Alder Hey Children's NHS Foundation Trust

C62 – TRANSITION TO ADULT SERVICES

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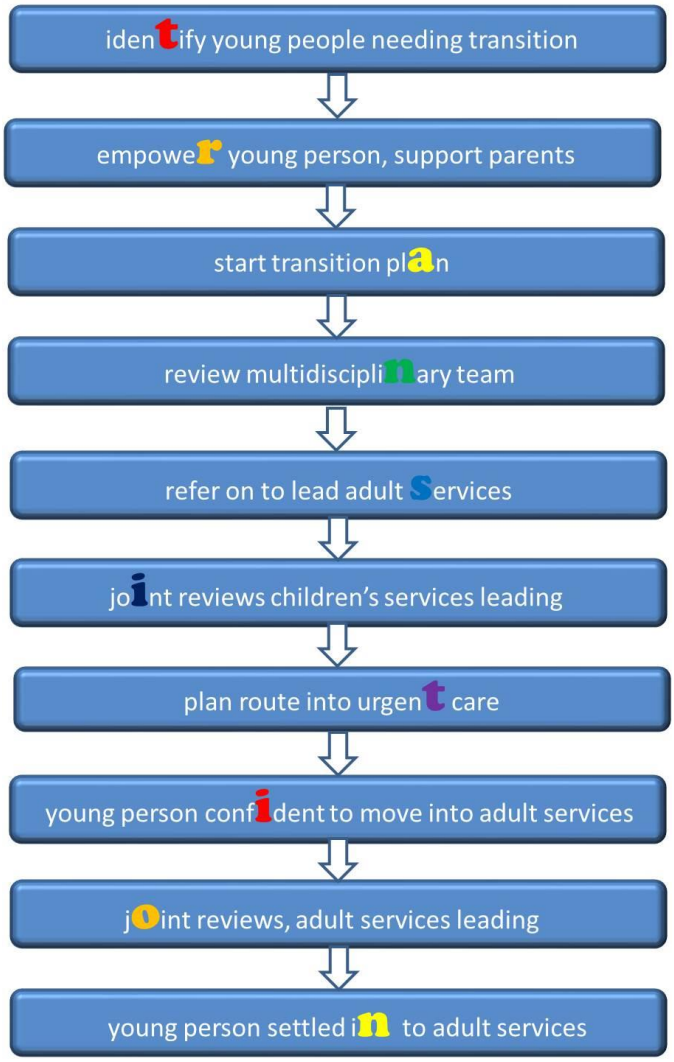
Quick Reference Guide – Transition to Adult Services

This policy outlines the Trust's vision of transition for young people with long-term conditions from children's to adult services. The policy applies to all young people, aged 14 and over, with long-term conditions that are expected to continue through adolescence into adulthood. This policy is also relevant to young people diagnosed with long-term conditions during the transition period.



Transition planning in readiness for the transfer to adult services is a pro-active, person-centred, developmentally appropriate, planned and co-ordinated process. The timing of the move to adult services is tailored to individual needs of the young person depending upon their emotional maturity, cognitive and physical development. In the majority of circumstances this move takes place before the young person's 18th birthday. Transition support continues after the move until the young person is adequately settled into adult services.

Transition to adult services requires specialty teams and services to work in partnership. Where two or more teams or services are involved, one specialty should take the lead role with other specialties taking a supporting role for transition. Condition specific transition preparation is delivered by each clinical specialty. The Lead Specialty for transition provides overall leadership, co-ordination of care and

support for the young person, to ensure their health needs are met as they move from children's to adult services. This includes identifying a Lead Consultant and keyworker to support transition, taking overall responsibility for the young person's Transition Plan and working in partnership with identified transition leads for Social Care and Education as appropriate.

Additional specialist transition advice and support is available from the Transition Team.

Safe, effective, developmentally appropriate and person-centred transition to adult services requires a co-ordinated approach with ten distinct steps, each of which is supported by auditable standards (see Appendix B). Some of these steps continue for a considerable period of time and one step does not necessarily need to be completed before the next step is started.

Additional guidance is available to support transition for young people with long-term conditions diagnosed or recognised during transition age, life-threatening illness, and conditions requiring ongoing treatment in children's services beyond normal transition age.

Young people whose transition is anticipated to be delayed or difficult, including those aged 18 or over whose care needs are most appropriately met in children's services (until reciprocal services are established and transition to adult care is safe), must be notified to the Trust's Transition Team and entered on the Trust's Transition Exception Register (TER).

The Transition Team supports Divisional management teams, Transition Leads, Transition Champions and clinical teams to achieve the standards outlined in this policy. The Transition Team provides transition training, tools and resources to support implementation of the 10 Steps to Adult Services throughout the Trust.

Implementation and ongoing monitoring of the Trust Transition Policy is overseen by the Trust Transition Steering Group chaired by the Executive Lead for Transition.

It is recognised that certain duties within this policy are outside of the Trust's control. Commissioners, Target Adult Services and General Practitioners are not bound by Alder Hey's policy, but have responsibilities in achieving effective transition. The Trust works in partnership with these stakeholders in order to implement the policy.

Version Control, Review and Amendment Logs

Version Control Table				
Version	**Date**	**Author**	**Status**	**Comment**
2	May 2022	Lynda Brook Jacqui Rogers	Current	
1.2	December 2020	Lynda Brook Jacqui Rogers	Archived	3 month extension
1.1	August 2017	Lynda Brook Jacqui Rogers	Archived	
1	March 2017	Lynda Brook Jacqui Rogers	Archived	

Record of changes made to Transition to Adult Services Policy – Version 2			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
QRG	3	Updated	Now established policy
1.4, 5.11	8, 15	Factors increasing likelihood of poor transition updated	Added new factors e.g. palliative care
3	11	Added arrangements for action planning where standards are not met	To ensure solution focused approach
3.4	11	Transition Service Lead Nurse responsibility for aligning with best practice standards including NICE NG43 and National Transition Competencies Framework. Also informs design of research, and advises national bodies	New national guidance. Ensures a bridge between evaluation and implementation.
5.11, App C	16 29	Added SOP for transitioning complex young People to local adult services	To support transition for this group of young people.
Various	Various	Executive Lead for Transition now Chair of Transition Steering Group	Delegated by Medical Director
Various	Various	Edits to way of working: • Divisions are responsible for owning, implementing, embedding and auditing transition. • Transition Service Lead Nurse provides transition training, support and expert advice, and help with any barriers.	Transition embedded into Divisional responsibilities

Various	Various	Change of scope of Transition Exception Register	To prioritise young people who are likely to require access to inpatient services at Alder Hey beyond their 18th birthday
Various	Various	Process for completing Transition Exception Register request updated.	On Meditech
6.3, 7	20	Safeguarding vulnerable adults information amended and link to Mental Capacity Act Policy	Recommendation from Safeguarding Team
7.3	22	NWAS notified of young people on the Transition Exception Register	To ensure appropriate transfer to Alder Hey rather than adult Trust.
7.5	23	Legal restriction on use of mortuary facilities for over 18's added	To ensure compliance
9	23	NICE and National Transition Framework added	Compliance with national guidance
11	24	Reduced Additional Information section	Signposted to DMS and websites
App A	26	NICE NG43 Transition Assessment Standards added	New national guidance
N/A	30	Equality Analysis added to policy	New policy template

Contents

1 Introduction

This policy outlines the model of transition to adult services adopted by Alder Hey Children's NHS Foundation Trust. It also outlines the processes used to implement and monitor safe, effective, person-centred transition throughout the Trust, and signposts to professionals, resources and training materials available to support professionals, young people and their families during the transition process.

