Sheffield Children's NHS
NHS Foundation Trust

Healthcare Transition Strategy 2023-2028

Contents

1. Executive summary

The Transition Strategy is framed within the Trust's Caring Together strategy, and our overall purpose of providing a healthier future for children and young people. The Caring Together strategy sets our three aims:

- Outstanding Care
- Brilliant Place to Work
- Leader in Child Health

The Transition Strategy helps us deliver our Quality Promise for children and young people:

Safe, Kind and Outstanding Care for Everyone

This Transition Strategy also directly sets out how we deliver the following ambition from the Integrated Care theme of our Clinical Strategy (2022-2027):

"Adolescence is a time of physical, psychological, educational, and social change. We will deliver developmentally appropriate joined up healthcare services with our partners, providing a consistent, safe, individualised high-quality transition service across physical and mental health pathways that enables young people and carers to move and engage with adult services with minimal disruption to their care, resulting in a positive carer experience."

The refreshed Transition Strategy 2023-2028 supports the delivery of this ambition and sets out objectives for the Trust to deliver the best experience for young people who are moving to adult services in accordance with national standards and guidance. We know that well-planned transition improves clinical, educational, and social outcomes for young people.

Our overall aims for our Transition Strategy are:

- To provide a safe, effective, developmentally appropriate transition process and transfer (handover) from children's services to adult-orientated healthcare services for all young people with long-term conditions requiring ongoing care.
- To ensure young people and carers experience a transition process that equips them with the required knowledge and skills to manage and engage fully in adult services.
- To work collaboratively with the adult services and other partner organisations to bridge identified gaps between paediatric and adult healthcare, improving continuity and outcomes.
- To support, empower and listen to young people in the development and improvement of transition services to ensure excellent patient experience.

2. Our approach to developing the strategy

During the development of the Clinical Strategy in 2022, transition came up as a strong theme that people wanted the Trust to focus on. We heard that whilst great progress had been made, practice around transition was still inconsistent, leading to variable experience for young people.

We heard that our partners wanted to collaborate with us further on this – both senior clinical leaders and senior managerial leads. There was great feedback on the work of the central transition team, a sense that while good progress had been made on the physical health side, there was more work to be done on our mental health pathways.

This led to the articulation of the specific ambition regarding transition in the Integrated Care theme of the Clinical Strategy.

Sheffield Children's central transition team refreshed the Transition Strategy by gathering feedback and input from all the members of the Trust's transition steering group.

Feedback was also sought from the Executive Lead for transition, from members of the Youth Forum, from Sheffield Health and Social Care NHS Foundation Trust, wider Sheffield Place Partners, and the Integrated Care System. The clinical executive team provided input in January 2023.

Existing strategies

Alongside the development of the Clinical Strategy, work has also been done to ensure the content of this strategy informs, supports and helps to deliver a joined-up approach within the context of the wider Trust strategic context, including:

- Our People Plan
- Our Quality Promise
- The five other enabling strategies (Digital, Estates, Education & Learning, Workforce and Research & Innovation)

3. A changing strategic landscape

The national context and evidence

The Transition Strategy is launching at a challenging time. 328,000 children and young people live in South Yorkshire and, even prior to the Covid-19 pandemic, we had some of the highest deprivation rates, health inequalities and worst health outcomes in the country. The Covid-19 pandemic has worsened this and driven up waiting lists for children across our services.

We know from the evidence that people often receive fragmented, poorly coordinated care, which leads to poorer experience and outcomes (King's Fund 2022). This particularly affects:

- Children and young people with complex conditions, disabilities and needs
- Children and young people undergoing transition between paediatric and adult health care
- Vulnerable young people from specific inclusion groups who have complex needs

There is a particular risk of these people falling between gaps. Our strategy responds to this evidence and sets out our objectives to deliver the best experience to achieve more seamless, integrated care for young people who are moving to adult services in accordance with national standards and guidance.

We know that doing this well will particularly benefit those children, young people and families who experience the greatest health inequalities, and in this way meet the wider strategic themes of our Clinical Strategy.

Our strategy has researched best practice in terms of the national work on transition and worked with partners across South Yorkshire in its development. Using that best practice, the definition for transition we are adopting for Sheffield Children's is:

"a purposeful, planned process that addresses the medical psychosocial and educational/vocational needs of adolescents and young adults with chronic physical and medical conditions as they move from child-centred to adult-orientated healthcare systems" (Department of Health (DOH) 2006, page 14)

The other key term in this strategy is 'transfer', which we define as the actual point at which the responsibility for providing care and support to a person moves from a children's to an adults provider. Transfer usually occurs between 16 years and 18 years at a time of relative stability *(see NICE guideline NG43, Cross Trust Transition Pathway for Sheffield Children's Hospital and Sheffield Teaching Hospitals, Trust Transition Policy CP1551)*.

