Waitemata
District Health Board

Best Care for Everyone

Hospital Services
North Shore Hospital Campus
Shakespeare Road, Takapuna
Private Bag 93-503, Takapuna
Auckland 0740
Telephone: 09 489 0527
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30 January 2019

[redacted]

Dear [redacted]

Re: Official Information Act request – facilitating education access and transition between services

Thank you for your Official Information Act request received 10 January 2019 seeking information from Waitemata District Health Board (DHB) on:

- *Our current core policy document on facilitating education access for inpatient and outpatient children and young clients (including tertiary age) and/or*
- *Our current core policy document on the transition and monitoring of transition from paediatric to adult services.*
- *Our current core policy document on transitions and/or co-management between*
  a) genetic and paediatric services
  b) paediatric and other specialist services and
  c) genetic and adult services

Core policy document on facilitating education access for inpatient and outpatient children and young clients (including tertiary age)

Our inpatient and outpatient services do not have a documented policy on facilitating education access. However, each service has its own process to follow:

- *Rangatira Ward* – this acute inpatient medical ward has a very short length of stay and the majority of children do not miss out on much schooling. When it is identified that a child will be having a longer stay, the family is encouraged to contact the child's school and bring in work. A child with a complex health condition who is having a lengthy stay will have a referral sent to Northern Health Schools.
- *Child Rehabilitation Service* – reintegration into school is part of a child's rehabilitation programme. This service accesses the policies and procedures of the Northern Health Schools which is located on site.
- *Community health services* – the DHB has a local level agreement with North Shore Special Education Providers that fosters cooperation and collaboration between education and health services. The community health teams work closely with Learner Support Education services and visit education centres. When it is deemed necessary, and agreed with the family, they will share information with the child's learning team.

Current core policy document on the transition and monitoring of transition from paediatric to adult services

Waitemata DHB has a policy document (**Appendix 1**) to guide the process of children with long-term conditions and disabilities who are moving from the Child Health service into Adult services. We also have a transition pathway (**Appendix 2**) to guide staff and are currently trialling a summary of needs form (**Appendix 3**) to assist with transition.

Young people with long-term conditions and disabilities are identified as they turn 14 years. Planning for how they will be supported towards discharge is discussed at a series of multi-disciplinary meetings that includes key clinicians from the adult services.

Current core policy document on transitions and/or co-management between
a) genetic and paediatric services
b) paediatric and other specialist services and
c) genetic and adult services
We do not have any policy documents specific for transitions or co-management between paediatrics and genetics or specialist services. It is not normal practice to transition a child to genetics or to a specialist service. Instead, our model of practice is to refer for a consultation while the duty of care for the child remains with paediatrics. The co-management of children is based on effective communication between clinicians and formal clinical documentation.

I trust that this information meets your requirements. Waitemata DHB, like other agencies across the state sector, supports the open disclosure of information to assist the public's understanding of how we are delivering publicly-funded healthcare.

This includes the proactive publication of anonymised Official Information Act responses on our website from 10 working days after they have been released.

If you feel that there are good reasons why your response should not be made publicly available, we will be happy to consider this.

Yours sincerely

Cath Cronin
Director Hospital Services
Waitemata District Health Board

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Best Care for Everyone

Transition of Care from Child, Women & Family to Medicine and Health of Older People

Contents

1. Introduction

Purpose

Transition is a process which requires planning and facilitation to ensure continuity of care as young people and their family move from paediatric to adult health care services.

This document provides a guideline and service level agreement for the transition of care for young people and their family/whānau from Child Women and Family (CW&F) services to Medicine and Health of Older People (MHOP).

This guideline will ensure there is an agreed process and established lines of communication for a coordinated across service approach for children and young people requiring on-going disability and/or health care provision for their adult lives. This is an important part of improving the transition experience for young people and their family/whānau, as well as for the health care professionals involved.

Objectives

- To define the process for transition in order to improve the quality and access of services provided to young people with on-going health and disability related needs and their families/ whānau
- To promote an integrated service approach between CW&F and MHOP that will enable seamless service during a period of transition
- To ensure appropriate resourcing and infrastructure is in place to enable facilitated transition
- To ensure communication pathways are established for the transfer of sufficient and timely information regarding the young person and their family/ whānau between services
- To ensure appropriate hand-over of the client into adult services to reduce risk and ensure patient safety is maintained when transitioning between services.