1.1 What is transition to adult services?

Transition to adult services (transition) is defined as "a purposeful, planned process that addresses the medical, psychosocial and educational / vocational needs of adolescents and young people with [long-term] conditions as they move from child-centred to adult-oriented health care systems"[1]

1.2 Which young people will be transitioned to adult services?

Transition to adult services is relevant to all young people, aged 14 and over, with long-term conditions and / or disabilities that are expected to continue through adolescence into adulthood. This policy is also relevant to young people of transition age diagnosed with a long-term conditions during the transition period.

A long-term condition is defined as a condition that will require active ongoing management, long-term follow up or will have lifelong implications as the young person moves from children's into adult services. Examples include asthma, diabetes, cancer, juvenile idiopathic arthritis, congenital heart disease, epilepsy, complex neuro-disability, chronic kidney disease, sickle cell disease, severe visual impairment or learning disability. This list is not exhaustive and transition to adult services has important implications throughout the Trust.

1.3 Why is good transition to adult services important?

Transition to adult services ensures that young people are able to access the most appropriate services according to their age, developmental needs and the nature of their long-term condition. 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.

[1]Transition: getting it right for young people. Improving the transition of young people with long-term conditions from children's to adult health services. DfES 2006

If young people remain inappropriately in children's services, there is less capacity within the Trust for younger children and babies.

1.4 How can we ensure good transition to adult services?

Safe, effective, developmentally appropriate and person-centred transition to adult services can only be achieved by addressing three challenging areas of health care provision:

- Adolescent health and social care
- Long-term condition management
- Continuity and co-ordination of care across service or organisational boundaries

Normal adolescence is a period of significant change. Physiological changes of puberty are accompanied by significant emotional and social change as the young person develops their own identity and becomes an independent adult. Whilst physical changes of puberty may be complete by the young person's mid-teens, brain development, thinking skills and emotional development happen more slowly and will continue into the early 20's.

Normal features of adolescence including changes in sleep patterns, mood swings, changes in body image and self-esteem, increasing independence, questioning and challenging social and societal norms, spending less time with parents, increased importance of peer relationships, emerging sexual identity, experimentation and risk-taking behaviour can have a significant impact on the stability of long-term conditions.

The incidence of a number of long-term conditions increases in adolescence, particularly in mental health. New problems and health needs associated with congenital disease may also manifest in adolescence or early adulthood. A number of childhood long-term conditions are associated with relapse, recurrence, increasing morbidity or disease complexity in adolescence and early adulthood.

A number of factors increase the likelihood of poor transition to adult services. These include specialties, such as community paediatrics, or neuro-disability, where there is no adult equivalent, and specialties such as hospices where the models of care are very different in the children's and adult sector. Some conditions such as juvenile chronic arthritis are not recognised in adult disease classifications, other conditions such as early onset Cockayne Syndrome are rarely if ever seen in adulthood. Transition is also very difficult to manage if the young person's underlying condition is particularly unstable for example if the young person is receiving palliative care. In these circumstances, transition may need to be paused and then resumed if the young person's condition improves.

Most of the high-prevalence mental health disorders (mood, anxiety and substance use) emerge during adolescence and early adulthood, as do the psychotic disorders. Early age of onset has been shown to be associated with a longer duration of untreated illness, and poorer clinical and functional

outcomes. Transition to adult services is difficult if the definitive diagnosis is unclear as the underlying mental health condition may still be emerging or if there is a possibility of stable remission before adulthood.

Long-term condition management is particularly difficult during transition. Physiological emotional and social changes outlined above, the reduced role of parents experienced in management of the long-term condition, the increased role of the young person, and their need to learn how to manage their condition interact, making management of long-term conditions more difficult.

Continuity and co-ordination of care across service and organisational boundaries is particularly difficult during transition. Transition to adult services is associated with a large number of changes happening around the same time. This is associated with a significant loss of continuity. In terms of healthcare provision often the only source of significant long-term continuity between children's and adult services is the young person's GP. Continuity from within the family is also compromised as the young person's parents become less actively involved in the young person's care and the young person takes over management of their long-term condition.

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[2].

2 Definitions

Safe, effective, person-centered transition to adult services requires specialty teams and services to work in partnership. Any specialty team or service e.g. diabetes, epilepsy, CAMHS, may take on the role of Lead Specialty or supporting specialty depending on the needs of the individual young person.

2.1 The Lead Specialty for Transition

(Essential)

- Provides overall leadership, co-ordination of care and support for the young person, to ensure their health needs are met as they move from children's to adult services.
- Identifies a Lead Consultant in Children's Services to liaise with the appropriate Target Adult Service to facilitate transition.
- Co-ordinates contributions to the young person's ongoing health care for other involved specialties, if applicable.
- Takes overall responsibility for developing, delivering and updating the young person's Transition Plan (incorporating Transition Steps 4 to 10, Section 5.4 to 5.9) in partnership with the young person and their family

[2] Cochrane Database Syst Rev. 2016 Apr 29;4:CD009794. doi: 10.1002/14651858.CD009794.pub2.
Transition of care for adolescents from paediatric services to adult health services.
Campbell F1, Biggs K, Aldiss SK, O'Neill PM, Clowes M, McDonagh J, While A, Gibson F

unless, in exceptional circumstances, additional specialist transition support is being provided by the Transition Team (Section 2.3).

- Ensures condition-specific advice and support is provided directly to the young person and their family, to ensure their health needs are met as they move from children's to adult services.
- Works in partnership with identified transition leads for Social Care and Education as appropriate to ensure a coordinated multi-agency approach to transition.