Relationships and partnerships

The Health and Social Care Act 2022 has redrawn relationships between NHS organisations and their partners, at city, system, regional and national level. The duty to collaborate will further benefit the aims of the Transition Strategy.

Successful delivery of the Transition Strategy will require teams in the Trust to develop close partnership working with commissioners, health organisations, schools and colleges, voluntary sector organisations, local networks and other health and social care providers including general practice.

We will use the additional statutory powers of the ICB as context to help deliver our Transition Strategy and the opportunity to agree shared priorities for transition across place and South Yorkshire level. The Acute Federation and the Mental Health Provider Collaborative and more formal obligations to collaborate provides further vehicles through which we can lead, influence and advocate for transition to be a priority across the board.

Additionally, we anticipate the greater collaboration through the Children and Young People's Alliance and Children's Hospital Alliance will enable us share good practice, learn from others and advocate for stronger representation of young people's issues, such as transition, at national level.

4. Our context – where we are now

In May 2017, a transition team was established, to improve transition services within the Trust. This followed a CQC visit in June 2016, which had rated transition services in the Trust as 'requires improvement'. The team successfully drove forward several improvements including:

- Development of cross-trust transition meetings
- Complex transition support pathway
- Transition champions directory
- Annual transition study days
- Incorporation of transition into mandatory training
- Trust-wide audits
- The development of a transition policy and strategy
- Sharing learning from transition-related incidents
- Transition tab in the electronic records including a live transition plan
- Improved communications including a quarterly transition newsletter and the introduction of the 'transition awareness week'

These activities enabled the Trust to secure a 'Good' rating for transition services in 2019. The transition team was further expanded in 2020 and works in an advisory and supportive capacity. The team includes clinical leadership time, an overall lead transition nurse and further dedicated sessional nursing leadership time from both physical health services and CAMHS. The team also includes management support, a Trust-wide transition coordinator and administrative support.

The central transition team worked collaboratively with Sheffield Teaching Hospitals NHS Foundation Trust to develop cross-trust Covid transition principles in 2020 with an individualised approach maintained and care managed in partnership.

Following the pandemic, transition services were fully recovered and the central transition team has continued to build on the successful progress following the CQC reviews. Further improvements since 2021 include:

- Transition mandatory training included in compliance reports
- Transition flag on electronic clinic outcome forms developed to enable specialities to record young people needing transition plans
- Use of live transition plans in the Trust increased by targeted education and updates and a creation of a 'top tips' poster, informed by a recent audit on live transition plans
- Restarting the complex transition support pathway and standardising the transition MDT approach (an example is transition MDT support for a young person that required transition across 24 pathways). The work of this team has grown – from June 2020 to March 2023, 57 young people have been supported through this team
- Collaborative working with primary care, adult trusts and the integrated care system
- Audits reviewing patient experience of transition
- Transition included as an agenda item in the surgery and critical care and medicine care group meetings quarterly
- Involvement from the Youth Forum
- Sharing good practice through hosting a virtual national transition conference
- Supported development of specific specialty transition pathways amongst other workstreams

The total number of young people with a transition plan has increased because of the work, education and support of the transition team. This is monitored via the Board Integrated Performance Report and shows that in February 2023, 2344 young people over 14 had a transition plan, compared to 1982 in February 2022 and 1935 in February 2021.

Additionally, the team is now contributing to wider leadership and research nationally. The clinical lead co-leads the transition theme for the National Institute for Health Research Children and Young People Medical Technology (NIHR CYP MedTech) Cooperative and has been involved with collaborative projects related to digital resources for healthcare transition.

The Trust has participated in the recent National Confidential Enquiry into Patient Outcome and Death (NCEPOD) study on transition and has been invited as a site for the National Transition Evaluation Study.

