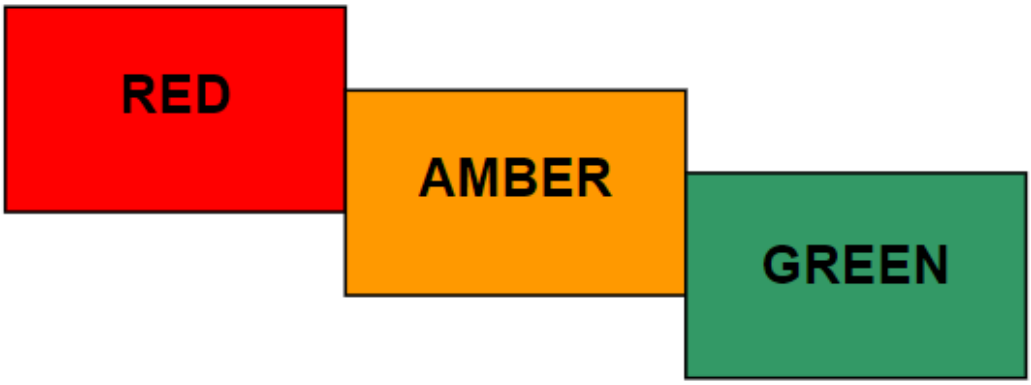
www.10stepstransition.org.uk



Stage	Where will this happen?	Who will be involved?	What knowledge and skills will be needed?	How can we ensure the right information and support is available?
1				
2a				
2b				
3				
4				
5				

The Patient Passport

“The Patient Passport”



This gives hospital staff important information about you.

Please take it with you if you have to go into hospital.

Ask the hospital staff to hang it on the end of your bed.

Make sure that all the staff who look after you read it.

Note for Hospital Staff - Please remember the 5 main points in the Mental Capacity Act (2005)

This Patient Passport has been adapted by the Health Access Team, South Staffordshire & Shropshire Healthcare NHS Foundation Trust from the original work "Traffic Light Assessment" - Gloucester Partnership NHS Trust and taken from *'Working Together: Easy steps to improving how people with a learning disability are supported when in hospital - Guidance for Hospitals, Families and Paid Support Staff;* Pho-to Symbols and the National NHS Patient Passport.
Updated August 2014

RED - ALERT

Things you MUST know about me

Name: **Male** ☐ **Female** ☐ **Organ Donor** ☐

Prefers to be called: **Do you need an interpreter? Yes** ☐ **No** ☐

NHS No:

Address: **Tel No:**

Date of Birth:

Doctor: **Address:** **Tel No:**

Next of Kin: **Relationship:** **Tel No:**

Relevant Person/Carer: **Tel No:**

Other Professional/Advocate: **Tel No:**

Religion: **Religious preferences:**

Is there anyone you would like hospital staff to talk to about your treatment? Yes ☐ **No** ☐

Is there anyone you would like to help you with your care whilst you are in hospital?
(e.g. carer, parents — add names here) **Yes** ☐ **No** ☐

MEDICAL HISTORY
Have you got problems with any of the below:

Blood Pressure	☐	**Swallowing**	☐	**Mobility/Falls**	☐
Diabetes	☐	**Epilepsy**	☐	**Dementia**	☐
Heart	☐	**Skin Integrity**	☐	**Thyroid**	☐
Breathing	☐	**Anxiety** (behaviour)	☐	Other:	
Bladder/Bowels	☐	**Hearing**	☐	Please list:	
Allergies	☐	**Vision**	☐		

If any of the above ticked please give details:

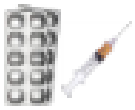
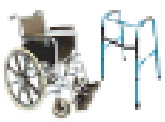
Current Medication:
(Please bring along your MARS Sheet if possible)

Brief medical history:

AMBER – ALERT

This is a signpost to further information

Things that are really important to me

Communication How to communicate with me and how I communicate with you. 		**Taking medication** Crushed tablets, injections, syrup; how to take my blood. 	
Information Sharing How to help me understand things. 		**Pain** How you know I am in pain 	
Seeing/Hearing Problems with sight or hearing 		**Sleeping** Sleep pattern, sleep routine. 	
Eating/Drinking (Swallowing) Food cut up, small amounts, choking, help with feeding, PEG Management plan, feeding aids. 		**Being safe** Bedrails, posture, supporting behaviour, absconding. 	
Going to the toilet Continence aids, help to get to the toilet, assistance, bowel frequency 		**Personal Care** dressing, washing etc 	
Moving around Posture in bed, hoists/slings, walking aids. 		**Level of support** Who needs to stay and how often. 	

