

# NICE Transition Guideline: Key points for services

1. Ensure transition support is developmentally appropriate
  - Person centred
  - Transition plans jointly agreed with young people
  - Plans have a positive focus
2. Ensure young people have a named GP.
3. Start transition early ensuring it is developmentally appropriate taking into account young people's abilities, needs and hopes for the future.
4. The point of transfer should not be rigid and should take place at a relatively stable point for the young person.
5. Hold an annual review of the transition plan, or more frequently if needed.
6. Information from the transition plan should be shared with those involved in delivering care to the young person.
7. Transition plans should be linked to other care plans in place.
8. A named worker should be nominated for each young person in transition- the named worker may be supported by an administrator.
9. Named worker chosen to fit with the young person's need and someone who has a meaningful relationship with them.
  - Named worker should support the young person for a minimum of 6 months.
  - For disabled young people the named worker should liaise with education practitioners to ensure comprehensive, student focused transition planning is provided.
10. Services should involve young people in transition planning including:
  - Peer support
  - Coaching
  - Mentoring
  - Advocacy
  - Use of mobile technology
11. Age appropriate communication tools and literature/ information
  - Consider offering individual peer support or mentoring during transition

- Help young people to self-manage long-term conditions as part of transition including assessment of young person's ability to self-manage and readiness to move to adult services
12. Ask young people regularly how they would like their parents and carers to be involved, including when they have moved to the adult service.
  13. Ensure you consult the young person's parents and carers to understand their expectations of transition
    - Take into account the young person's wishes
    - Take into account the young person's capacity and consult the Mental Capacity Act if required
  14. Help young people to develop confidence when dealing with adult services helping them to raise concerns for themselves.
  15. Adult services need to ensure they take the young person's wishes into account when involving parents or carers in planning support.
  16. Support before transfer - ensure young people meet a practitioner from the adult service before transfer.
  17. Ensure a contingency plan in place if named worker leaves their position.
  18. Personal transition folder including:
    - A one page profile
    - Information re health condition, education, social care needs
    - Preferences re parent/ carer involvement
    - Emergency plans
    - History of unplanned admissions
    - Strengths, achievements and hope for the future and goals
  19. All services should give young people and families' information about what to expect from services and what support is available to them.
  20. Support young people to visit adult services.
  21. Support after transfer - if not engaged follow steps to re-engage. if not engaging then consider referring back to the named worker.
  22. Ensure the young person sees the same practitioner in adult service for the first 2 appointments.

23. Ensure they see the same social worker through the assessment and planning process.

24. Planning and developing transition services

- Consider independent advocacy being available to young people after transfer to adult service
- Youth Forum to look at transition services - gain feedback
- Ensure data from Education Health and Care Plans are used to inform service planning
- Gap analysis support in children's versus support in adults service- take into account primary care provision with attention to neurodevelopmental disorders, Cerebral Palsy, and challenging behaviour, or supported in palliative care.

25. Developmentally appropriate service provision

- Consider age banded clinics

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