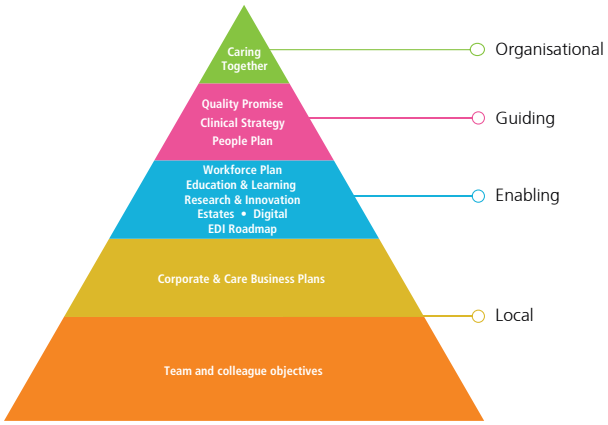
Whilst significant progress has been made, there remains more work to do. The core messages for the next stage of the journey, from our engagement with young people, families, colleagues, and partners were:

- Whilst great progress had been made, practice around transition was still inconsistent, leading to variable experience for young people.
- A sense that while good progress had been made on the physical health side, our mental health pathways needed further focus and support.
- Inadequate resources within individual specialty teams across the Trust has been brought up as a recurring issue impeding further progress at pathway level as well as difficulties when a mirror adult service to transition care does not exist. Speciality teams are highlighting these on their care group's risk register and indicate the further work required to build on the progress made so far.

5. How the Transition Strategy aligns with the other Trust strategies

'Caring Together' sets the organisation's overall purpose of "providing a healthier future for children and young people". This is delivered via three 'guiding' strategies - the Quality Promise, the Clinical Strategy and the People Plan.

Together, these strategies will deliver an aligned, coherent,strategic approach:



The Transition Strategy supports commitments in both the Quality Promise and Clinical Strategy.

Quality Promise

Our Quality Promise sets out what children, young people and families should expect whenever and however they receive care. Our Quality Promise consists of a core Quality Promise for children, young people and families:

The Quality Promise is underpinned by our four foundations for care:

- Listen and involve
- Quality improvement
- Culture for quality
- Systems and processes

Through our engagement on the Clinical Strategy and Quality Promise we listened to strong feedback from children, young people and families, alongside colleagues across the Trust and our partners, that transition needed to be a priority area for the Trust.

We heard that whilst great progress had been made, there were still improvements to be made. The Transition Strategy directly helps deliver all dimensions of our Quality Promise and specifically how they apply for young people undergoing transitions between care providers.

Clinical Strategy

The Transition Strategy directly sets out how we deliver the strategic ambition focused on transition, within our Integrated Care theme:

"Adolescence is a time of physical, psychological, educational, and social change. We will deliver developmentally-appropriate joined-up healthcare services with our partners, providing a consistent, safe, individualised high-quality transition service across physical and mental health pathways that enables young people and carers to move and engage with adult services with minimal disruption to their care, resulting in a positive carer experience."

Additionally, the strategy supports all wider themes with its intention to deliver care in the most appropriate setting, depending on the developmental needs of the young person where needed, and will particularly benefit children and young people from communities and inclusion groups that experience health inequalities, in turn supporting and empowering them to live healthier lives.

People Plan

The Transition Strategy will be implemented by all healthcare professionals who work with young people with long-term health conditions, and in this way aligns with the People Plan theme 'New ways of working and delivering care'.

The transition team will drive forward and support teams to develop robust transition services. National guidance, lessons learned from within the Trust, external stakeholders and organisations, and our local network underpin this.

6. Our goals

This strategy outlines the Trust's plans to deliver transition over the next five years to meet the expectations of young people and their families who use our services. Our overall aims for this strategy are:

- To provide safe, effective, developmentally appropriate transition process and transfer (handover) from children's services to adult-orientated healthcare services for all young people with long-term conditions requiring ongoing care
- To ensure young people and carers experience a transition process that equips them with the required knowledge and skills to manage and engage fully in adult services.
- To work collaboratively with the adult services and other partner organisations to bridge identified gaps between paediatric and adult healthcare, improving continuity and outcomes.
- To support, empower and listen to young people in the development and improvement of transition services to ensure excellent patient experience.

These four aims are supported by the following specific objectives for all services at Sheffield Children's who support transitioning young people to providers of adult healthcare:

1. Young people who will move from children's to adult's services to have their transition planning by health and social care practitioners started by school year 9 (aged 13-14yrs) or immediately if they enter children's services after that.
2. Every young person who can participate in decision making will be involved in discussions and make informed decisions about their own care.
3. Work with young people and their families to identify key contacts to coordinate their transition care and support, until the first adult appointment is attended.
4. Every young person transferring across care settings will have transition documentation to ensure relevant professionals have access to essential information.
5. Every young person moving to adult services will be supported to prepare themselves and their families for the transition to adult care.
6. Listen to the needs of young people and their families during transition, including when transferring to adult services.
7. Work with regional health and social care providers to plan and coordinate care for young people moving to adult services.
8. Everyone involved in the transition of healthcare will be provided with training and support.
9. The Trust will maintain up-to-date transition policies, pathways and guidance.

