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Welsh Government

Welsh Government Consultation Document

Transition and Handover guidance

Welsh Government guidance on the management and accountability of Transition and Handover processes in Healthcare Services, for children and young people as they grow older and move from using children's to adults' services.

Date of issue: 27 Jan 2020

Action required: Responses by 20 April 2020

Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
This document is also available in Welsh.

Overview This consultation seeks your views on the draft Welsh Government guidance on the management and accountability of Transition and Handover processes in Healthcare Services, for children and young people as they grow older and move from using children's to adults' services

How to respond This consultation will close on 20 April 2020. You may respond online, by email or by post.

Online

Please complete the online questionnaire on the consultation pages of the Welsh Government website:

Email

Please complete the consultation response form and send it to: ChildrensHealth@gov.wales

Post

Please complete the consultation response form and send it to:

Children's Health
Welsh Government
Cathays Park
CF10 3NQ

Further information and related documents **Large print, Braille and alternative language versions of this document are available on request.**

Contact details For further information:

Children's Health
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The Welsh Government will be data controller for any personal data you provide as part of your response to the consultation. Welsh Ministers have statutory powers they will rely on to process this personal data which will enable them to make informed decisions about how they exercise their public functions. Any response you send us will be seen in full by Welsh Government staff dealing with the issues which this consultation is about or planning future consultations. Where the Welsh Government undertakes further analysis of consultation responses then this work may be commissioned to be carried out by an accredited third party (e.g. a research organisation or a consultancy company). Any such work will only be undertaken under contract. Welsh Government's standard terms and conditions for such contracts set out strict requirements for the processing and safekeeping of personal data.

In order to show that the consultation was carried out properly, the Welsh Government intends to publish a summary of the responses to this document. We may also publish responses in full. Normally, the name and address (or part of the address) of the person or organisation who sent the response are published with the response. If you do not want your name or address published, please tell us this in writing when you send your response. We will then redact them before publishing.

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Welsh Government
Cathays Park
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The contact details for the Information Commissioner's Office are:

Wycliffe House
Water Lane
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Tel: 01625 545 745 or
0303 123 1113

Website: <https://ico.org.uk/>

Introduction

This consultation seeks your views on the draft Welsh Government guidance on the management and accountability of Transition and Handover processes in Healthcare Services, for children and young people as they grow older and move from using children's to adults' services.

Background

There is a real need to ensure that the child or young person's move from children's to adults' services is as well coordinated as possible and that service users have a say in the process. This Welsh Government guidance will make this process more transparent and easy to navigate.

Rather than take a strict age bound approach, the system must respond to the child or young person's individual needs. A child's experience of growing older into adulthood is a process, not an event, and may span a wide age range.

The focus of this Guidance is on what health services need to do to ensure that a well-structured, effective process is in place to meet the integrated healthcare needs of children, young people and young adults, promote quality and safety, access, autonomy and efficient care for better health outcomes.

**Welsh Government guidance on the management, handover and accountability of
Healthcare Services
for children and young people during their transition from children's to adults'
services -
'Transition and Handover guidance'**

1. Introduction

- 1.1 The provision of appropriate healthcare for children and young people to age 25, and handover of care and accountability from children's to adult services has been highlighted as a key priority for improvement. This was flagged by the National Assembly for Wales Children, Young People and Education Committee in its 2014¹ report on Child and Adolescent Mental Health, and by the Children's Commissioner for Wales in recent years², calling for good quality 'transitional care' for this group of the population, from all health services.
- 1.2 The 2016 NICE guidance³ on transition should be used by all health services. Health Boards and Trusts should take into account the recommendations within the NICE guideline and associated quality standard⁴ to help young people and their carers have a better experience of transition and handover by improving the way it's planned and carried out.
- 1.3 This guidance aims to support consistent implementation of the NICE guidance throughout Wales. It provides direction and a standard template for Welsh health boards and trusts to develop consistent local guidance. These guidance documents should be underpinned by robust processes, procedures, administrative and governance arrangements to which organisations are expected to adhere to ensure that there is no interruption in healthcare or gaps in service provision.
- 1.4 The underlying principles are those of prudent, integrated, high quality, person centred care, where, regardless of age, disability, or any protected characteristics, every individual can access a suitable service, offering the correct skills and expertise, complying with expected NHS Wales Health Care Standards. This guidance is underpinned by a human rights approach, including the UN Convention for the Rights of the Child. The strategic and legislative framework is set out in Appendix 1.

