A round 40,000 children and young people (CYP) are living with a complex physical health condition in England alone (Care Quality Commission, 2014). As they enter adulthood, they may encounter more challenges than those commonly associated with the transition into adult life. Most young people who need ongoing healthcare will receive it from the same multidisciplinary team for most of their childhood. However, once they transition into adult services, a new multidisciplinary team will care for them, possibly in a different hospital environment or location.

An exploration of current health issues suggests the prevalence of CYP with complex health conditions is set to increase. This is due to a number of contributing factors including: advances in medical provision, development of new and improved medical devices, and a reduction in mortality rates for children with complex health conditions and pre-term babies (NHS England, 2014). The public health agenda also forecasts an increase in CYP needing emotional and psychological support, and their being exposed to sexual health problems and alcohol problems at a much younger age than older generations (NHS England, 2014; Department of Health, 2013).

This article explores how such factors might influence how children’s nurses approach transitional care. It outlines relevant national and local policies and procedures, explores the role of the children’s nurse in transition, and considers how best to equip those involved in supporting CYP through the transition process.

Policy and guidance

Government policy on the transition of care from children’s to adult services, nationally and locally, has remained unchanged for several years. A key driver for health professionals to consider the importance of transition was Lord Lamington’s (2003) report of the Victoria Climbie inquiry. This sparked publications such as Every Child Matters (HM Treasury, 2003), which highlighted the needs of young people with learning disabilities and the importance of taking appropriate steps...
towards successful transition. The need to support CYP’s transition into adult services was also highlighted in the DH’s (2004) publication, *Getting the Right Start: National Service Framework for Children*, which focused on improving standards in children’s hospital services. This was followed by a National Service Framework (NSF) for Children, Young People and Maternity Services (DH, 2004), a core standard of which focused on moving into adulthood.

These publications focused attention on meeting the needs of CYP and their families by providing individual care at the point at which they needed it. The 2004 NSF has often been referred to as a ‘needs-led’ policy, providing a common-sense approach by which care could be improved. Each of its core standards contains a vision statement and markers of good practice – including the rationale for change – to help health professionals achieve and demonstrate delivery of a high-quality service. There is also an ongoing drive to measuring the progress of key interventions.

The framework’s Standard 4, *Growing Up into Adulthood*, aims to help with the transition process, while ensuring CYP achieve their full potential. It emphasises the importance of supporting them to take responsibility for their health and make informed choices, while remaining sensitive to their needs. The publication has made a significant contribution to the field, giving health professionals the confidence to consider the needs of CYP, as well as those of their families, and involve them throughout the transition journey.

More recent significant publications relating to transition are the CQC’s (2014) *From the Pond Into the Sea and Ready Steady Go* (Bit.ly/SCHReadySteady), a set of resources developed by Southampton Children’s Hospital designed to help deliver on transition-planning recommendations set out in the National Institute for Health and Care Excellence’s (2016a) guidance.

To improve transition, the following factors are important:

- Good communication;
- Identification of young people’s needs;
- Working alongside other organisations and/or local establishments.

The forecasted rising demand for emotional and psychological support among CYP is potentially increased during transition. HM Government’s (2018) *Working Together to Safeguard Children* highlights the need for advance planning to prepare for transition. Advance planning relies on young people being confident enough to ask questions about their own healthcare and its delivery.

Transition should follow the same principle as safeguarding – supporting young people is everyone’s responsibility. This requires a team, not an individual, approach. The team should be multi-agency and ensure CYP’s voices are heard by involving them in decisions about their care. Transition need not be nurse led, but clear lines of responsibility are needed to ensure all areas are covered, including:

- Medical;
- Social;
- Psychological;
- Educational;
- Vocational.

While all professionals share responsibility for supporting CYP, policy guidance advises the appointment of a key worker or named worker (NHS England, 2019). This is clearly beneficial to the patient but can be problematic if the named worker on whom the young person has come to depend changes their job. NICE’s (2016b) guidance considers this issue and the need to ensure there is a replacement.