The specific actions that sit under each of these objectives are set out in detail in the following chart, mapped to the Trust's three aims:

		Outstanding patient care	Brilliant place to work	Leader in children's health
Objective 1	**Young people who will move from children's to adults services to have their transition planning by health and social care practitioners started by school year 9 (aged 13-14yrs) or immediately if they enter children's services after that**	X		X
	What we will do			
	1.1 Discuss transition with young people and their families from an early age about what to expect during and after transition.	X		X
	1.2 Transition and transfer processes will be developmentally appropriate considering the maturity, cognitive abilities, need in respect of long-term conditions, social and personal circumstances and psychological status of the young person.	X		X

		Outstanding patient care	Brilliant place to work	Leader in children's health
Objective 2	**Every young person who can participate in decision making will be involved in discussions and make informed decisions about their own care**	X		X
	What we will do			
	2.1 Advocate the use of tools such as 'Ready, Steady, Go' to enhance opportunity for participation and discussion with the young person	X		X
	2.2 Prompt professionals to consider Mental Capacity Act for all young people over 16 years	X		X
	2.3 Utilise feedback from Youth Forum, young people groups and the Parent Carer Forum in the delivery of this strategy	X	X	X
	2.4 Encourage services to offer every young person the opportunity to be seen alone for part of their consultation from the age of 14 years where appropriate	X		X
	2.5 Give patients the opportunity to express their concerns about moving to adult services and support them through a quality transition	X		X
	2.6 Promote autonomy to improve the young person's confidence in managing their health	X		X
	2.7 Encourage individualised person-centred planning to empower patients and families	X		X
	2.8 Ensure young people 16 years and over are included in any correspondence	X		X
Objective 3	**Work with young people and their families to identify key contacts to coordinate their transition care and support, until the first adult appointment is attended**	X		X
	What we will do			
	3.1 There will be a key worker to support the transfer of every young person from children to adult health services	X		X
	3.2 The key worker will initially be someone based in young people's services but will hand over their responsibilities to an appropriate professional in the adult services	X		X
	3.3 For young people with an Educational Health Care Plan (EHCP), we will work alongside education practitioners to ensure educational needs are included in their transition planning	X		
	3.3 For young people with an Educational Health Care Plan (EHCP), we will work alongside education practitioners to ensure educational needs are included in their transition planning	X		

		Outstanding patient care	Brilliant place to work	Leader in children's health
	3.4 To work closely with Sheffield Teaching Hospitals transition team, Sheffield Health and Social Care Trust and other providers to improve transition pathways for young people. To use the learning to develop pathways for young people transitioning to other adult trusts both regionally and nationally	X		X
	3.5 Promote and encourage good relationships between young people and the GP and primary care services	X		X
	3.6 Support young people whose transition planning is complex, by referring to the complex transition support pathway	X		X
Objective 4	**Every young person transferring across care settings will have transition documentation to ensure relevant professionals have access to essential information**	X		X
	What we will do			
	4.1 Ensure transition documentation is put in place by the specialties involved and in consultation with young people and parents/carers where appropriate	X		X
	4.2 Health Passports will be promoted for patients who may benefit from their use	X		X
	4.3 Improve the Trust's database to better monitor young people in transition and ensure accurate shared records are maintained	X	X	X
	4.4 Establish and maintain a pathway to ensure relevant Sheffield Teaching Hospitals staff have access to Sheffield Children's electronic records and explore pathways to provide such access to other adult receiving services	X		X
	4.5 Ensure relevant information is shared with other organisations, in line with local information sharing and confidentiality policies	X		X
Objective 5	**Every young person moving to adult services will be supported to prepare them and their families for the transition to adult care**	X		X
	What we will do			
	5.1 Act as an advocate and engage with young people holistically about what to expect during transition	X		X
	5.2 Support young people to maximise engagement with their outpatient care by exploring the use of virtual meetings	X		X
	5.3 Signpost the support available to young people, by ensuring all resource links are up to date and accessible	X		X
	5.4 Introduce a transition plan to gradually prepare the young person for adult services, to be reviewed annually	X		X