¹<http://www.assembly.wales/laid%20documents/cr-ld10016%20-%20report%20by%20the%20children,%20young%20people%20and%20education%20committee%20-%20inquiry%20into%20child%20and%20adolescent%20mental%20health/cr-ld10016-e.pdf>

² <https://www.childcomwales.org.uk/wp-content/uploads/2019/10/Annual-Report-2018-19.pdf>

³ <https://www.nice.org.uk/guidance/ng43>

⁴ <https://www.nice.org.uk/guidance/QS140>

1.5 Rather than take a strict age bound approach, the system must respond to the child or young person's individual needs. A child's experience of 'growing up' into adulthood is a process, not an event, and may span a wide age range. The 16 year old automatically becomes able to consent to healthcare for themselves, and the 18 year old becomes an adult in all legal respects, but the under 16 year old may be 'Gillick competent' and able to give valid consent in a range of circumstances.

1.6 The Social Services and Well-being (Wales) Act 2014 provides a legal framework placing a safeguarding duty on healthcare staff for any age of patient or client. Guidance and procedures for child or adult safeguarding must be applied appropriately, which includes taking account of the all Wales protection procedures⁵. Staff must be equipped with training and skills to serve this age group safely and effectively.

1.7 Health Boards have the duty to provide healthcare to meet the needs of their population, whether they provide them within their own borders, or commission them from other Health Boards or Trusts, within or outside Wales, to achieve equivalent standards of care.

2 Consent and mental capacity for handover of care

2.1 Young people aged 16 can give their consent to health care. At 16 they must be engaged directly in decisions about their health care, and especially involved in the decision about which service they should enter, if there is a choice of children or adult services.

2.2 Children under the age of 16 can give their own consent to receive or decline health care, even in opposition to the views of their parent, if they can be demonstrated to be Gillick competent. Any assessment of Gillick competence should be documented in the health care record⁶.

2.3 The Mental Capacity Act (MCA) applies in most respects to young people from the age of 16. Any young person who is felt to be lacking capacity to make a specific decision once they are aged 16 should be assessed under the MCA to determine their best interests and the appropriate course of action. Where care and treatment arrangements amount to a deprivation of liberty of the young person, the relevant Deprivation of Liberty Standards or Liberty Protection Standards (DOLS/LPS) or other procedures should be followed to lawfully safeguard their wellbeing whilst giving due regard to their human rights.

2.4 Transition and Handover of care should avoid making the young person feel that they are being pushed into unfamiliar services with no support. Continuity of care should be offered during a period of transition and handover, as required for the individual to build relationships with the clinicians who will continue their care.

⁵ <http://www.childreninwales.org.uk/policy-document/wales-child-protection-procedures-2008/>

⁶ <http://www.wales.nhs.uk/governance-emanual/page/65162>

2.5 Services must ensure the collection of appropriate data and service user feedback on transition and handover arrangements and documentation for consent and mental capacity assessments, including Gillick competence, in order to assure these services.

3 Implementation Principles

3.1 Health Boards will be expected to identify a named Transition and Handover lead (Assistant Medical Director, Nurse Director or Director of Therapies) with accountability for ensuring implementation and quality of the transition and handover guidance across all primary, secondary, and tertiary healthcare services. In addition, the named Transition and Handover lead will be responsible for liaising with other statutory agencies to ensure that mechanisms are in place so that young people and their families with complex needs receive a co-ordinated transition experience.

3.2 Health boards should ensure that feedback from the young person is captured so that the voice of the young person is heard and at the centre of care. There should be a continuity of care across all services.

3.3 Health boards and trusts should use the 5 principles of the children's rights approach as laid out by the Children's Commissioner when implementing this guidance:

1. Embedding rights:

Ensure that policies link to appropriate children's rights and other human rights such as the United Nations Convention on the Rights of Persons with Disabilities. This ensures that young people receive the message that they are entitled to these services as they have the right to healthcare, to be listened to, to be supported to achieve their potential etc., this avoiding a deficit approach.

2. Equality and discrimination:

Health boards/trusts should examine carefully which groups of children may face more barriers to accessing services than others and put in measures to mitigate this. They should also consider whether children are discriminated against as a whole, e.g. by not having a clear pathway for young people aged 16 or 17 who require secondary care for the first time, or who present for emergency care.

3. Empowerment:

Children should be informed using accessible methods about their rights concerning transition and handover of care. They should have access to an advocate where needed.