2.2 Supporting Specialties

(Where the young person's care requires input from more than one specialty)

- Works in partnership with the Lead Service for Transition to contribute to the development, delivery and updating of the young person's Transition Plan.
- Ensures condition-specific advice and support is provided directly to the young person and their family, to ensure their health needs are met as they move from children's to adult services.
- Liaises with the appropriate Target Adult Service to facilitate transition to adult services for their individual specialty needs.

2.3 Specialist Transition Support

- The Transition Team will work primarily in a specialist advisory and facilitative capacity, providing transition training, advice and support to professionals from both children's and adult services as they transition their patients from children's to adult services.
- In circumstances where transition is extremely complex or challenging the Transition Team may provide additional direct support specifically to:
    - Ensure that a thorough transition needs assessment is undertaken, and used to develop an appropriate Transition Plan for the young person
    - Facilitate delivery of the young person's Transition Plan
    - Ensure that the young person's Transition Plan is reviewed and updated regularly depending on their changing needs
    - Development of health information passports, self-management plans/route into urgent care

3 Duties

3.1 Trust Management Board

- Identify an Executive Lead for Transition
- Ensure there is an effective transition policy within the Trust

3.2 Executive Lead for Transition

- Member of the Trust Executive team with overall accountability for transition to adult services within the Trust
- Provide executive leadership for the Trust Transition Steering Group
- Provides senior-level outward facing representation with regard to transition for the Trust

- Provides senior leadership for transition within the Trust via the Transition Team
- Works with the Trust Clinical Lead for Transition, Lead Nurse and the Transition Steering Group to determine Trust Transition Policy and Strategy
- Where standards are not being met, providers senior leadership to empower the Transition Team to work in partnership with Divisional Teams and commissioners to devise and implement and appropriate action plan with a solution focused approach

3.3 Trust Clinical Lead for Transition

- Senior Clinician from within the Trust (any discipline as appropriate)
- Chairs the Trust Transition Steering Group
- Provides senior clinical leadership for transition within the Trust including supporting the Transition Team
- Works with the Executive Lead for Transition and the Transition Steering Group to determine Trust Transition Policy and Strategy
- Works with the Transition Service Lead Nurse, Divisional Managers and Transition Leads to deliver the Trust Transition Policy and Strategy
- Where standards are not being met, supports Transition Service Lead Nurse, working in partnership with Divisional Teams and commissioners to devise and implement and appropriate action plan with a solution focused approach

3.4 Transition Service Lead Nurse

- Experienced nurse with transition expertise, and expertise in clinical care, management, and leadership
- Principal member of the Transition Team
- Works with the Executive and Clinical Lead for transition and the Transition Steering Group to determine Trust Transition Policy and Strategy
- Senior Nurse leading the nursing workforce
- Works in partnership with the Executive and Clinical Lead for Transition, providing support and training to Divisional Managers and Divisional Transition Leads to implement Trust Transition Policy and Strategy
- Works in partnership with Divisional Transition Leads, supported as necessary by the Clinical Lead for Transition, to actively monitor delivery of transition across the Trust
- Where standards are not being met, works in partnership with Divisional Teams and commissioners to devise and implement and appropriate action plan with a solution focused approach
- Works with the Clinical Lead to develop and deliver transition training
- Ensures transition within the Trust continues to be aligned with latest research evidence and national best practice standards and including NICE IOG NG43 and the National Transition Competencies Framework (anticipated launch mid 2022)
- Provides expertise of the practical realities of transition, informing design of transition research programmes, advising national bodies including Royal Colleges, NHS Improvement and NHS England/Patient Safety

Collaborative, thus ensuring a bridge between evaluation and implementation

3.5 Divisional Transition Leads

- Named representatives (Divisional Associate Chief Nurses or Divisional Service Managers) with responsibility for transition within each Division
- Provide formal link between the Division and Trust with regard to transition
- Ensure prompt escalation of issues and concerns with regard to transition to the Transition Steering Group
- Work with the Clinical Lead for Transition and the Transition Service Nurse Lead to deliver the Trust's Transition Policy and Strategy
- Actively monitor delivery of transition across the Division
- Where standards are not being met, work in partnership with Divisional and Trust Transition Teams and commissioners to devise and implement and appropriate action plan with a solution focused approach

3.6 Transition Champions

- Individuals with a passion and enthusiasm for improving and facilitating transition from anywhere within the organisation
- Role approved by individual's line manager, including attendance at Trust Transition briefing and update events (maximum 2 x half days or 1 full day per year)
- Provide an informal link between individual teams and services to the Division Transition Leads, Trust Clinical Lead for Transition, Transition Service Nurse Lead, Executive Lead for Transition
- Raise awareness of issues and concerns with regard to transition to the Transition Steering Group
- Work within Divisions, with support from Divisional Transition Leads and with guidance from the Clinical Lead for Transition and the Transition Service Nurse Lead to deliver the Trust's Policy and Strategy

3.7 Condition-specific Keyworker

Nurse Specialist or other healthcare professional providing key-working support to a young person of transition age

- Ensure others are aware of their role
- Work with consultants to identify risk factors for complex or difficult transition and notify the Transition Team
- Provide keyworker support for transition to adult services depending on identified Lead Specialty unless, in exceptional circumstances, additional specialist transition support is being provided by the Transition Team
- Lead on education and empowerment of young person for self-management of relevant long-term condition(s)
- Work with condition-specific Keyworker in adult sector
- Participate in joint reviews (Transition Steps 6 & 9, Section 5.6 & 5.9)
- Handover to adult condition-specific Keyworker when leadership for the young person's long-term condition management is handed over to adult services (Transition Step 8, Section 5.8).

3.8 Consultants caring for young people with long-term conditions

- Work with other involved consultants to identify Lead Specialty for Transition (Section 2.1)
- Take on the role of Lead Consultant or support Lead Consultant to co-ordinate transition depending on identified Lead Specialty
- Identify risk factors for complex or difficult transition and notify the Transition Team accordingly
- Work with other involved Consultants to provide a concise but comprehensive summary of the young person's health needs to support referral to adult services and ongoing care in the adult sector.
- Identify and refer to relevant Target Adult Services
- Contribute to joint reviews (Transition Steps 6 & 9, Section 5.6 & 5.9)
- Handover to adult consultant when leadership for the young person's long-term condition management is handed over to adult services (Transition Step 8, section 5.8).