		Outstanding patient care	Brilliant place to work	Leader in children's health
	5.5 Acknowledge and raise awareness of the adolescent population to ensure developmentally appropriate healthcare is in place to reduce the risk of disengagement	X		X
	5.6 Support young people within the Youth Forum to transition to equivalent adult support networks and services	X		X
Objective 6	**Listen to the needs of young people and their families during transition, including when transferring to adult services**	X		X
	What we will do			
	6.1 Support and empower the young person to make decisions and build their confidence to direct their own care and support over time	X		X
	6.2 Work with adult services to bridge the gap between young people moving from paediatric care across to adult services, until they have attended their first appointment	X		X
	6.3 Continue to collect patient feedback from within the patient experience audit questionnaire to further develop services	X	X	X
Objective 7	**Work with regional health and social care providers to plan and coordinate care for young people moving to adult services**	X		
	What we will do			
	7.1 Work with commissioners and other care providers to ensure arrangements are made and communicated clearly to young people and their families and carers	X		X
	7.2 Our Transition Strategy will be shared with all relevant health and social care providers	X	X	X
	7.3 Adopt a systems leadership approach to work collaboratively, review systems and practices to identify where changes are required	X	X	X
	7.4 During the transition process, jointly review service provision where there are no equivalent pathways to agree appropriate care in adult or primary care services	X		X
	7.5 Identify pathways or specialty that would benefit from support in developing their transition pathways. Implement a six-month transition pathway support package by reviewing and improving their local transition process	X		X
	7.6 Build collaborative relationships with Primary Care and regional hospitals to improve communication around young people's care	X		X
	7.7 Be part of developing regional and national online resources for young people, their families and carers	X		X

		Outstanding patient care	Brilliant place to work	Leader in children's health
	7.8 Work with external young person's services to improve support networks for the young people in the transition process	X		X
Objective 8	**Everyone involved in the transition of healthcare will be provided with training and support**	X	X	X
	What we will do			
	8.1 Ensure the mandatory transition training module is updated to include and promote adolescent health as well as transition	X	X	X
	8.2 Monitor compliance of mandatory transition training within the Trust	X	X	
	8.3 Identify and maintain an up-to-date record of Transition Champions within each speciality	X	X	X
	8.4 Work alongside the adult trust, meeting regularly together with cross-trust steering groups	X		X
	8.5 Host Professionals' Transition Forums with the adult trust to provide up-to-date information, topics and knowledge sharing	X	X	X
	8.6 Host an annual study day with regional and national speakers	X	X	X
	8.7 Provide transition training and support to specialties within the Trust	X	X	
	8.8 Maintain and grow a learning environment that shares learning from others and includes developments through research and education	X	X	X
	8.9 Continue to share best practice and learning in regional and national transition networks. Work collaboratively with these networks to learn from their work/experiences	X		X
	8.10 Build upon the links developed with the Trust's CAMHS team	X		X
Objective 9	**The Trust will maintain up to date transition policies, pathways, and guidance**	X	X	X
	What we will do			
	9.1 Maintain transition documentation based on local and national guidance, subject to a programme of clinical audit to monitor progress	X	X	X
	9.2 Continue to use and develop e-forms to support transition planning	X	X	X
	9.3 Continue to work with regional and national networks to learn from each other and share best practice and latest developments thus improving the service provided	X		X

		Outstanding patient care	Brilliant place to work	Leader in children's health
	9.4 Monitor feedback from young people, their families and carers to continually review and improve our processes	X	X	X
	9.5 Investigate transition-related incidents and complaints to ensure learning points are acknowledged and reflected in the relevant documentation and processes	X	X	X
	9.6 Engage and support in research that promotes and improves transitional experience for young people and their carers/families	X	X	X
	9.8 All specialties will implement the Transition Strategy for their team and maintain their own standard operating procedure	X	X	X

7. Approach to delivery

The executive lead for transition is the Chief Nurse, providing executive ownership in the Trust.

The strategy will be implemented by all healthcare professionals who work with young people with long-term health conditions.

Successful delivery of this strategy will require teams in the Trust to develop close partnership working with commissioners, health organisations, schools and colleges, voluntary sector organisations, local networks and other health and social care providers including general practice.

A project plan has been developed for this strategy, setting out actions by each of the objectives of the strategy outlined above. Risks and action logs are maintained. The overall plan will be overseen by the Transition Steering Group with oversight from the executive lead for transition and the Medical Director.

8. Conclusion

Developing our Transition Strategy is a key part of our Quality, Safety and Experience Strategy and delivers the ambition of the Clinical Strategy.

Our team has made great progress since 2017 and this strategy sets out how we take this work to the next level to deliver consistent, safe, individualised, high-quality transition service that enables young people and carers to move and engage with adult services with minimal disruption to their care resulting in a positive patient care experience.

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Sheffield Children's NHS
NHS Foundation Trust

Sheffield Children's NHS Foundation Trust
Western Bank
Sheffield, S10 2TH

www.sheffieldchildrens.nhs.uk