Audit Standards- North East Transition Journey

Step One

All CYP aged 15 years with long-term conditions are aware of the need to transition and eventually move to adult services. This is discussed with them and documented in notes/clinic letters

Trusts have a policy to identify and highlight patients aged 14 years + with a long-term condition on electronic noting systems

Patients aged 15 years and above with a long-term condition have a transition flag on their notes

Exceptions:

- Patient diagnosed after 15th Birthday

Step Two

All CYP aged 14 years + with a long-term health condition have started a ready steady go programme or similar

All CYP aged 14 years + have the option to receive a copy of the clinic letter or a separate letter sent to the patient

All CYP aged 14 years + are offered the chance to be seen alone

Exceptions:

- Patient lacks the capacity to be seen alone without an appropriate adult

Step Three

All CYP have a hand-held transition plan (or App) before their 15th birthday

Exceptions:

- Patient diagnosed after 15th Birthday

Step Four

All CYP with long-term health conditions have a named key worker documented in notes

All CYP with > three specialities have a named lead consultant for transition

All CYP with neuro disability and LD have health passports by their 16th birthday

Patient attends annual review with GP if applicable

CYP see GP for minor ailments and prescriptions

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Step Five

All CYP offered a choice about where to have adult care, tertiary or local hospital

Exceptions:

- Rare condition service only offered at one hospital

Lead adult consultant identified for all those requiring ongoing adult secondary or tertiary care by 16th birthday.

CYP with LD attend an annual review at GP from their 14th birthday

CYP has a copy of the transition plan/summary of care

Step Six

CYP are given appropriate information about adult services prior to the clinic appointment.

Patients are seen in joint clinics with children and adult services

Patients are given contact details for adult services after clinic appointments

Consent and confidentiality updated in the clinic

CYP receive a summary of the clinic appointment or a copy of the clinic letter with adult services

Step Seven

The young person has a written plan of what to do if acutely unwell

GP is copied into any acute admission plans

For patients with EMHCP and Hospital passports, these are flagged on A&E notes

The young person has been offered an opportunity to visit acute adult admission areas and meet the new team prior to transfer

Or

The young person has been able to watch videos of new acute clinical areas and meet the team virtually

EMHCP and /or hospital passports are flagged on admission systems

Step Eight

The agreed transfer date is documented in the notes

The young person and GP have a copy of the transition plan and route into urgent care

Documentation that the young person is happy to move to adult services

Step Nine

Young people with a long-term condition have at least one joint review with adult services leading.

Attendance at the transition clinic is actively monitored and non-attendance is followed up

RSG checklist completed and documented in notes

Step Ten

All young people will be in adult services by their 19th birthday

All young people have the opportunity to feedback on the transition service

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