4. Participation:

Children and young people should be able to actively take part in decisions about their own care, as discussed throughout this guidance. Health boards and trusts should also involve groups of young people to advise on arrangements to implement this guidance using the Wales Participation Standards.

5. Accountability:

Health boards/Trusts should ensure that there are adequate arrangements for responding to any complaints made about transition and handover services by young people. They should also make transparent to young people in their locality their progress in implementing transition and handover arrangements and where they have consulted with young people, they should make clear how their views have been used to develop services.

In developing local transition and handover arrangements, health boards should apply the following principles to the individual – in every case considering the child, young person or young adult, and their family or carers, subject to the competent individuals' wishes. (see Box 1)

Box 1: Principles underpinning individual care delivery for transition and handover between child and adult services

(in every case considering the child, young person or young adult, and their family or carers, subject to the competent individuals' wishes)

1. Ensure the needs and wishes of the individual are at the heart of service delivery, with safe, responsive care and well-planned handover.
2. Promote early and easy access to care and support, particularly for those in crisis, or with disability or disadvantage.
3. Work in partnership with statutory services such as social care, education, criminal justice and voluntary agencies wherever cooperation is required to meet needs.
4. Ensure access to information and choices about giving valid consent, and Putting Things Right, including advocacy support if needed to make a complaint or representation. Health boards should ensure that the voice of the young person is heard and at the centre of care.
5. Have strong planning, monitoring and governance structures to offer assurance through reporting arrangements, ensuring feedback that captures the voice and views of the individual in a suitable format.

These principles support children and young people's rights under the UNCRC to take part in decisions that affect them (article 12), receive good quality information (article 13), to be protected from harm (article 19), receive extra support if they are disabled (article 23), receive good quality health care (article 24), and for adults to act in the best interests of the child (article 3).

4 Before the Transition and Handover of Care:

Identifying the appropriate age to start planning for transition and handover of care from child to adult services

- 4.1 Good transition and handover of health care should be a shared, co-produced process between service users and professionals, their family and any other relevant statutory services such as Social Services or Education.
- 4.2 When the young person is aged 13 to 14, the Health Board should identify their healthcare needs and wishes for support to plan the period of transition and handover of care from children's to adult services. An active decision about the appropriate future healthcare service should be made in partnership with the young person and their family at an early stage.
- 4.3 No young person should be denied access to an appropriate, safe, quality service on the grounds of age.
- 4.4 Planning for transition and handover should be tailored to the needs and wishes of the young person, rather than be based on an arbitrary age. Specific services will have different age thresholds driven often by legal frameworks. As a consequence, it may be necessary to reconcile these by agreement for an individual requiring multiple services.
- 4.5 There should be a period of joint working between services up to and after the period of transition and handover, emphasising continuity of care and clear clinical accountability.
- 4.6 Services should have a clear decision making approach to manage an individual's request to transfer to an adult service. Reasons must be given if a request is declined.
- 4.7 Young women who may become pregnant must be offered a plan at an appropriate stage clarifying advice on contraception, pre-pregnancy care, and how any long term condition and maternity/obstetric care will be integrated.

Young Person entering the healthcare system for the first time at 16 or 17

- 4.8 A young person being referred into any specialist secondary service or therapy (such as gastroenterology, cardiology, chronic pain, orthopaedics) for the first time at age 16 or 17 may be cared for by paediatric or adult specialists, or a combination of both, depending on local arrangements.
- 4.9 There should be a clear pathway for 16 or 17 year olds for both acute and emergency admissions so that no young person of this age experience delay or confusion surrounding their care, this includes the consideration on appropriate location. The young person must not be denied access to an appropriate, timely service because of their age and must not be disadvantaged by moving from a children's waiting list to the adult waiting list.

4.10 The professional making the referral will retain clinical responsibility in line with local guidance of accountability until the arrangements for transition and handover of care are formally agreed, ensuring that the young person is kept fully aware of which clinician has responsibility for their care.

4.11 Children and adult teams should work together to achieve continuity and the best services for the young person. If any clinician feels they are practicing outside their competence due to the age of the patient, they must escalate the matter through their scheme of clinical accountability.

Self- management

4.12 Support should be offered for the young person to self-manage their condition(s), along with their family as appropriate. Promoting empowerment, autonomy and skills can support the individual to understand and manage their condition, and provide the foundation for a successful move into adult services.