3.9 Line Managers

- Ensure that clinical staff are aware of the Transition Policy and their individual roles and responsibilities
- Ensure clinical staff have necessary skills and knowledge in order to fulfil their individual roles and responsibilities in relation to transition to adult services
- Release staff for relevant transition training and updates in order to fulfil their individual roles and responsibilities in relation to transition to adult services
- Support the role of Transition Champions

3.10 All Clinical Staff

- Be aware of Trust Transition Policy and their individual roles and responsibilities
- Ensure they have the necessary skills and knowledge in order to fulfil their individual roles and responsibilities in relation to transition to adult services
- Attend relevant transition training and updates in order to fulfil their individual roles and responsibilities in relation to transition to adult services

3.11 Commissioners

- Work with Trust Transition Team and relevant Children's and Adult Specialty Leads to participate in cohort planning meetings (Transition Step 1, Section 5.1)
- Work with service users, commissioners and providers from children's and adult services to address issues related to transition to adult services including:
    - Where standards are not being met, work in partnership with Divisional and Trust Transition Teams and to devise and implement and appropriate action plan with a solution focused approach

- When young people remain on the Transition Exception Register (Section 6)
- When standards in the Trust Transition Policy cannot be met due to significant resource issues or issues outside the Trust's control

3.12 Target Adult Services

- Work in partnership with the Lead Service for Transition to contribute to the development, delivery and updating of the young person's Transition Plan
- Identify an appropriate named consultant for each adult specialty
- Provide developmentally appropriate information regarding adult services and how they work (Transition Step 5, Section 5.5)
- Participate in joint reviews (Transition Steps 6 & 9, sections 5.6 & 5.9).
- Provide advice and support for Lead Specialty as they plan the young person's route into urgent care in the adult sector (Transition Step 7, Section 5.7)
- Take over from paediatric consultant when leadership for the young person's long-term condition management is handed over to adult services (Transition Step 8, Section 5.8).

3.13 General Practitioner

- Work in partnership with the Lead Service for Transition to contribute to the development, delivery and updating of the young person's Transition Plan
- Prescribe and monitor long-term medication
- Participate in shared care with adult specialties in accordance with standard practice for the young person's condition
- Provide overarching co-ordination of long-term condition management when this role is not more appropriately taken by an adult specialty
- Provide developmentally appropriate information regarding primary care services and how they work
- Provide advice and support for Lead Specialty as they plan the young person's route into urgent care in the adult sector (Transition Step 7, Section 5.7)
- Provide developmentally appropriate opportunities for health screening, primary prevention and health promotion relevant to the young person's long-term condition (Transition Step 4, Section 5.4)

4 Principles

- Transition is a pro-active, person-centred, developmentally appropriate, planned and co-ordinated process.

- The timing of the move to adult services is tailored to individual needs of the young person depending upon their emotional maturity, cognitive and physical development.

  In the majority of circumstances this move should take place before the young person's 18th birthday. However, transition support should continue

after the move, until the young person is adequately settled into the adult sector.

- There should be continuity and co-ordination of care across care settings and different care providers.

5 Generic Transition Pathway: Ten Steps to Adult Services

Children and young people with long-term health conditions 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. This process of education and empowerment should be guided by the needs and abilities of the young person and can begin at any age. Education, empowerment and development of self-management skills for long-term conditions should continue throughout children and young people's lives, extending throughout adulthood.

Safe and effective transition to adult services requires a co-ordinated approach with 10 distinct steps. These are presented in order. It is important to note that these steps represent a series of interdependent processes in the transition journey. 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.

5.1 Identifying young people requiring transition

Professionals will normally start talking to young people and their families about their health needs and Transition to Adult Services around the time of their fourteenth birthday. This will allow plenty of time for gradual planned Transition.

Patients seen infrequently may present late in transition due to oversight and the long interval between appointments. For instance, some paediatric cardiology patients, may be seen only once every couple of years. It is important to ensure that transition preparation begins sufficiently early for these young people, and arrangements must be put in place to ensure that late presentation in transition due to oversight and the long interval between appointments is not a regular occurrence.

The young person's Lead Consultant, and other involved professionals should write a letter summarising the young person's diagnosis and health needs. Alternatively, this information may be made available as a Health Information Passport or Advance Care Plan. Young people should be given a copy of this information, have the opportunity to read it and ask questions. This information should be updated as the young person progresses through Transition.

5.1.1 Identifying young people whose transition is likely to be difficult or complex

Young people of transition age whose transition is likely to be particularly difficult or complex and are likely to remain under the care of Alder Hey Children's NHS Foundation Trust beyond their 18th birthday, must be notified to the Trust Transition team. The Team should be notified as soon as the possibility of difficult or complex transition is recognised, or at the latest before

their 18th birthday. This will allow the young person to be entered on the Transition Exception Register (Section 7) if they are likely to require access to inpatient services beyond their 18th birthday.

The following characteristics are considered to be indicators of difficult or complex transition. This list is not exhaustive and young people who do not have any of these characteristics may also experience difficult or complex transition requiring notification to the Trust Transition team

Markers of difficult or complex transition:

- Severe clinical instability, particularly patients requiring palliative care
- No identified Target Adult Service
- No identifiable Lead Service in children's or adult services
- Young people under local authority care / subject to a care order
- Severe behaviour management issues
- Young people who have recently left care

See **Safe Transition from CAMHS to Adult Mental Health Provider Procedures** (on DMS) for further guidance on mental health transitions.

For standards, see Appendix B – Step 1.

Previously transition was often delayed for young people with complex neuro-disability. There is now a standard operating procedure to support transition for this group of young people. See Appendix C.

5.2 Empowering young people, supporting parents

Professionals will work with young people, depending on their age and ability, to help them develop the knowledge and skills they need to keep healthy and well. 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. Young people should be supported and empowered to take part in Shared Decision Making e.g. Ask Three Questions.

Young people should be routinely offered the opportunity to be seen without their parents for part of their consultation. Wherever possible, young people should be offered a choice of clinic times and location in order to maximise accessibility and minimise disruption to other aspects of their life. Age and developmentally appropriate information regarding Trust policies on Consent and Confidentiality should be available. Copies of key letters and summaries should be given to the young person during transition to keep in a Personal Health Record.

Some young people with learning disabilities will require help to stay healthy and well, and to make decisions about their care when they are adults. The Lead Service should work with other involved services to ensure that there is someone available who can support and advocate for these young people, in order to meet the standards in Appendix B – Step 2.

5.3 Transition Plan

The Lead Specialty (Section 2.1) should work in partnership with Supporting Specialties (Section 2.2) young people and their families to create their personal Transition Plan. This should be tailored to the young person's health needs and co-ordinated with other aspects of Transition as necessary.

Ongoing development of the young person's Transition Plan should include continued generic and condition-specific education and empowerment (Section 5.2), mapping the young person's Circle of Support (Section 5.4), optimizing timing of joint reviews (Sections 5.6 & 5.9), optimizing timing of the move to adult services (Section 5.8) and planning emergency care (Section 5.7).

