Health Transition Pathway

Year 9 / 10

- Identify young person who will need transition plan
- Paediatrician / other health professional discuss transition process with young person and family. Explain process.
- Arrange any necessary assessments (nursing)
- Identify nursing/ therapy / mental health needs, including medication, nutritional provision, any equipment and intervention or maintenance service and what is available in proposed future placements
- Highlight needs for parents to be aware what areas of provision they need to investigate in future placement
- Liaison with specialist and therapy services about future provision
- Identify health provision options
- Discuss Carer/Family and Young Person taking an active role in managing healthcare needs.
- Highlight needs so that parents and schools can consider these in relation to any potential future placements
- Copy information to GP
- Encourage use of handheld record/ health passport and identification of relevant areas of EHCP to share with others

Year 11

- Identify any service transitions are planned for end of year 11 (e.g where attending a new educational provision, physiotherapy cases where there is no associated learning disability)
- Liaise with future service
- Agree plan for services post- 16, depending on future placement, needs and available service
- Communicate with professionals at future placement
- Communicate with families and take into account young person's views
- Identify and discuss any mental health needs where FACT involved
- Copy information to GP
- Encourage use of handheld record/ health passport and identification of relevant areas of EHCP to share with others

Year 12/13
In year prior to 18th birthday

- Meet with families to review current needs and care plan and transition plans. Work collaboratively with young person
- Transition meeting/ liaison arranged to discuss young person with relevant adult services and plan hand over to relevant adult teams
- Formulate care plans to inform transition/ contribute towards joint transition report (for new service provider), including care plans, therapy intervention and advice and any ongoing equipment needs
- Work collaboratively with young person and family to create onward referral to adult mental health services/ orthotics/wheelchair service/ tertiary services/ neurologist etc as appropriate
- If young person does not meet criteria for adult services (e.g. mental health), discuss with young person and family to explore alternatives
- Write to GP to clarify any future arrangements for services, ongoing health surveillance (Down's Syndrome, medication review) nursing and therapy needs and any equipment needs (e.g. orthotics/splints/ nursing)
- Key person from the health team to contact young person/family to ensure everything has been set up and needs are met
- Highlight any ongoing specialist needs (e.g. second skin, splints)
- Discharge young person to adult services from 18 years of age
- Encourage use of handheld record/ health passport and identification of relevant areas of EHCP to share with others