Named worker

4.13 If considered necessary, a named worker should be identified that will work with the young person and their family to help coordinate services.

4.14 The named worker could be, depending on the young person's needs:

- A nurse
- An allied health professional
- The named GP
- A health advocate

4.15 The named worker will support the young person in the coordination of healthcare plans and services during the period of transition and handover of clinical accountability for care. The named worker will have a role in coordinating a summary of all health needs, especially where there are complex health needs.

4.16 The named worker will promote and advocate the wishes and views of the young person to ensure appropriate access for them and their family to all necessary healthcare services and wider services as appropriate. They will support the young person to feed back on their experience.

4.17 Where other agencies are involved, a 'key' worker should be identified from either the local authority or health board to liaise across agencies.

Transition and handover planning

- 4.18 A Transition and Handover Plan (THP) will be co-produced with the young person, their parents or carers and professionals (with support of the named worker as appropriate) for the transition and handover of care period using resources such as '*Ready Steady Go*'⁷. The THP will be held as a 'Passport' by the young person and include information about what is important to them, the care and treatment required and the timeline and expected health and wellbeing outcomes. The young person should be given information on their condition and the care plan in a form that they can understand.
- 4.19 Healthcare professionals should involve the young person and their representatives and be responsive to their wishes feelings and needs in planning and delivering transitional care to adult services.
- 4.20 The THP should be linked or integrated with other care plans (e.g. IDP, Continuing Care Plan, CTP, Care and Support plan). The THP should be reviewed and updated at appropriate intervals.
- 4.21 Young people with long term conditions commencing during childhood, must be offered choices about handover of care at a point determined by their overall needs, including any national condition specific guidance (for example for diabetes, asthma, epilepsy, mental health, cerebral palsy, Duchenne muscular dystrophy, traumatic brain injury).
- 4.22 The young person should not have to repeat their story unnecessarily. They should be encouraged to contribute in developing their own healthcare information for their THP and 'Passport' to help smooth the process of transition and handover of care. An example is at Appendix 3.
- 4.23 Information should be readily available and in an accessible format for the young person and their family prompting their engagement, explaining the process, their rights and what they can expect when their care is transferred from children to adult services. In each case a plan for handover of the young person's care between services to another must be written and shared.
- 4.24 The Transition and Handover Plan should be supported by common IT systems in order for information to be shared via secure online platforms, with appropriate consents to ensure that the information is accessible to all. This is essential data for continuing monitoring and quality assurance.

5 Reviewing the Transition and Handover Plan in preparation for the 16th birthday

- 5.1 As the young person is able to make their own decisions about healthcare at the age of 16, plans for a joint review of the care plan should be undertaken in preparation for their 16th birthday. Transition and handover planning should have commenced earlier in line with condition specific arrangements.
- 5.2 The named worker has the responsibility to convene a review meeting for this 'rising 16 THP'. Membership should include the young person and their family if wished, an advocate, all relevant professionals from Primary Care, children's and adult medical, nursing and therapy services and any other significant individuals involved in providing care.
- 5.3 The agenda for the 'rising 16 THP review' should include the young person's needs and wishes for healthcare, any legal, mental competence and service boundary issues that may affect quality or access to healthcare, and any other impact on health outcomes for the young person.
- 5.4 The aim of the 'rising 16 THP review' is to ensure the plan is person centred, clinically appropriate, realistic, and meets the wishes and best interest of the young person. The Plan must document the ongoing clinical accountabilities for care by respective services, the timing and nature of clinical handover and coordination (e.g. clinical lead, need for joint clinics, referral for additional services, timing and handover, etc.).
- 5.5 Once the THP is agreed by the young person, family, all clinicians and other relevant parties it should be kept by the young person and copy kept in young person's health care record.

6 The completion of Handover from children's to adult services

- 6.1 At formal discharge from any paediatric service, a written clinical summary of health needs, diagnosis /formulation, management plans and recommended interventions (medication, therapy, investigations, etc.) should be provided by all paediatric clinicians as part of the handover process, so that the adult accountable clinician(s) can plan an appropriate healthcare offer. This document should be copied to the young person and their GP.
- 6.2 The named worker will offer support as needed to the young person through the period of handover of care. This might include the need for a visit to a new centre for the young person and family to meet the new team, support at the first appointment with the adult accountable clinician, information about in- or out-patient facilities as appropriate to the condition and individual needs.
- 6.3 The young person should remain under the care of children's services until formal transition and handover is completed, signified by attendance at a consultation with adult services.

