ASSESSMENT OF NEED

The Transitional Nurse Coordinator will:
- Undertake a health needs assessment of the young person to ensure smooth access to appropriate transfer of care to adult services.

- Undertake joint assessments with other professionals, to reduce the number of face to face contacts with families.

- Work in partnership with families and professionals in the statutory and voluntary sectors, to develop individual care pathways and protocols.

- Aim to have a detailed multi-disciplinary plan agreed with young people in place as soon as possible.

MISSION STATEMENT

This service works with young people who have complex physical health needs or life-limiting conditions, to negotiate a plan and support for them and their families throughout their transition from children's to adult services.

The service aims to meet the young person's needs and values the importance of each young person being given the opportunity to meet their full potential.

The service acknowledges the physical, social, emotional, cultural and spiritual need of every individual child, young person and their families.

REFERRALS

Anyone can make a referral to the service
Telephone for a referral form on:

01923 470680
Post completed forms to:

The Administrator
Hertfordshire Health Transitional Service
Peace Children's Centre
Prospect House
Watford
Herts
WD17 470680

Or

Email : hct.transition.herts@nhs.net

Our opening times are:
Monday to Friday 9 – 5pm
Public Holidays Closed

Website: http://www.hct.nhs.uk/our-services/herts-young-peoples-health-transitional-service

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Hertfordshire Community NHS
NHS Trust

Young People's Health Transitional Service

Guidelines for professionals

Hertfordshire Young People's Health Transitional Service

AIMS

The aim of the Transitional Nurse Coordinator is to:

- coordinate the transfer of health care from paediatric to adult services, for young people with complex physical health needs or with life limiting conditions throughout Hertfordshire

- link with the following agencies:
  - Health services in the acute and community sector
  - Children's, Schools and Families and Health and Social Care
  - Voluntary Agencies and Hospice Care

- act as a resource on health care matters to families and multi-disciplinary / multi-agency teams

- coordinate training for carers, based on the young person's individual health care needs

REFERRAL CRITERIA

Any young person aged 14-21 years with complex physical health needs where there is not an identified health referral pathway at the age of 14 years.

A young person who requires jointly commissioned health, education and social services i.e. they require greater resources than those available in an individual service.

Complex Physical Health Needs

Technology dependent children, complex or intense medical, nursing or other clinical needs i.e. ***two*** of the following:-

- Complex, chronic, respiratory conditions requiring ventilatory support CPAP / BIPAP
- Child with a tracheostomy
- Child receiving Total Parenteral Nutrition via a central line
- Renal dialysis i.e. peritoneal / haemo-filtration
- Acquired brain / spinal injury
- Administration and monitoring of complex drug regimes
- Artificial feeding via naso-gastric, naso jejunal or Gastrostomy tube
- Restricted mobility which requires regular and frequent positioning, moving and handling in order to treat/prevent pressure sores
- Oxygen dependence

Life-Limiting Conditions

A young person aged 14-21 years who has developed a condition in childhood, which is likely to result in their premature death (before the age of 40 years) and who may have palliative care needs. These may include the following conditions:-

- Duchenne Muscular Dystrophy
- Cystic Fibrosis
- Progressive conditions such as Battens Disease, CJD, Mucopolysaccharides
- Neurological disability such as severe Cerebral Palsy, brain or spinal cord injuries
- Cancer when treatment fails
- Irreversible organ failure