Young people should be given a copy of their Transition Plan, have the opportunity to read it and ask questions. The Transition Plan should be reviewed at each appointment, and as part of discharge planning when a young person has been admitted as an inpatient.

For standards, see Appendix B – Step 3.

5.4 Reviewing the multidisciplinary team

A young person's Circle of Support is the group of people, professionals, friends and family, who are there to help them. The Lead Specialty (Section 2.1) should, where required, work in partnership with Supporting Specialties (Section 2.2) young people and their families to list the professionals in the young person's Circle of Support and identify the most appropriate service to take over when the young person transitions to adult services.

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.

The Lead Specialty will identify a Lead Consultant in Children's Services (Section 2.1) to oversee the young person's transition, together with a keyworker to provide transition support.

For standards, see Appendix B – Step 4.

5.5 Referral to adult services

The Lead Specialty in children's services should refer the young person to the appropriate Target Adult Service. The Target Adult Service should be asked to identify a Lead Consultant in the adult sector. Once the Lead Adult Service has been confirmed, referrals to other Supporting Specialties in the adult sector can be co-ordinated with the aim of optimising co-ordination and continuity of care as much as possible. Adult services should provide the young person with appropriate information, including how services are accessed, professional roles and responsibilities.

For standards, see Appendix B – Step 5.

5.6 Joint reviews led by children's services

The young person should be invited to attend a Transition Clinic, led by professionals from children's services with support from adult services, so that they can get to know the professionals who will be taking over their care. If there is not an appropriate Transition Clinic available, professionals from adult services should be invited to attend the young person's normal clinic appointments. Additional time may be needed to discuss transition in addition to ongoing management of the young person's long-term condition.

For standards, see Appendix B – Step 6.

5.7 Planning a route into urgent (emergency) care

Once a young person has moved into adult services, they need to know what to do and who to call when they are unwell. The Lead Specialty will work with the young person's GP and other Supporting Specialties to ensure that the young person has an appropriate self-management plan for their long-term condition(s).

The young person should not be transferred to Alder Hey A&E by emergency ambulance or admitted to Alder Hey for hospital treatment once they have moved into adult services. The Lead Specialty, working with the young person's GP and other Supporting Specialties, should ensure that the young person is aware which hospital they are likely to be taken to and that necessary information regarding the young person's health needs is available to support their care.

Young people with learning disabilities may also need additional advocacy support in order to safely access emergency and inpatient care, including a hand-held Health Information Passport or similar document.

Young people with complex long-term conditions may be eligible for continuing care and support in the inpatient setting and may include carers (or parents) in-reaching in order to provide the young person's "everyday" care e.g. through the use of the Carer Skills Passport www.carerskillspassport.org.uk .

For standards, see Appendix B – Step 7.

5.8 Moving to adult services

Eventually the young person will be ready to attend the adult clinic or be admitted to the adult hospital ward. The aim is for sufficient transition preparation so that the young person feels confident and ready to make the decision regarding the timing of their move to adult services. Most young people will be ready to move into adult services when they are 16 or 17. This means children's services can provide support to adult services for a while, ensuring that the young person is properly settled in before they are discharged from the service.

For standards, see Appendix B – Step 8.

5.9 Joint reviews led by adult services

Children's services should be available to provide advice and support to professionals from adult services after a young person moves over to the adult sector. The young person will be invited to attend a Transition Clinic, led by professionals from adult services with support from children's services, in order to provide continuity and ensure the young person is confident in with the professionals who are taking over their care. If there is not an appropriate Transition Clinic available, professionals from children's services should be invited to attend the young person's routine clinic appointments. Additional time may be needed to discuss transition in addition to ongoing management of the young person's long-term condition.

It is recognised by the Transition Steering Group that additional capacity for Lead Consultants, and possibly in some specialities, Specialist Nurses will need to be identified to support the implementation of Transition preparation clinics. This may be achieved by having separate Transition clinics, which may need ICS or Specialist Commissioning support, or by allocating double appointments to patients of transition age, i.e. 14 years and older.

For standards, see Appendix B – Step 9.

5.10 Settling into adult services

Finally, usually before a young person's 18th birthday, the young person will feel confident and well supported in adult services so that they can be safely discharged from children's services.

For standards, see Appendix B – Step 10.

6 Special Circumstances

6.1 Long-term conditions diagnosed or recognised during the transition age range

When a long-term condition is diagnosed or recognised during the transition age range, the young person should be offered the choice of being referred directly to adult services, or being referred to children's services.

Unless the young person referred to children's services is not anticipated to require anything more than GP follow up after their 18th birthday, they should be made aware of the need for transition to adult services at the time of diagnosis or recognition. Ongoing active management of the long-term condition will then continue in parallel with transition to adult services.

Young people who are likely to require access to inpatient services at Alder Hey beyond their 18th birthday must be entered on the Transition Exception Register (Section 7).

Professionals should provide developmentally-appropriate support to help young people develop the knowledge and skills they need to keep healthy and well, regardless of whether the young person is initially referred to children's or adult services (Section 5.2). This will include an appropriate self-management

plan for their long-term condition(s) and ensuring they have the knowledge and skills to access support from their GP and emergency services (Section 5.7).

6.2 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 young people 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.

Active transition should be paused if a young person is critically unwell and is not expected to live, and professionals would be surprised if the young person were alive beyond a few weeks' time (Spectrum of Palliative Care Needs[3] – Red), or if survival is uncertain and professionals would not be surprised if the young person died within the next few months (Spectrum of Palliative Care Needs – Amber - months).

Young people who are likely to require access to inpatient services at Alder Hey beyond their 18th birthday must be entered on the Transition Exception Register (Section 7).

6.3 Conditions requiring ongoing treatment at Alder Hey beyond the age when transition is normally completed

Some services are commissioned on a life-time basis with the same provider supporting patients of all ages. The Paediatric Oncology Unit at Alder Hey has a specific Teenage Oncology Unit which accepts referrals of young people up to 19 years of age with paediatric malignancies. Some young people remain under the care of Alder Hey beyond their 18th birthday because they are taking part in specific clinical trials. Whatever the circumstances it is still important that care is developmentally and age appropriate. Wherever possible, outpatient clinics and hospital inpatient care for young people of 18 and over should be provided in a designated young person's unit or adult environment.

Young people who are likely to require access to inpatient services at Alder Hey beyond their 18th birthday must be entered on the Transition Exception Register (Section 7).