An alternative could be to appoint more than one named worker. This would avoid the young person going through ‘transition during transition’ if a key worker leaves. Another option is to use the coaching model; coaching often promotes and encourages self-care, rather than dependence, through the involvement of named workers. A further advantage is that it encourages and actively seeks peer support, providing the young individual with a wider support network.

The Royal College of Nursing’s (2013) guidance, *Adolescent Transition Care*, advocates the use of a planning checklist alongside evidence of achievement, with accompanying signatures from a relevant health professional. Ready Steady Go has moved more towards a list of requirements, rather than being a true reflection of young people’s ability, understanding and knowledge of their own medical needs; it relies heavily on young people providing an accurate account of their knowledge and understanding, as opposed to testing their concordance with their care and ability to self-care. This approach can foster a ‘checklist’ mentality rather than a joint plan of care.

Making Every Contact Count (MECC, Bit.ly/MECC_UK) focuses on health professionals using day-to-day contact time to enable clients/service users to make positive changes to improve their physical and mental wellbeing. This can be used to help address a child’s or young person’s ongoing needs as part of the transition process. It may not always be adequate however – transitioning for CYP with obesity, for example, is one instance in which advice in a ‘moment in time’ may not be enough to encourage long-term changes to health and lifestyle.

PHE and HEE’s (2018) MECC implementation guide aims to address this by recognising that contact time with patients is brief; it provides a toolkit to help health professionals achieve optimal benefit from these interactions so their patients are more confident and motivated to change. The need to maximise parents’ ability to support their children in education, training and employment was also highlighted by the DH’s (2004) NSF.

**Nursing education**

The only module in current nurse training that contains indicative content about transition from child to adult services – as outlined in the NMC’s (2010) pre-registration education standards – is in the second year of the undergraduate children’s nursing programme (Box 1). These pre-registration education standards for all fields of nursing require nurses to:

- Maximise patient self-care and self-management;
- Coordinate the transition between different services and agencies.

For children’s nursing they require nurses to:

- Work closely with other organisations, young people and their families to ensure smooth and seamless transition.

---

**Box 1. Nurse training module on transition**

The undergraduate children’s nursing programme module, *Working in Partnership with Other Agencies and Services to Ensure Seamless and Well Supported Transition to Adult Services*, while Ensuring that Decisions about Care are Shared, equips nurses to:

- Develop knowledge, skills and professional values, resulting in high-quality essential care for all
- Deliver complex care to service users in their field of practice
- Utilise leadership and management skills to contribute to the planning, designing, delivering and improvement of future services

Source: Nursing and Midwifery Council (2010)
Review

Teaching transitional care at each stage of the undergraduate programme could have benefits: the cross-field two-year approach could introduce transition to all fields of nursing. This would include all those who may potentially be involved in the care of CYP as they go through this programme of transition, instead of the focus being entirely on children’s nurses.

In the current undergraduate programme at Birmingham City University (BCU), the teaching of transitional care includes service users wherever possible to give students first-hand perspectives of the process. This is highly valued by students but, in more recent times, there have been difficulties securing service users who can commit to regular teaching. It is essential to consider the evolving health and wellbeing needs of those involved. It is also important to be mindful of the fact that people may find it hard to discuss their healthcare journey, as doing so can evoke difficult memories and highlight challenges they need to overcome.

Another way to capture service users’ voices is through the use of interactive health community websites such as healthtalk.org and talkhealthpartnership.com. These are often used for post-sessional work and proves a valuable tool for our students. Lecturers can also draw on their professional experience in clinical practice and share this in the confidential environment of the classroom.

Teaching transition within a curriculum that provides a two-year all-field programme enhances nurses’ understanding of transition in all fields of practice. It is everyone’s responsibility, not just that of children’s nurses, to know, recognise and understand processes in relation to transition – especially given that local trusts offer young adult clinics for 19-25-year-olds in the adult hospital setting.

Within the BSc (Hons) nursing programme at BCU there are two hours of taught education about transitional care across the three-year undergraduate programme. This is in children’s nursing only and excludes other fields of nursing including adult, learning disability and mental health. Education in the undergraduate programme is mapped to NMC standards and so meets the requirements of clinical practice, but it is questionable whether it is sufficient and reaches enough of our undergraduate students.

