SCH to STH Cross Trust Transition Pathway

Consider whether or not the young person is likely to have the mental capacity to make decisions for themselves when they reach the age of 16.

If it is unlikely, the processes in the Mental Capacity Act 2005 will need to be followed.

Advice should be given to families about decision making powers, i.e., court appointed deputies.

For out of area patients there must be exploration of what care can be provided in the patient's local area at an early stage of the transition process.

If the required care can be provided locally, that must be considered as the place of transition and transfer.

SCH transition ideally starts at age 11yrs (But no later than 13-14yrs or soon after diagnosis)

- Start individual transition plan using Ready Steady Go or local equivalent approved document, e.g. Health Passport.
- Give written information to patient and family, e.g., SCH transition leaflet.
- Put patient and family in contact with their named key worker.
- Identify within clinic outcome at 13.5 years if long term condition that will require Transition. If yes, commence Live Transition Plan.

SCH (at 14-15 years)

- Continue Individualised Transition Plan.
- Review plan at least annually.
- Ensure EDMS Live Transition Plan is updated.
- If the complex transition criteria are met, support is available via referral to the SCH Transition Team.
- Joint Clinics as appropriate to individual speciality (minimum annually), to include: -
  - SCH medical/nursing/AHP staff
  - STH medical/nursing/AHP staff.
- Opportunity to visit adult facilities.
- STH Moving On leaflet to be given to patient and family by STH staff.

Check if patient has an Education, Health & Care Plan and note any health actions required.

SCH to STH (age 16-18 years, dependent on need)

- SCH finalises live transition plan and shares this with STH team.
- SCH completes and sends STH the local transfer documentation/Individual Transition Plan/appropriate imaging/hospital records/ operation notes/safeguarding concerns.
- STH & SCH to copy all transition and transfer related correspondence to GP.
- A copy of the STH clinic letter of the patient's first appointment, post-transfer, must be sent to the SCH team to confirm successful transfer to adult services.
- All non-attended first post-transfer appointments at STH to be considered a failed transfer.
- STH must inform SCH by sending SCH a DNA letter.
- STH to follow local policy to offer further appointments and make contact with patient and inform GP.

- **ALL NEW PATIENT REFERRALS FOR PATIENTS AGED 16+ WILL BE REFERRED STRAIGHT TO STH.**

- **SCH contacts:** Dr Priya Narula, Consultant Paediatric Gastroenterologist, Trust Clinical Lead for Transition priya.narula@nhs.net; Lucy Hathaway, Deputy Divisional Manager, Transition Management Lead l.hathaway@nhs.net; Hannah Cash, Lead Nurse, Central Transition Team h.cash@nhs.net; Natalie Bell, Transition Coordinator Natalie.bell15@nhs.net, Rabia Khan, Transition Coordinator rabia.khan2@nhs.net, Amanda Drake, Transition Administrator Amanda.drake3@nhs.net

- **STH contacts:** Dr Alenka Brooks, Associate Medical Director for Young People's Services and Clinical Lead for Transition, Consultant IBD Gastroenterologist Alenka.brooks@nhs.net, Christina Blaydon, Lead Nurse CYP and Head of Safeguarding Christina.blaydon1@nhs.net; Kirsty Morris, Named Nurse for Children and Young People Kirsty.morris17@nhs.net; Gemma Kent Complex Transition Coordinator gemma.kent@nhs.net , Teresa Quinsey, STH Transition Team Secretary teresa.quinsey@nhs.net

- **Useful links:**
  http://www.uhs.nhs.uk/OurServices/Childhealth/TransitiontoadultcareReadySteadyGo/Transitiontoadultcare.aspx

  NICE (2016) Guidelines https://www.nice.org.uk/guidance/ng43 NICE (2016) Quality Standardshttps://www.nice.org.uk/guidance/qs140