If a young person of 18th or over is admitted to Alder Hey, a Safeguarding Order along with a Vulnerable Adults Assessment on Meditech 6 must be completed on Meditech. This is the responsibility of the admitting nurse and ensures all appropriate processes are followed in terms of Capacity and Consent. See

[3] Shaw KL, Brook L, Mpundu-Kaambwa C, Harris N, Lapwood S, Randall D. The Spectrum of Children's palliative Care Needs: a classification framework for children with life limiting or life threatening conditions. BMJ Support Palliat Care. 2015 Sep;5(3):249-58

Mental Capacity Act and Deprivation of Liberty Safeguards (DOLS) Policy – M69 (on DMS)

7 Transition Exception Register

The Transition Exception Register is a Trust record of young people aged 18 and over, who would most appropriately be cared for in children's services should they require inpatient admission. This may include inpatient care at Alder Hey based on availability of resources and risk assessment by the young person's consultant(s).

The register has three purposes:

i. To provide assurance for the young person and their family that their healthcare needs will continue to be met in the most appropriate setting.

ii. To provide a method of identifying and actively managing transition for patients who remain under the care of the Trust beyond normal transition age, allowing active discussion with adult providers and commissioners to ensure that appropriate services are identified or developed.

iii. To enable young people of 18 or over to be identified within the Trust and ensure that appropriate support and resources are implemented.

    The Trust already has a system in place to routinely identify all inpatients who are 18 or over with specific reference to privacy and dignity requirements, vulnerable adults and safeguarding. The Register also allows additional needs of these young people to be more easily identified and addressed.

Young people will only be eligible for inclusion on the Transition Exception Register if there are genuine and compelling reasons why the young person cannot be safely transitioned to adult services. The Transition Exception Register is not an excuse for professionals not fulfilling their duty in transitioning patients in a timely fashion. The ultimate decision to include a patient on the Transition Exception Register will be made by the Trust Executive Lead for Transition or their nominated deputy.

7.1 Young people who will be included on the Transition Exception Register

Young people who are likely to require access to inpatient services at Alder Hey Alder Hey beyond their 18th birthday must be entered on the Transition Exception Register

Patients are likely to be eligible for inclusion on the Transition Exception Register if one or more of the following apply:

i. There is no appropriate target service due to a relative or absolute lack of skills and experience with this type of patient in the adult sector.

ii. Transition is delayed or paused due to patient instability

a. Long-term conditions diagnosed or recognised during the transition age range

b. Life threatening illness or palliative care

iii. Conditions requiring ongoing treatment at Alder Hey beyond the age when transition is normally completed

a. The commissioned patient pathway specifies Alder Hey as the provider of care to young people aged 18 or over e.g. young people aged 18 – 23 on active treatment for paediatric malignancies

Referrals for new conditions and re-referrals for existing conditions

Referrals for new conditions (and re-referrals for existing conditions) in young adults over the age of 16-18 years (transition age appropriate to the individual speciality) should be redirected to adult service providers. If this is not felt to be appropriate, they must be discussed with the Transition Team.

7.2 Active management of the Transition Exception Register

Patients will remain on the Transition Exception Register for a period of six months in the first instance. This is to allow work to proceed in order to allow the young person to complete transition or to ensure additional time so that transition can proceed sensitively and at an appropriate pace. If necessary, the Transition team will work with the Lead Specialty, adult providers and commissioners in order to address the shortfall in skills and experience in the adult sector and set up an appropriate transition pathway.

Extensions may be granted in exceptional circumstances as long as the patient continues to satisfy criteria for inclusion on the Transition Exception Register, and where appropriate involved professionals have engaged with the Trust, commissioners and adult providers in an attempt to identify an appropriate target service in the adult sector.

7.3 Identifying young people on the Transition Exception Register

Patients on the Transition Exception Register will have a Transition Exception Register letter in Medisec. This letter will also be copied to the young person so that they can bring it with them when they attend the hospital.

The North-West Ambulance Service (NWAS) will also be notified of young people on the Transition Exception Register (TER). This ensures that an ambulance crew called to the young person's home is aware that if appropriate and possible the young person should be transferred to Alder Hey Childrens hospital rather than an adult Trust.

7.4 Referring a patient for inclusion on the Transition Exception Register

Young people can be referred to the Transition Exception Register by the clinician caring for the young person by completing a Transition Exception Register request in Meditech 6.

7.5 Care of patients on the Transition Exception Register

If a young person aged 18 or over on the Transition Exception Register requires hospital admission, a risk assessment should be undertaken by the young person's consultant(s) at the time of admission. In some instances, this may mean caring for the young person aged 18 or over in a paediatric inpatient unit (Alder Hey or a District General Hospital). Their case should be considered on an equitable basis as compared with a young person aged 14 - 17 years with similar needs.

Legal regulations restrict the simultaneous use of mortuary facilities by deceased adults (over 18) and deceased children. The mortuary team will do their utmost to ensure the needs of all service users are met in the most sensitive and appropriate way.

8 Specialty-Specific Guidance

The Alder Hey Transition Map and associated resources provide detailed specialty-specific guidance regarding transition pathways for most common conditions. The most up to date version of the Alder Hey Transition Map can be found on the Intranet. Specialty-specific Transition Pathways may include Specialist Commissioned Services transitioning to CCG Commissioned Services. Often the role of the GP is increased in adult services compared with children's services.

The Transition Team is available for advice and support if professionals are unable to identify the most appropriate Specialty Specific Transition Pathway depending on a young person's identified needs.

9 Implementation

Implementation of the 10 Steps to Adult Services Transition Pathway together with relevant national guidance specifically NICE NG43 and the forthcoming National Transition Framework is a dynamic and ongoing continuous quality improvement project.

The Trust Transition Team is supporting each Division Management Team and Transition Leads, by sharing the NICE NG43 Transition Standards for each clinical speciality to self-assess their specialities against the standards. Corporate elements of Transition standards have been completed in compliance with NICE guidance. The development of an action plan is required where specialities do not meet the standards (see Appendix A).

Teams should also monitor their compliance against the 10 Steps Transition Pathways auditable standards (Appendix B), including measuring transition outcomes and 'You're Welcome' criteria.

Monitoring is ongoing and continuous. Incidents and near misses relating to transition to adult services will be reported in the first instance via the Trust Incident Reporting System (Ulysses). These will be reviewed by the Transition Team and the incident, together with any required actions, discussed at the Trust Transition Steering Group, as appropriate. Progress against Divisional action plans will also be reported through the Trust Transition Steering Group to the Executive Team.

The Trust aims to achieve compliance with NICE NG43 and 10 Steps to Adult Services standards through process and service redesign. However, there are aspects of transition that cannot be achieved without collaboration with other service providers. In some circumstances there will be a requirement for negotiation with commissioners around resources.

