# Transition Pathway for Young People with Complex Health Needs

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WellChild
the national charity for sick children

## 11-13 Years — Transition Preparation Phase:

Begin discussions with the young person and family about future transfer from childrens to adult service

Identify Lead Consultant

Discuss what healthcare needs the young person will potentially need as an adult and whether they will require a specialist service or be discharged back to the GP

Identify a key worker to support the young person and their parent/carer through transition

Use a transition preparation tool if appropriate to support transition discussions e.g. Ready Steady Go Transition Programme / Ten Steps

Agree a developmentally appropriate transition plan with young person and parent/carer including goals and timescales

Complete Healthcare Passport (HCP) and update 6-12 monthly

Ensure the young person and their parent/carer are aware of changes to the law regarding mental capacity

## 14-16 Years — Pre-Transfer Phase:

Identify the adult health services the young person will require

If available, provide written information about the adult service they will be referred to in the community / hospital

Arrange for the young person / parent / carer to meet adult healthcare professionals / unit and discuss transition plan and any reasonable adjustments required to meet complex health needs

If young person has a learning difficulty remind GP to do annual health check

Arrange a multi-professional transition planning meeting to co-ordinate transfer arrangements if the young person is under multiple specialties

Ensure the young person and family know their route into urgent care whilst in transition

Make appropriate and timely referrals and complete transfer documentation

Update any Healthcare Passport (HCP)

Ensure Advanced Care Plan (ACP) is discussed and completed prior to transfer

Send updated HCP and ACP to relevant teams along with transfer documents / letters ensuring young person / parent / carer are provided with copies

Agree date of transfer

## 16 Years Plus — Post-Transfer Phase:

Ensure the young person and family have a key worker to support them post transfer

Ensure the young person and family have any reasonable adjustments met to support complex health needs

Provide the young person and family with contact details for the adult service

Ensure the young person and family are aware of their route into urgent care

Remind the young person and their family about changes to the law regarding mental capacity and best interest decision making

Ensure safety net is in place for any young person failing to engage with adult services by referring back to children's services or GP

Review and update HCP and ACP on transfer and every 6-12 months

Agree date of transfer

- Liaise with specialities and professionals across health, community, social care, and education throughout all phases to align transition preparation and plan
- Refer to MFT Transition of Care for Young People Strategy and NICE Guideline 2016: Transition from children's to adults' services for young people using health or social care services

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