The 10 Stages of Transition

DAH Transition for people with complex needs is a needs led approach to support people who are open to 2 or more healthcare services (or who have been open to 2 or more services) and who may have other additional education or social care needs and who may have emotional and mental health needs that are obscured by their complex health needs.

Overall principles:
Encourage young people to develop self-care skills
Meet the adult team before the transfer
Appropriate parent involvement

Step 1 **Identify YP who may have additional complexity needing transition* to adult healthcare services**

- Consider the long-term health needs of CYP aged 14 years plus in all your clinics.
- Identify YP who require regular follow up with multiple specialists; have no adult speciality equivalent to key paediatric speciality; are under both physical and mental health teams; have a moderate to severe learning disability as well as long term health condition; have complex care needs (including care leavers); or where clinicians identify another concern
- Identify YP who may need frequent intensive care or intervention (including paediatric critical care)
- If identified as long-term health need discuss the transition process with CYP and their carers.
- Identify and document any safeguarding/child protection plans and any needs around care experienced young people.
- Signpost to generic trust information and disease-specific information on transition and where appropriate link to semi-generic resources for people with learning disability/mental health/life-limiting conditions.
- Discuss who will be the key worker.
- Identify local transition team where this exists and clarify the provisions of the existing teams to support each patient
- Refer to the transition team if complex neuro disability and physical health needs require MDT transition.
- Highlight transition in all clinic letters and review progress at each clinic visit.
- Ensure healthcare transition is included in Education Health and Care Plan
- Inform the young person and parents about the change in roles and decision making after 16/18 with Mental Capacity Act, with particular reference if the young person's mental capacity may need to be assessed
- Discuss consent and confidentiality at each appointment
- Signpost to Healthier Together resources regarding capacity and consent and links to relevant information and guidance.
- Involve GP/Primary Care Team early on, encourage GP visits for minor ailments, prescriptions and encourage uptake of Annual Health Checks.
- Request that GP practice ensures that the young person continues to have a named GP as they move to adult care
- Identify the parents/carers and initiate carer review/needs assessment, consider the establishment of a local carers passport scheme or encourage that they seek out local authority carers assessment

- *Trusts to set up flags on electronic noting systems.*
- *All CYP aged 14 years to identify whether they need a transition or not.*
- *Flag on CYP notes identified as needing transition from 14-25 years to highlight transition patient with a long-term condition.*

* It is acknowledged that the phrase Transition is used in many different forums with different meanings, for the purposes of this document and guidance transition refers to the move from paediatric healthcare services to adults healthcare services.

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