10 Outcome Measures

The Trust Transition Team works with Divisions and Specialties to identify appropriate outcome measures for transition. Wherever possible, this will include standardised process and outcome measures repeated over the duration of transition including measures of:

- Condition-specific outcomes (e.g., HbA1C in diabetes)
- Quality of life (QoL)
- Transition readiness, including condition specific knowledge and confidence (through progress against the young person's Transition Plan and Measurement of Transition-related Competence[4]
- Continuity of care against policy standards: 2.3, 4.1, 4.2, 4.3, 5.2, 7.1, 7.2 (See Appendix B) together with incident and near-miss reporting.
- Health and social care resource utilisation (DNA rates and loss to follow up)
- Young person and family satisfaction: Mind the Gap Scale[5]

11 Further Information

www.10stepstransition.org.uk

Trust Intranet Transition Page

Transition section (Community Paediatrics) in Alder Hey Document Management System (DMS):
https://alderheynhsuk.sharepoint.com/sites/ClinicalGuidancePortal/ClinicalGuidelines/Forms/COM_Transition_Team.aspx

www.carerskillspassport.org.uk

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[4] Herrmann-Garitz C, Muehlan H, Bomba F, Thyen U, Schmidt S. [Conception and Measurement of Health-related Transition Competence for Adolescents with Chronic Conditions - Development and Testing of a Self-Report Instrument]. Gesundheitswesen. 2015 Aug 13 e-pub ahead of print

[5] Shaw KL, Southwood TR, McDonagh JE. *Young People's satisfaction of transitional care in adolescent rheumatology in the UK.* Child: Care, Health & Development 2007;**33**:368-379

Safe Transition from CAMHS to Adult Mental Health Provider Procedures (see on DMS)

Framework for Transitioning Complex Young People to Local Adult Community Primary Care and Acute Secondary Care Services SOP (see on DMS)

Related policies (see on DMS)

- Informed Consent Policy – C7
- Data Protection and Confidentiality Policy – RM44
- Confidentiality Code of Conduct
- Safeguarding Adults Policy – M3
- Privacy and Dignity Policy – C47

Appendix A: NICE NG43 - Transition Self-Assessment Standards

NICE NG43 FINAL
-January 2020 standa

NICE NG43 transition
Baseline-assessment-t

Appendix B: Transition Policy Standards Based on the 10 Steps to Adult Services

Step 1

1.1. All young people with long-term conditions and their families are aware of the need for Transition to Adult Services before their 15th birthday

1.2. Consultants caring for young people with long-term conditions identify markers for complex or difficult transition before the young person's 15th birthday and notify the Transition Team if appropriate

1.3. Individual Specialties, the Trust Transition Team, Adult Services, Commissioners from both Adult and Children's Services, and Patient Representatives meet at least annually to plan services for the cohort of young people with long-term conditions as they move into adult services

Step 2

2.1 All young people have access to a developmentally appropriate generic health education and empowerment programme developed and delivered in partnership with their local education provider, commenced before their 15th birthday

2.2 All young people with long-term conditions have access to developmentally appropriate information and advice regarding their condition and its management, before their 15th birthday

2.3 All young people with long-term conditions have the option to receive copy letters, together with opportunities for explanation and discussion of the letter and its contents.

2.4 All young people have the opportunity to be seen without their parents for part of their consultation.

Step 3

3.1 All young people have access to a handheld, personalised Transition Plan, commenced before their 15th birthday

Step 4

4.1 All young people with long-term conditions who are supported by three or more specialist medical services have a clearly identified Lead Consultant identified before their 15th birthday

4.2 Young people of transition age (14 – 25 years) with long-term conditions receive transition support from a Condition-specific Keyworker

4.3 The young person's GP is actively involved in the young person's transition including routine prescriptions, reviews for minor illnesses and planning the young person's route into urgent care at the latest from their 15th birthday

Step 5

5.1 Each young person with a long-term condition is referred to adult services at the latest before their 16th birthday.

5.2 The Lead Consultant liaises with other involved consultants to plan referral to adult services where a young person is supported by three or more specialist medical services

5.3 A detailed summary of the young person's medical records is available for each specialist medical service in the adult sector

Step 6

6.1 Each young person with a long-term condition has at least one joint with children's services leading

6.2 Professionals from adult services introduce themselves to the young person and their family and explain their role

Step 7

7.1 Each young person has a clear plan for access to urgent (emergency) care including a self-management plan and the role of their GP

7.2 Young people have the opportunity to visit adult A&E and inpatient facilities before moving to adult services

7.3 Support for young people with complex long-term conditions in inpatient settings includes carers (or parents) in-reaching to continue to support the young person's "everyday" care needs, where appropriate

Step 8

8.1 The young person themselves, adult and children's services decide and clearly communicate the date after which the young person will be admitted to adult services if they require inpatient care

8.2 The young person themselves, adult and children's services decide and clearly communicate the date after which the young person's outpatient reviews take place in the adult sector

Step 9

9.1 Each young person with a long-term condition has at least one joint with adult services leading

9.2 Attendance at adult clinics for transition patients is actively monitored and non attendance is followed up.

Step 10

10.1 All young people previously cared for by Alder Hey children's hospital will be in adult services by their 19th birthday

10.2 Young people completing transition have the opportunity to feedback on their experience of transition

There will be a phased approach towards achieving the above standards. This will start with 4 identified specialties in the first 12 months, then cascading the tools and learning over years two and three.

(For exceptions see Special Circumstances, Section 6)

Appendix C

Framework for Transitioning Complex Young People to Local Adult Community Primary Care and Acute Secondary Care Services SOP

(see on DMS)

Equality Analysis (EA) for Policies
The Public Sector Equality Duty (section 149 of the Equality Act 2010) requires public authorities to have due regard for the for need to achieve the following objectives in carrying out their functions: a) Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010. b) Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it. Please refer to Equality Analysis Step-Wise Guide for Policies when completing this form

Policy Name	Transition to Adult Services	
Policy Overview	To ensure a safe, smooth, coordinated, person-centred, Transition to Adult Services for all young people with long term conditions under the care of Alder Hey Children's hospital.	
Relevant Changes (if any)	Click here to enter text.	
Equality Relevance Select LOW, MEDIUM or HIGH	HIGH	
If the policy is LOW relevance, you **MUST** state the reasons here.	Click here to enter text.	
Form completed on:	Date: 06/05/2022	
Form completed by:	Name: Jacqui Rogers	Job Title: Trust Transition Nurse Lead

If LOW relevance, proceed to Approval and Ratification Section. No further information required

If MEDIUM or HIGH Equality Relevance, complete all sections		
Equality Indicators Identify the equality indicators which will or could potentially be impacted by the policy and include details of how they may be impacted. (use **Equality Relevance** to assess the impact on each protected characteristic)	Protected Characteristic	Mitigation
	Age ☑ How: Click here to enter text.	Transition preparation is for all children from the age of 12-14 years until they move to adult health care providers
	Disability ☑ How: Click here to enter text.	Protecting the most vulnerable patients
	Gender reassignment ☐ How: Click here to enter text.	Click here to enter text.
	Marriage & Civil Partnership ☐ How: Click here to enter text.	Click here to enter text.
	Pregnancy or Maternity ☐ How: Click here to enter text.	Click here to enter text.
	Race ☐ How: Click here to enter text.	Click here to enter text.
	Religion or Belief ☐ How: Click here to enter text.	Click here to enter text.
	Sex ☐ How: Click here to enter text.	Click here to enter text.
	Sexual Orientation ☐ How: Click here to enter text.	Click here to enter text.