7 Service quality and environment

7.1 Specific aspects of the culture, environments and capabilities of the care offered in children's and adult services should include:

- Settings should be appropriate to the individual's developmental circumstances and needs.
- Skills, equipment and facilities should be available for both children and adults appropriate to their individual clinical needs and wishes, physical size and maturity, and not only dependent on their age. Safeguarding must be observed appropriately at any age.
- Inpatient accommodation should be age appropriate for medical and surgical care, investigations, therapies, anaesthetics, intensive care, maternity care or other specialist health care.
- Clinicians may require additional skills to care for a young person up to 25 in either paediatric or adult specialisms. Clinicians must work within the boundaries of their expertise, but must establish mechanisms to consult with colleagues in the short term. In the longer term, Clinical Directors must identify skills deficits in consultation with clinicians, and develop educational strategies to bridge any gaps. Medical Directors will have oversight of the overall service.
- All clinicians must have safeguarding skills and competencies appropriate to the nature of their employment. Employment checks (DBS), relating to requirements for managing children and adult at risk (SSWB 2014) are a universal NHS Wales employment requirement.
- Robust governance arrangements should be in place to ensure safe prescribing of medications, including off licence and off label prescribing.

8 General Practice and Primary Care teams

8.1 The young person's GP should be appropriately involved in planning or implementation of any handover of care, especially if the plan includes discharge from secondary care back to primary care services.

8.2 The Primary Care clinician may already be the named worker for young people with chronic conditions such as asthma or epilepsy. The THP might need to include appropriate recommendations for future follow-up, investigations, preconception advice, or signposting to other services including patient support groups.

8.3 Primary care clusters should develop and coordinate named workers for young people undergoing transition and handover planning.

9 Working with other agencies

- 9.1 Transition and Handover of care for young people with multiple needs or complex conditions may span a number of professionals, specialisms and agencies. A coordinated approach to service provision will achieve effective care for the young person, good communication, engagement and continuity of care, and staff feeling clear about roles and responsibilities.
- 9.2 Agencies need to agree who should be the named worker for the young person to help co-ordinate transitions across a number of services.
- 9.3 The support services for the period of transition and handover should be strength-based and focus on the needs and wishes of the young person.
- 9.4 Healthcare advocacy and support should be available for every child and young person.
- 9.5 Services are expected to work together and engage with any organisation that the child / young person is involved in. Also that safeguarding standards are met and a clear guidance on information sharing is in place.
- 9.6 Building resilience is an important part of ongoing care for young people. Information should be available about how they can access support to develop and sustain social, leisure and recreational networks

10 Recommended measures to monitor and report on service quality and user satisfaction:

- 10.1 Health boards have a mechanism to capture young person/family/carer impression of process after 6 months and 12 months to help inform future service provision. (Collation of form satisfaction and narrative/complaints or concerns).
- 10.2 Health boards have arrangements for annual review of transition and handover arrangements in past year to learn lessons and to share best practice. (Annual report of 1 and 2 above).
- 10.3 Health boards monitor implementation of the transition and handover guidance using service user feedback and recognised national audit outcomes, and undertake a review of structures, processes and outcomes after 2 years to ensure it remains fit for purpose and key services user outcomes have been achieved.

10.4 The Transition and Handover lead (Assistant Medical Director, Nurse Director or Therapies Director) in the health board or trust will:

- promote the requirements of this guidance and share innovative and successful practice more widely;
- promote its effective operation across the organisation
- ensure effective implementation of this guidance within their area or service, and seek continuous improvement;
- report to their Executive Board on the implementation of this guidance,
- act as a source of advice to clinical and other staff on implementation;

10.5 Welsh Government will undertake a review of these arrangements after two years of implementation to ensure quality and consistency across Wales.

11 Dispute resolution

11.1 The health board/trust must have a responsive representations and complaints system to monitor and address any problems in real time, including concerns about prolonged waiting times or clinical delay.

11.2 The young person and carers must have access to information and support, including advocacy support and to use Putting Things Right to raise concerns if required.

