Great Ormond Street Hospital for Children NHS Trust

Name: **DOB:** **NHS Number:** **Hosp. No:**	(Affix patient label)	**Lead Consultant** **Speciality** **Transition Coordinator**	

Transition to Adult Health Services Integrated Care Pathway

Inclusion criteria

- All young people aged 12 years and over. For use over the period prior to their transfer to adolescent or adult health services.

Instructions for using this ICP

- Appropriate ages for interventions have been suggested, although actual timing will depend upon individual need and the clinical judgement of staff involved.
- The ICP incorporates the details and information required for this patient journey with specific activities and variance tracking, comparing planned and actual care.
- For use by the individual young person's designated transition co-ordinator and identified transition key workers. Other members of the care team may refer to the pathway as a guide to the young person's progress through the transition process.
- When activities are started the practitioner should initial and date the 'Activity started' box.
- When activities are completed the practitioner should initial and date the 'Activity completed' box.
- In the event of variance from the plan or if an activity is not met the practitioner should initial the 'Activity not completed' box, enter the date and complete the variance tracking at the foot of the page.
- If an activity is not applicable, record N/A in the 'Activity not completed' column

Important

- Professionals making an entry in this record must complete the signature sheet on page 2 and thereafter use initials when making an entry.
- In using this ICP the practitioner should refer to trust policies, clinical practice and procedure guidelines and protocols, which provide evidence and support the activities contained herein.
- The integrated care pathway forms part of the legal record of care received so must be completed fully.

For further information or assistance regarding this document or any other aspect of the transition process please contact the Adolescent Medicine Team Ext 5582 / 8541

Signature Sheet

Name	Designation	Signature	Initials	Date

Abbreviations

Abbreviation	Term in full
GOSH	Great Ormond Street Hospital
CNS	Clinical Nurse Specialist
MDT	Multi-disciplinary Team
GP	General Practitioner
DOH	Department of Health
ICP	Integrated Care Pathway

Contacts Page
(Including telephone and bleep numbers)

GOSH

Lead Consultant	Transition Co-ordinator / CNS
Other GOSH Consultant	Transition Co-ordinator / CNS
Other GOSH Consultant	Transition Co-ordinator / CNS
Other GOSH Consultant	Transition Co-ordinator / CNS

MDT

Dietician	Psychologist
Occupational Therapist	Social Worker
Physiotherapist	Other Speciality Teams
Play Specialist	Other GOSH Staff
GP	Shared Care Hospital / Paediatrician / Ward
School / College / Connexions advisor	Other

ADULT SERVICES

Consultant	Transition Co-ordinator / CNS
Consultant	Transition Co-ordinator / CNS
Consultant	Transition Co-ordinator / CNS
Consultant	Transition Co-ordinator / CNS

Early Stage Transition (suggested age 12-14)

ID	Activity	Activity started	Activity completed	Activity not completed
1	Discuss transition process with young person & family and provide GOSH Transition Leaflet			
2	Discuss differences between paediatric and adult services			
3	Discuss skills required for young person to function in adult health services			
4	Discuss health summary and treatment plan with young person & family			
5	Discuss adolescent development / puberty with young person & family			
6	Offer young person chance to have part / all of consultations without carer present			
7	Confidentiality explained to young person and family			
8	Offer young person option of receiving own copy of clinic letters			
9	Explain young person's right to consent and give copy of DoH Guide to Consent for Young People			
10	Discuss psycho-social & peer support for young person & family			
11	Inform relevant staff that transition plan has been started (see contact sheet, page 3)			
12	Identify any activities to be carried forward			

Activities not completed, or requiring further input or practice should be identified and carried over to Middle Stage Transition (Pages 6 / 7)

Variance Tracking

ID		Date

Any additional notes, evaluations and comments should be recorded on page 12. If necessary continue on a separate sheet attaching a patient sticker patient and numbering the pages accordingly.

Transition Plan (1)

Potential / identified differences between paediatric and adult service care delivery:

Summary of young person's preparation needs / goals:

Summary of family's preparation needs / goals:

Outline of supportive / educational interventions:

Agreed review dates:

Signature: Date:

Middle Stage Transition (suggested age 14-15)

ID	Activity	Activity started	Activity completed	Not completed
20	Ensure young person is booked into transition clinic at GOSH (if available)			
21	Encourage young person to be routinely seen in appointments without their carers for some of the time			
22	Assess progress with skills required to function in the adult service / transition skills checklist (page 10)			
23	Provide details of charities or support groups that will be available to young person during and after transition			
24	If appropriate arrange meetings with agencies to discuss any life expectancy issues / implications for adult lifestyle & choices (including Genetic counselling)			
25	Ensure young person knows where to obtain advice on sexual health, educational & vocational planning, general health & lifestyle (highlighting any specific effects of their illness or medications)			
26	Continue discussion & document evaluation of transition process so far, identifying goals and plan supportive interventions. Agree any additional education / support / key workers and next review date. Record on page 7.			
27	Encourage young person to receive own copies of clinic letters			
29	Identify any of the above activities to be carried forward			

Activities not completed or requiring further input or practice should be identified and carried over to Late Stage Transition (Pages 8 / 9)

Variance Tracking

ID		Date

Any additional notes, evaluations and comments should be recorded on page 12. If necessary continue on a separate sheet attaching a patient sticker and numbering the pages accordingly.