	Human Rights (FREDA principles) ☑ How: This policy will apply the FREDA principles, Fairness, Respect, Quality, Dignity and Autonomy, and is related to all children and young people within the age group 12-18, and those who may have a disability.	FREDA principle 1: All patients will be treated fairly, having the same access to health care and planning. Plans of care will be designed around the individual needs of every patient using a person centred approach. FREDA principle 2 & 4: All patients will be cared for with respect and dignity. Plans for Transition will be person centred, ensuring all patients and their families and carers feel empowered, supported and worthy. All patients and families will be treated with the highest of respect and given the best possible care, tailored around their health, educational, social, emotional, psychological, physical and cultural needs. FREDA principle 3: All patients will receive a tailored, person centred quality Transition plan, using the transition tools designed by the Trust. Patient and family satisfaction will be monitored, and an end of year report will be produced outlining and addressing any quality issues.FREDA principle 5: All patients will be empowered (where they have capacity) their parents and carers will also be empowered and supported to manage the patients' health care, promoting self-management and independence
Equality Information & Gaps What equality information is available for protected groups affected by the policy? If none available, include steps to be taken to fill gaps.	The policy has been informed and driven by research, national guidance, feedback from patient and parent engagement, professionals roadshows, a web based survey, and a full day workshop. Keeping patients safe, using shared decision making, empowerment and involving patients, parents and carers with planning has been fundamental in the development of the Ten Step Transition Pathway. We do not know if this group of patients (relevant according to age and disability) who have additional protected characteristics will have greater vulnerability in the transition process and this will be monitored.	

Stakeholder Engagement What stakeholders are engaged to help understand the potential effects on protected groups? See **Gunning Principles** for public consultation requirements. **How has consultation influenced the policy?**	This policy was consulted widely in paediatric and adult health sectors to shape and influence it. Parents have and will continue to be included in the development of this policy. The effective implementation of this policy will support Transition for all patients to adult service providers. This will result in improved engagement of the patient with adult service providers and lead to improved health and life outcomes. Key stakeholders include: • Parents • Safeguarding Lead Alder Hey • Alder Hey Children's Inpatient Nursing lead • Adult inpatient nursing • Children's community nursing • Adult community nursing • Community paediatrics • Adult Respiratory Consultant • Respiratory paediatrics • GP/ primary care • Paediatric Neurology • Adult Neurology • Paediatric palliative care • Adult palliative care • Adult Learning Disabilities • Education Special Schools • Social care • CAF Plus/ One Plan facilitators • Together for Short Lives Transition taskforce • Palliative Care Network for People with Learning Disabilities • Alder Hey Transition Research Project • Liverpool Local Authority Transition Group • Northwest Ambulance Service • A number of Adult District General Hospitals Engaging with a local adult Trust we were able to work collaboratively to address a service provision gap for patients with very complex long term conditions. This Trust is now using intelligence from our Trust, developing a business case for CCG commissioners to seek funding to set up a service to enable this complex cohort of patients to move to adult service provision, where before there was none identified. These patients currently remain in paediatric services.
Interdependency How will this affect other policies, projects, schemes from an equality perspective?	This policy will impact positively and support the carer skills passport project, as it will identify markers of complexity to enable us to identify complex patients. This will inform the complex patient database, and support the delivery of carer skills training to the parents and carers who require this support. This policy will also impact positively and support the following policies: records management, duty of candour policy, privacy and dignity policy, the patient information leaflet and patient access policies, the management of patient flow policy, equality, diversity and human rights policy, discharge planning policy, support the safeguarding procedures, and the advanced care planning policy

Public Sector Equality Duty Include a summary of how each of the PSED requirements have been considered in order to demonstrate compliance with the Act.	a) Eliminate discrimination, harassment, victimisation etc Click here to enter text.	
	b) Advance equality of opportunity Click here to enter text.	
	c) Foster good relations Click here to enter text.	
	Has the Public Sector Equality Duty been met? Yes ☒ No ☐ This policy is intended to impact positively on all patients particularly with disability and age group 12-14 years in relation to Transition preparation and handover of care to adult services as this is the purpose of the policy. The aim is to make this Transition Policy a Liverpool wide policy (framework), or a North West Transition (framework) policy including paediatric and adult service providers. It promotes joint working for the benefit of all patients with a long term health conditions, who will take part in Transition preparation, and who will move to adult health care providers. Audit will establish the inclusivity of this policy, to ensure the policy mitigates negative equality impact on patients who have other protected characteristics	
Monitoring Include details of how the equality impact will be monitored.	Monitoring will be focused on the effectiveness of this policy to support delivery of a seamless transition to adult health service providers, promoting continued engagement with adult service providers for all young people. The policy is not condition specific and its inclusiveness will be monitored also. Monitoring will also include the identification of complex patients, to ensure we are able to offer recruitment to the carer skills passport for carers and parents of all patients with long term, complex health care needs. Outcomes will be measured and delivered in an end of year report which will be developed to identify the success and learning, findings will be disseminated Trust wide. The equality analysis review will run in parallel to the service audit and production of annual reports, and equality analysis results will be included.	
Review of Equality Analysis (if indicated)	Rationale for review: Click here to enter text.	
	Changes made: Click here to enter text.	Reason for change: Click here to enter text.

If **MEDIUM** or **HIGH r**elevance, the EA should be reviewed annually. Complete Approval and Ratification Section.

Approval & Ratification of Equality Analysis		
Policy Author:	Name: Jacqui Rogers	Job title: Trust Transition Lead Nurse
Approval Committee:	Community and Mental Health Policies Sub-Group	Date approved: 01/05/2022
Ratification Committee:	Clinical Quality Steering Group	Date ratified: 14/06/2022
Person to Review Equality Analysis:	Name: Jacqui Rogers	Review Date: 14/06/2022
Comments:	Click here to enter text.	