Appendix 1

Strategic and Legislative Framework

1. This guidance is supported by the Welsh Government strategic and legislative framework. The United Nation Convention on the Rights of the Child⁸ (UNCRC) is the basis for all Welsh Government work with children and young people, with the Seven Core Aims for developing policy for children and young people. The Rights of Children and Young Persons (Wales) Measure 2011 imposes a duty on the Welsh Ministers to have regard to children's rights set out in the UNCRC. The Children's Rights Scheme 2014 sets out the arrangements for Welsh Ministers to comply with the duty to have due regard to children's rights when exercising any functions.
2. The participation standards identify seven key topics that all workers should be aware of when working with children and young people in Wales. These are:-
 - Information – this must be easy for children and young people to understand and make an informed decision
 - Choice – children and young people have the right to choose to be involved in and work on things that are important to them
 - No Discrimination - children and young people are all different and you have the right to be treated fairly
 - Respect – children and young people have the right to have a say. Their opinions are important and must be respected.
 - Children and young people will get something out of it - they have the right to learn and be the best they can be
 - Feedback – children and young people have the right to know what difference their involvement has made
 - Working better - those who make decisions that affect children and young people should put children's rights at the centre of everything they do.
3. The standards have been ratified by the Welsh Government and are underpinned by the UNCRC and the Well-being of Future Generations (Wales) Act 2015 that puts the involvement of children at the heart of improving their well-being. The standards have been adapted to make them more accessible for disabled children and young people under the name of *Having a voice, having a choice*.
4. The United Nations Convention on the Rights of Disabled People. In the Convention, disabled people are not viewed as subjects of charity but as subjects with rights who are capable of claiming those rights and making decisions for their lives based on their free and informed consent and are active members of society.
5. Taking Wales Forward⁹ (2016-2021) is the Welsh Government's five year plan to drive improvement in the Welsh economy and public services, delivering a Wales which is prosperous and secure, healthy and active, ambitious and learning, united and connected.

⁸<http://gov.wales/topics/people-and-communities/people/children-and-young-people/rights/uncrc/?lang=en>

⁹<http://gov.wales/docs/strategies/160920-taking-wales-forward-en.pdf>

6. Healthcare delivery plans are the strategic framework for service improvement across 9 serious conditions or clinical service areas (diabetes, cancer, end of life, heart disease, stroke, critical care, respiratory, liver disease, neurology). All plans incorporate an aspect of care relating to children.
7. Together for Mental Health¹⁰ (2012) is the Welsh Government's all-age strategy over 10 years, to improve mental health services and outcomes. It highlights service user experiences that at the points of transition between services that care and treatment can break down. It states that transfers between services should be based on need and not on artificial age boundaries and focuses on how to improve the lives of service users and their families using a recovery and enablement approach.
8. The Mental Health Act 1983 and associated Code of Practice for Wales¹¹ (2016) sets out the duties and provides guidance to medical practitioners, clinicians, managers and staff of hospitals, independent hospitals and care homes, independent mental health advocates and approved mental health professionals on how they should proceed when exercising their functions and duties under the Act. It also gives guidance to doctors and other professionals about certain aspects of medical treatment for mental disorder more generally.
9. The Mental Health (Wales) Measure¹² (2010) placed legal duties on local health boards and local authorities about the assessment and treatment of mental health problems. In particular it ensured care is in place across Wales which focuses on people's mental health needs by making sure all patients in secondary services have a Care and Treatment Plan.
10. The Social Services and Well-being (Wales) Act¹³ (2014) provides the legal framework for transforming social services in Wales. The Act has integration at its heart, and has implications for the Welsh NHS and the way in which it provides services.
11. The Well-being of Future Generations (Wales) Act¹⁴ (2015) came into force in April 2016 and seeks to improve the social, economic, environmental and cultural well-being of Wales. It makes public bodies think more about the long-term, work better with people and communities and each other, look to prevent problems and take a more joined-up approach.
12. Health boards also need to consider how their IT systems support information sharing between children's and adult services.

¹⁰<http://gov.wales/docs/dhss/publications/121031tmhfinalen.pdf>

¹¹<http://gov.wales/docs/dhss/publications/160920mentalacten.pdf>

¹²<http://gov.wales/topics/health/nhswales/mental-health-services/measure/?lang=en>

¹³<http://gov.wales/docs/dhss/publications/141111actnhsen.pdf>

¹⁴<http://gov.wales/topics/people-and-communities/people-and-communities/future-generations-act/?lang=en>

Appendix 2

Transition and Handover Flowchart

Health Board/Trust to identify a named **Transition and Handover lead** with accountability for ensuring implementation of the transition and handover guidance across all primary and secondary services