Completed by:…… Date:……

AMBER – ALERT

This is a signpost to further information

Things that are really important to me

	Further Plans in place
My **Preferred Priorities for Care** should my physical health get worse. How and where I would like to be looked after:-	☐
I have a **Lasting Power of Attorney** (LPA) - **Yes** ☐ **No** ☐ My **Lasting Power of Attorney relates to** *(please tick one)*:- **Health Welfare and Treatment** ☐ **Finances** ☐ **Both of these** ☐	☐
I have an **Advance Decision** *(please tick one)* **Yes** ☐ **No** ☐	☐

GREEN

LIKES / DISLIKES

Things that will make a difference to me during my stay in hospital

 **THINGS I LIKE**	 **THINGS I DON'T LIKE**
Think about – what upsets you, what makes you happy, things you like to do i.e. watching TV, reading, music. How you want people to talk to you (don't shout). Food likes, dislikes, physical touch/restraint, special needs, routines, things that keep you safe.	

Completed by:…… Date:……

Ask 3 Questions

NHS

Ask 3 Questions

There may be choices to make about your healthcare.
Make sure you get the answers to these three questions:*

What are my choices?

What is good and bad about each choice?

How do I get support to help me make a decision that is right for me?

? ? ? 3

Your healthcare team needs you to tell them what is important to you.

It's all about shared decision making.

AQuA Advancing Quality Alliance

Right Care Shared Decision Making Programme

*Ask 3 Questions has been adapted with kind permission from the MAGIC programme, supported by the Health Foundation

Ask 3 Questions is based on Shepherd HL, et al. Three questions that patients can ask to improve the quality of information physicians give about treatment options: A cross-over trial. Patient Education and Counselling, 2011;84: 379-85

Other questions I would like to ask during my appointment:

1 .....

2 .....

3 .....

4 .....

5 .....

Remember, you can bring someone else with you to your appointment, such as a relative, carer or friend.

E-Learning Training Resources

Adolescent Health Programme

The Adolescent Health Programme (AHP) is an e-learning programme for all healthcare professionals working with young people. It is the third programme in the Healthy Child Programme 0-18 series of e-learning resources, following the http://www.e-lfh.org.uk/programmes/healthy-child-programme/ and http://www.e-lfh.org.uk/programmes/healthy-school-child/

https://www.e-lfh.org.uk/programmes/adolescent-health/

Disability Matters programme

Disability Matters is developed by disabled young people, parent/carers and other experts. This E-learning is by bite-sized learning package matching the needs of different individuals offering practical advice about supporting disabled children, young people and their families to achieve the outcomes that matter to them.

https://www.disabilitymatters.org.uk/Catalogue/TileView

Making healthcare work for young people

This toolkit gives practical suggestions about how healthcare can be tailored to young people's needs as they develop and change through adolescence into young adulthood – such care is termed 'Developmentally Appropriate Healthcare' – or DAH.

The toolkit is designed to support everyone 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.

https://www.northumbria.nhs.uk/quality-and-safety/clinical-trials/for-healthcare-professionals/

Me First

The Me first communication model has been developed in partnership with children, young people and healthcare professionals. It highlights the key steps to guide shared decision making and encourage CYP-centred communication.

https://www.mefirst.org.uk/the-model/

Queens Nursing Institute Transition of Care Programme

The transition of Care Programme' is for community nurses, to help them understand the issues that young people (and their families) face. The resource aims to improve practice in this key area and improve the experience of young patients.

https://www.qni.org.uk/nursing-in-the-community/from-child-to-adult/

RCPCH

The Royal College of Paediatrics and Child Health bring together best practice examples, resources and experiences of young people.

https://www.rcpch.ac.uk/resources/transition-adult-services