Transition Plan (2)

Identified Charity / support / information groups:

Young Person's evaluation of transition process to date:

Family's evaluation of transition process to date:

Additional education / support / key-workers required to progress to late stage:

Agreed review dates:

Signature: Date:

Late Stage Transition (suggested age 16-18)

ID	Activity	Activity started	Activity completed	Activity not completed
30	Ensure young person is routinely seen without their carers for most of the time during consultations, maintaining family involvement as appropriate			
31	Ensure young person demonstrates the skills required to function in the adult service /completed transition skills checklist (page 10)			
32	Discuss & confirm a transfer date, taking into account any events that may affect the timing (e.g. surgery, school /college exams)			
33	Identify remaining issues and agree supportive measures for before transfer takes place			
34	Ensure young person has contact details for adult service, including appointments office			
35	Ensure young person knows how to travel to adult service			
36	Discuss information that will be included in transfer summary with young person & family & complete Transition Plan 3 (page 9)			
37	Agree supportive interventions to be taken over by transition key worker in adult service.			
38	Transfer the young person to the adult service & handover to their transition key worker.			
39	Ensure young person has date of first appointment in adult service			
40	Inform relevant staff of transfer (See contact sheet – page 3)			
41	Final GOSH appointment (debrief)			
42	Discuss & document an evaluation of the transition process with young person & family			
43	Agree follow up evaluation date (if applicable)			

IF ACTIVITIES HAVE NOT BEEN ACHIEVED, WHAT ADDITIONAL SUPPORT IS REQUIRED FOR THEM TO BE ACHIEVED?

Variance Tracking

ID		Date

Any additional notes, evaluations and comments should be recorded on page 12. If necessary continue on a separate sheet attaching a patient sticker and numbering the pages accordingly.

Transition Plan (3)

Dates of informal visits to adult service:

Young person's thoughts / concerns about moving to the adult service:

Family's thoughts / concerns about moving to the adult service:

Summary / List of information to be forwarded to the adult service:

Date of first appointment in adult service (after transition)

TO BE COMPLETED WITH THE YOUNG PERSON

Things that I would like staff at the adult service to know about me:

Things that I would like staff from the adult service to support me with while I settle into the new service:

Signature: Date:

Transition Skills Checklist

	N/A	Unable to perform	Performs with help	Performs independently
Can describe health problem and implications on daily life				
Can describe previous and current treatments				
Can describe future health and treatment expectations				
Can describe current health, including recent changes and / or symptoms and identifies any allergies and / or special requirements				
Can describe how smoking, alcohol and drugs affect their health, illness and medicines				
Knows how to obtain information, support and advice about their health (including genetic / fertility counselling if appropriate)				
Can describe potential effect of their illness or disability on education and career plans and where to access careers advice				
Knows how to obtain assistance with finances, insurance, mobility aids and personal care support				
Keeps own record of contact details for health professionals involved in their care				
Knows who to contact in an emergency and / or how to get emergency treatment				
Is responsible for / participates in own treatment or therapies				
Keeps own calendar of medical appointments				
Knows how to travel to adult clinic or how to arrange travel				
Can list (or keeps a record of) medications and their purpose				
Is responsible for taking medicines as prescribed				
Knows when and how to order medicines				
Knows the potential effects of their illness or disability on fertility, family planning and physical sexual ability				
If applicable takes care of her own menstrual needs and keeps track of her monthly periods				
Knows which forms of contraception are effective / safe to use with their medicine regime, and how to obtain supplies				
Knows how to deal with questions or comments about their health condition				

COMPLETED CHECKLIST SHOULD BE COPIED AND COPY SENT TO ADULT SERVICE WITH ANY ADDITIONAL NOTES

Adapted with permission from Royal Children's Hospital (Melbourne) transition project

Suggested feedback arrangements

ID	Activity	Met	Not met	Date
100	Document feedback from the Consultant, CNS and other involved professionals at the adult service regarding the young person's attendance, adjustment to the new service and clinical progress			
101	Document feedback from the young person regarding their progress in the adult service and their views on overall transition process			
102	Document feedback from the family regarding the young person's progress in the adult service and their views on the overall transition process			

Follow up comments / feedback

Variance Tracking

ID		Date

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Date	Additional Notes / Evaluation	Signature