GP Care Group Policy **Transition for Young Adults**	
Category	Clinical Governance
Policy drafted by	Lisa Henschen
Policy Approved by Operational Lead and date	N/A
Policy approved by Board Lead and date	Ruth Walters, Representative for Quality and Safety Sub-Committee, THIPP lead for Access and Clinical Pathways Nicola Hagdrup, THIPP lead for Access and Clinical Pathways
Date for review	01/08/2015

Introduction

The importance of transitional care has since been highlighted in the National Service Framework for Children and the intercollegiate report Bridging the gaps: health care for adolescents. The GP Care Group adhere to the recommendations within this report that health services have a requirements to take the needs of this group into consideration when planning and developing services, safe and effective transition is now "a key quality issue for the National Health Service".

The GP Care Group believe that services for adolescents should be given significant focus and priority. The transfer of young people, particularly those with special health needs, from child to adult services requires specific attention, taking into account that adolescence is a key period of developmental transition.

Young people (12 – 19 years old) with a chronic medical condition or physical disability will have to transfer from paediatric to adult services. The GP Care Group want to ensure the period of transition is positive, planned and leads to improved outcomes for these young people so that they are ready to take their place in society to the best of their ability.

Applicability

This policy applied to all staff directly employed or seconded to the GP Care Group. It is the responsibility of all clinicians working with children and young people to support a good transition to adult services

In relation to service users, adolescence is not strictly defined by age. It is recognised that transition will typically occur by the age of 18, but the GP Care Group will apply this policy through an assessment of the needs of the individual young people.

Process

- The process for transition will commence when the individual needs of the young people suggest that it would be appropriate. As a minimum, this should be at least six months before their 18th birthday.
- When a referral to adult services is made, the adolescent service user should be informed and assisted to prepare for the transition.
- The written referral to adult services should contain:
    - Clinical history details
    - Current clinical needs
    - Predicted level of future involvement
    - Medication history (where applicable)
    - History of significant side effects (where applicable)
    - Physical health needs
    - Mental health needs
    - Copies of any risk assessments completed.
- On receipt of the referral, the adult services team will make a decision as to whether the service user meets the eligibility criteria for the adult services. In decision on eligibility, the team can request further information.
- The adult services team will notify the children and young people's team about the outcome of the decision. If the referral is deemed not appropriate, a written explanation must be given.
- If the service user is deemed eligible, a care coordinator must be identified by the adult service team and a pre-transfer meeting held to plan the transition. The key purpose of this meeting will be to effectively manage the transition, familiarise the young people, and their family and carers, with the new service.
- The young person should be seen jointly by both services until a smooth transition is completed for them.
- When the point of transition is confirmed, it is the role of the manager of the adult service and the key worker from the children's service to ensure that administrative staff are aware of the transfer in and out of teams and that records (both electronic and manual) are updated.
- There is no set time period for the transition. The duration will be determined by the needs of the service user. However, it is envisaged that the whole process should take no more than 9months (and in exceptional cases 12 months). This should allow for effective planning to begin 6 months before the transition and for the continuation of joint working for 3months (exceptionally 6 months).