As we are affiliated with two large specialist hospitals, our experience shows that nurses in any field are likely to encounter at least one patient going through transitional services. The evolving curriculum is based on the 2+1+1 structure (Willis, 2015); this involves integrating undergraduate education across all fields of nursing in the first two academic years. The final year of undergraduate study is field-specific with an additional preceptorship year. This teaching from children’s to adult services (Box 2). These 2010 standards have been replaced (NMC, 2018) but are still relevant to years 2 and 3 currently going through training.

The NMC’s (2018) new education standards require nurses to “demonstrate the ability to coordinate and undertake the processes and procedures involved in routine planning and management of safe discharge home or transfer of people between care settings”. This is delivered in module 1 of year 3. It is hard to identify other areas in the NMC’s changes to education standards that could host education relating to transitional care.

Several platforms allude to transitional care, but they are non-specific, open to interpretation and for use across the whole curriculum (Box 3). As stated in the standards: “these proficiencies will provide new graduates into the profession with the knowledge and skills they need at the point of registration which they will build upon as they gain experience in practice and fulfil their professional responsibility to continuously update their knowledge and skills” (NMC, 2018). Taking this into consideration, and reviewing where these platforms exist in terms of the curriculum structure, it is arguable that transitional care should be reviewed at every stage – that is, each year – of undergraduate education.

**Box 2. Transition standards for children’s nursing**

The Nursing and Midwifery Council (2010) states that nurses should:

- Work closely with other agencies and services to ensure a seamless and well-supported transition to adult services (Domain 4)
- Know when and how to:
  - Communicate with, and refer to, other professionals and agencies to respect the choices of service users and others, promoting shared decision making
  - Deliver positive outcomes and coordinate smooth, effective transition within, and between, services and agencies (Domain 4:7)
- Work effectively with young people who have continuing health needs, their families, the multidisciplinary team and other agencies to manage smooth and effective transition from children’s services to adult services, taking account of individual needs and preferences (Domain 4:7.1)

from children’s to adult services (Box 2). These 2010 standards have been replaced (NMC, 2018) but are still relevant to years 2 and 3 currently going through training.

The NMC’s (2018) new education standards require nurses to “demonstrate the ability to coordinate and undertake the processes and procedures involved in routine planning and management of safe discharge home or transfer of people between care settings”. This is delivered in module 1 of year 3. It is hard to identify other areas in the NMC’s changes to education standards that could host education relating to transitional care.

Several platforms allude to transitional care, but they are non-specific, open to interpretation and for use across the whole curriculum (Box 3). As stated in the standards: “these proficiencies will provide new graduates into the profession with the knowledge and skills they need at the point of registration which they will build upon as they gain experience in practice and fulfil their professional responsibility to continuously update their knowledge and skills” (NMC, 2018). Taking this into consideration, and reviewing where these platforms exist in terms of the curriculum structure, it is arguable that transitional care should be reviewed at every stage – that is, each year – of undergraduate education.

**Box 3. NMC education standards referring to transitional care**

The Nursing and Midwifery Council (2018) states that nurses should:

- Understand and apply the aims and principles of health promotion, protection and improvement, and the prevention of ill health when engaging with people (platform 2.1)
- Identify and use all appropriate opportunities, making reasonable adjustments when required, to discuss the impact of smoking, substance and alcohol use, sexual behaviours, diet and exercise on mental, physical and behavioural health and wellbeing, in the context of people’s individual circumstances – transition provides an opportunity to discuss this (platform 2.4)
- Demonstrate an understanding of the complexities of providing mental, cognitive, behavioural and physical care services across a wide range of integrated care settings (platform 7.6)
- Understand how to monitor and evaluate the quality of people’s experience of complex care (platform 7.7)
- Understand the principles and processes involved in supporting people and families with a range of care needs to maintain optimal independence and avoid unnecessary interventions and disruptions to their lives (platform 7.8)
- Facilitate equitable access to healthcare for people who are vulnerable or have a disability, demonstrate the ability to advocate on their behalf when required, and make necessary reasonable adjustments to the assessment, planning and delivery of their care (platform 7.9)
- Understand the principles and processes involved in planning and facilitating the safe discharge and transition of people between caseloads, settings and services (platform 7.10)
Clinical Practice Review

Moving forward

Transitional care training for nurses in all fields should be delivered following the NMC’s (2018) guidance. It is essential to increase understanding of all CYP requiring transitional care, not just those with learning disabilities, complex needs or life-limiting conditions. This should include CYP with acute and long-term conditions, such as diabetes and cystic fibrosis.