Health Board to monitor implementation of the transition and handover guidance and undertake a review of structures, processes and outcomes after 2 years to ensure it remains fit for purpose and key service user outcomes have been achieved

At the earliest possible opportunity – Offer support for self-management of the young person's condition(s); promote person-centred approach; Empower young people to manage their condition and provide the foundation for their move into adult services

At 13 - 14 – Identify young person requiring support for transition and handover of care from children's to adults' services

Allocate **Named worker** for the young person (yp) who will:

- Work with yp, their families and services to coordinate plans and services during period of handover of clinical accountability for care.
- Promote and advocate the wishes and views of the yp to ensure appropriate access for them and their family to access all necessary primary, secondary and other healthcare services required.
- Support yp to access and coordinate other community, interagency and third sector services
- Liaising with other services outside of Health as necessary (including social care, education, youth services).

Ensure yp is offered **appropriate meetings** with named worker to ensure:

- A Transition and handover plan' (THP) is coproduced for the transition and handover period and handover of care using resources such as 'Ready, Steady, Go', held by the yp, including what is important to them, care and treatment required, the timeline and expected health and wellbeing outcomes.
- The yp and family to access information on their condition and the care plan that they can understand.
- The THP should be linked or integrated with other care plans (e.g. IDP, Continuing Care Plan, CTP, Care and Support plan). The THP should be reviewed and updated at appropriate intervals.

To allow plans to take effect between 16 and 18 – Joint Review of THP between children's and adults' services

The named worker convenes '**rising 16 THP review meeting**' in advance of 16th birthday to allow plans to take effect between 16 and 18 as agreed.

- To identify health needs and wishes, any legal, competence and service boundary issues that may affect quality or access to healthcare, and any other impact on health outcomes for the yp.
- Membership to include representation of all relevant personal, yp, family, advocate, all relevant professionals from Primary Care, Paediatric and adult medical, nursing and therapy services and other significant individuals.
- To agree that THP is appropriate, person centred and meets the needs, wishes and best interest of yp.
- To identify and document the ongoing clinical accountabilities for care by respective services, timing and nature of clinical handover (e.g. clinical lead, need for joint clinics, referral on additional services, timing and handover, etc.).
- Once the THP is agreed by the young person, family, all clinicians and other relevant parties it is formally recorded in the medical record.
- The named worker supports the yp through the first appointment with the new accountable clinician. This might include the need for a visit to a new centre for the young person/family/carer to meet the new team, information about in and outpatient facilities/and specialist nurses, as appropriate to the condition and individual needs.
- Clinical summary will be provided for the yp, GP and new accountable clinician ahead of the first meeting as part of the handover process.

Handover of clinical accountability is completed

- Follow up-discussion arranged by named worker with young person/family/carer within 3 months of completion of the handover.
- Health Boards to put in place a mechanism to capture young person/family/carer impression of process after 6 months and 12 months to help inform future service provision.
- Responsive representations and complaints system in place to address and monitor any problems in real time including prolonged waiting times or clinical delay.

Appendix 3

Young Person’s Transition and Handover Passport

Please respect that this document is private and confidential

All About Me...

My key health needs and wishes for my Transition and Handover Plan: (Include diagnosis, formulation, treatment, therapies and current clinicians)	
Likes: (What works well)	Dislikes: (Include triggers)
Strengths:	Challenges:

Creative, Expressive, Me...
(Things that are good and I enjoy in my life)

More to me...
(What I would like you to know about me)

