

TRANSITION

A guide for commissioners and hospital and clinical teams

The transition from paediatric to adult care should be a planned, collaborative process involving professional caregivers, the young person and family.

Early discussion of transition

The topic of transition should be introduced at least a year before transfer might be expected to take place, allowing time to explore feelings and resolve concerns which the young person and/or parent may have.

Time of transfer

The actual timing of transfer should then be flexible, in accordance with individual needs. In order to avoid either premature moves or prolonged delays, it is, however, recommended that broad age limits for transfer be set and that these should be 14 and 18 years.

Increasing young people's independence and responsibility for their own care

The emphasis in paediatric consultations should progressively be on the young person, but should not exclude parents prematurely or abruptly.

Preparation

Preparation for transfer should be thorough and well planned. The proposed procedure should be discussed with the young person and his or her parents and modified as appropriate. It should provide opportunities for the young person to familiarise him or herself with the new staff and new environment on an informal basis. This should normally include organised visits by the adult team to the paediatric centres, and by the young person to the adult centre.

Joint transition clinics

Joint clinics, where the young person and family can meet the paediatrician and adult physician together, should be held. They should also include opportunities to meet other members of the adult team, along with their paediatric counterparts. The focus on the clinics should be on how the young person's care has been, and will be, managed. The transfer should be managed sensitively, with full account taken of individual needs and concerns.

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TRANSITION/commissioners

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www.cftrust.org.uk

11 London Road, Bromley, Kent BR1 1BY Tel: 020 8464 7211 Fax 020 8313 0472 enquiries@cftrust.org.uk

An intermediary

A key person from the paediatric centre, with whom the young person has a good relationship, should facilitate the young person's introduction to the adult service, and provide emotional support where needed.

Information

A booklet about the adult centre should be provided which includes information about clinical arrangements, in-patient facilities, the names of team members and how to get to the centre.

Ward environment

In-patient facilities should be appropriate for young people, particularly in terms of sleeping and leisure facilities. Staff should be specially trained to respond to their physical and emotional needs.

Provision of service

Provision should be made for the planned management of the transition from paediatric to adult care. Protocols should be drawn up which can be used to negotiate personal plans for each young person, to enable him or her to transfer from the paediatric to the adult service smoothly and with confidence.

SUMMARY OF GUIDELINES

- A planned, collaborative process.
- Early discussion about transition.
- Flexible timing of transfer, reflection individual needs but within broad age limits.
- Gradual change of emphasis from parent to young person within paediatric centre.
- Opportunities provided to meet adult team and visit adult centre.
- Joint transition clinics.
- An intermediary to facilitate transition process.
- Information booklet
- Appropriate in-patient facilities.

This Factsheet was informed by the CF Trust *Coming of Age Project* which was funded by the Department of Health. Copies of the summary report (40 pages) are available from the Cystic Fibrosis Trust – address details are shown on the front cover of this Factsheet.