Use of the MECC framework should be considered for transitional care. Although it does not specifically refer to transitional care, it provides the opportunity to:

- Discuss many of the topics relating to transitional care;
- Teach students and qualified health professionals to optimise their use of the framework, not just in the area of health promotion and mental health, but also in relation to transition.

The NHS Long Term Plan (NHS England, 2019) explores the need for CYP services to move towards a service-based model by 2028, offering person-centred and age-appropriate care based on mental and physical health, rather than age alone as recommended in the DH’s (2004) NSF. This new strategic approach is essential to meet the evolving needs of CYP. It is important to have tools and mechanisms in place to assess effectively when these individuals are ready to transition to adult services, but the NHS Long Term Plan does not discuss this. Currently the Ready, Steady, Go programme is there to deliver on transition planning (NICE, 2016a) but it is unclear whether NICE guidance may change with the development of the NHS Plan (2019).

Rethinking family support

It is essential to consider why young people are expected to manage their condition independently once they reach adulthood. When a child or young person transitions into adult services, often they are no longer seen as part of a family, even though young people today often remain in the family home for much longer than in previous years. This recent trend needs to be reflected in healthcare. There are many scenarios in which we accommodate family support in healthcare, so why not transition?

When it comes to other milestones in the lives of CYP, parents do not ‘step away’ once a skill has been achieved. For example, once infants take their first steps, parents do not expect them to walk independently all the time. Transition is a similar process; it is gradual and CYP need time to develop the skills of independence, in the knowledge that support mechanisms are there if they need them. In spite of this, the CQC’s (2014) report showed that 54% of families felt they had not been involved in the transition process as much as they would have liked.

Wright et al (2016) explored this further, demonstrating parents’ integral role in the ability of CYP to self-manage their condition. However, parents’ views and perceptions are largely undocumented. Colver et al (2018) found appropriate parental involvement was associated with improved health outcomes but, in their study, parental involvement only happened for 34% of patients during transition.

Conclusion

There is a clear need for further research, as well as policy and guidance development on transitional care. It is not apparent why guidance has been scaled down when the evidence demonstrates that there is an increasing need for transitional care. Existing guidance is dated; even the CQC’s widely used From the Pond to the Sea is now five years old. The ability of current policy and guidance to meet the evolving needs of CYP is therefore questionable and needs to be reviewed.

References

Care Quality Commission (2014) From the Pond into the Sea: Children’s Transition to Adult Health Services. Bit.ly/CQCPond
National Institute for Health and Care Excellence (2016a) Transition from Children’s to Adults Services for Young people using Health or Social Care Services. nice.org.uk/ng43
National Institute for Health and Care Excellence (2016b) Transition from Children’s to Adult’s Services. nice.org.uk/g3140
Nursing and Midwifery Council (2010) Standards for Pre-registration Nursing Education. Bit.ly/NMC2010

For more articles on children’s nursing, go to nursingtimes.net/childrensnursing

To use this article for a journal club discussion with colleagues, go to nursingtimes.net/NTJournalClub and download the discussion handout. Your journal club activity counts as participatory CPD hours or can be used as the basis for reflective accounts in your revalidation activities.

For more Nursing Times Journal Club articles and tips on how to set up and run your own group, go to: nursingtimes.net/NTJournalClub

There are many scenarios in which we accommodate family support in healthcare, so why not transition?”

For more on this topic online

● Peer support to assist in transition to adult services
  Bit.ly/NTPeerSupport

Nursing Times [online] November 2019 / Vol 115 Issue 11