Physical Me (Being healthy and active, meeting my basic needs housing, money, my responsibilities etc)	Things I do Well (Strengths) Goals (What I need to do) Who can help me How By When
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Emotional Me (My relationship how I think about things/people)	Things I do Well (Strengths) Goals (What I need to do) Who can help me How By When
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<p>Social Me (Things I do, places I go)</p>	<p>Things I do Well (Strengths)</p> <p>Goals (What I need to do)</p> <p>Who can help me</p> <p>How</p> <p>By When</p>
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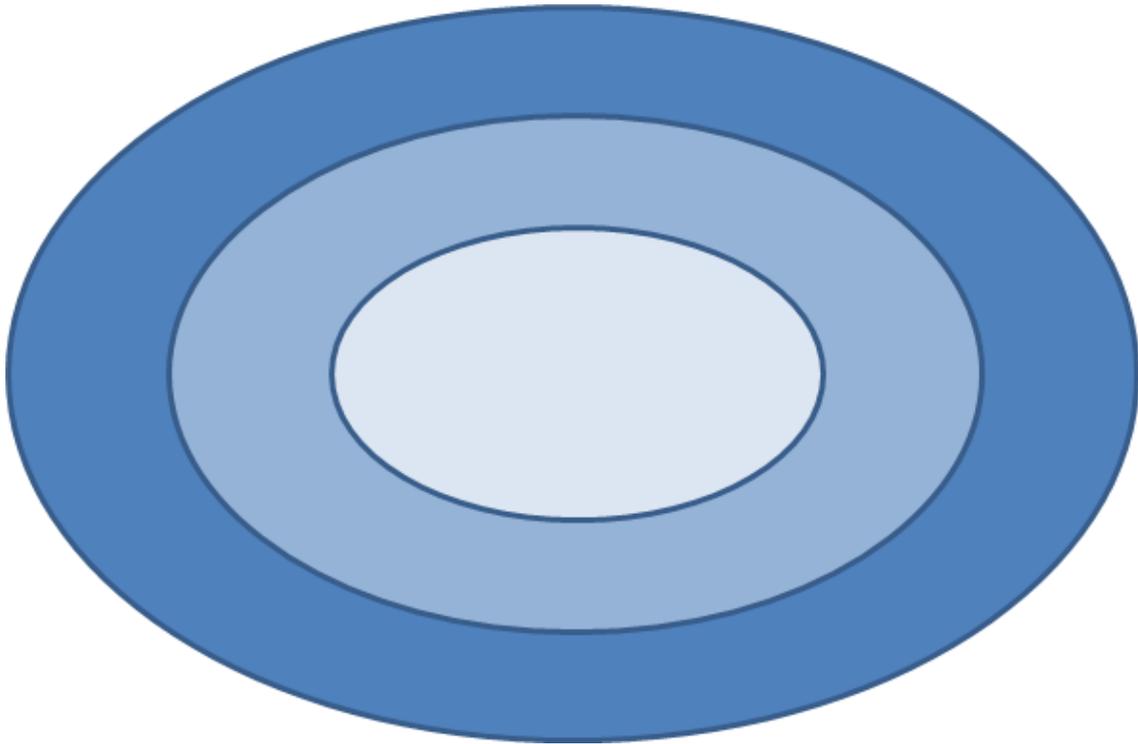
<p>Productive Me (Work, Education Training volunteering etc)</p>	<p>Things I do Well (Strengths)</p> <p>Goals (What I need to do)</p> <p>Who can help me</p> <p>How</p> <p>By When</p>
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People Who Are In My Life...

(List positive and supportive people and any others who are not supportive but are or have been significant in your life)

Who they are	Relationship	What they do for me

Eco Map



If you are at the centre, using the eco map identify where people fit around you, indicating whom you get most support from and how important people are to you in respect of your recovery/wellbeing.

This exercise can also be used to explore changes in relationships and may be used to measure and review progress if reviewed in later sessions

Transition and Handover Plan

What I want my future to look like...

Things to stay the same	Things to change	Who can help	How can I help myself	By When

Appointment guidance

Young people discussed their difficulties during appointments and consultations including fear, managing expectations and wanting to know more about what professionals do. These pages can be used by professionals to introduce themselves to young people and set out specifically what service/intervention they offer. They can be completed prior to appointments or with the young person as a tool to discuss the treatment options available. At the bottom of each contact detail is a consent confirmation sheet that can be checked if the young person wants their information to be shared with any other individual or team for further support or intervention, this avoids them having to repeat their story.

Professionals - Please answer the following;

Who are you	How will you help	Your contact details	How often will I see you

What will I achieve from this appointment	Has anything got better/ or worse	Am I happy with the treatment, Do I need extra support?	What needs to happen next?

Appendix 4

Useful resources

Children and Young People's National Participation Standards to help organisations and individuals make sure the process, quality and experience of all work involving the participation of children and young people:

<http://www.childreninwales.org.uk/our-work/participation/participation-standards/>

Supporting transition to adulthood for young people with life-limiting and life-threatening conditions:

Together for Short Lives, "Stepping Up – a guide to enabling a good transition to adulthood for young people with life-limiting and life-threatening conditions"

<https://www.togetherforshortlives.org.uk/resource/transition-adult-services-pathway/>
<https://www.togetherforshortlives.org.uk/resource/transition-adult-services-pathway/>