Background

Transition from paediatric to adult care is a significant and challenging event in the life of a young person with ongoing health and/or disability needs and their family. It is reported that transitional care requires a "multi-dimensional, multi-disciplinary process that addresses not only the medical needs of adolescents as they move from children's services to adult services but also their psychosocial, educational and vocational needs", (Transition paper prepared by Waitemata DHB Disability Strategy Coordinator, 2010).

The goal of this policy is to establish an agreed process for the identification, referral and facilitated handover between paediatric and adult services. In addition, transition will occur for all disciplines at one time to avoid unnecessary difficulties for multidisciplinary team work. As a result, young people requiring on-going care will have continuous access to health care services and a seamless transition across the continuum of care.

Transition of Care from Child, Women & Family to Medicine and Health of Older People

Scope

This document covers the following services

- Community Child Health and Disability staff within CW&F (including Child & Family, HC4K, Child Development)
- General paediatrics at Waitemata DHB
- Community allied health staff within MHOPs
- Home Health including District Nursing and Continence and Ostomy Service staff within MHOPs
- Relevant managers, team leaders and charge nurse managers responsible for these areas
- Relevant clinical, professional and divisional leaders responsible for these areas.

Out of Scope

- Child and Adolescent Mental Health Services

Associated Documents

Contracts	• Ministry of Health – Community Health Transitional and support services. Tier level one service specification. June 2012 • Ministry of Health – Community Health Transitional and support services. Allied Health services (Non inpatient) Tier level two service specifications. June 2012 • Ministry of Health – DSS Child Development Services (DSS1012). Revised October 2010. • Waitemata DHB Funder - SLA 080-00 HC4K - Medically Fragile • Waitemata DHB Funder - SLA 087 – Services for Children and Young People School and Pre School Health Services • Ministry of Health – Services for children and young people – general and community paediatric services – Tier Level Two Service Specification
Waitemata DHB Policies	• Entry Criteria for Allied Health Community and Outpatients • Entry & Transfer of Care Criteria – District Nursing • Entry Criteria for Continence Service • Entry Criteria for Ostomy Service • Transfer HC4K-Home Health-District Nursing & Continence and Ostomy Service • Entry to Services – Child Development Service • Service Transition Meeting – Terms of Reference (To be developed by Child, Women and Family) • Transition to Adult Care Pathway
Waitemata DHB Forms	• OA&HH Referral Form • Transfer of Care Summary to Community Dietitians

2. Entry Criteria

For clarification around the correct services to meet the young person's needs refer to Entry Criteria for:

- Allied Health Community and Outpatients – Medicine and Health of Older People Service
- District Nursing Entry & Transfer of Care Criteria
- Continence Service
- Ostomy Service
- Child Development Service
- Home Care for Kids.

Transition of Care from Child, Women & Family to Medicine and Health of Older People

3. Transition Process

Preparation for transition

The preparation period for transition will begin at 14 years of age with a transition occurring at 16 years of age and completed by 18 years of age. Transition planning will be individualised according to the needs and circumstance of the young person and their family/whānau. CW&F will be responsible for identifying individuals who meet the age band criteria and preparing the young person and their family/whānau for transition.

Facilitated Transition

A service transition meeting will be held quarterly to discuss active cases needing to be transitioned from paediatric to adult services. This meeting will be coordinated by CW&F and will involve relevant team leaders/charge nurse managers and clinicians from both divisions.

The purpose of this meeting is to achieve an efficient and streamlined process that is timely, coordinated and inclusive of all services. There will be a key contact person identified in each service to discuss and advise as required.

A young person will transition to the MHOP service when it is determined by the multidisciplinary team that their medical health care is being transferred to their GP or adult medical team e.g. no longer under the care of a paediatrician.

A meeting to facilitate a co-ordinated handover between clinicians that can include the young person and family will be planned by CW&F and held on a case by case basis.

Transition for Young People not Currently Receiving Paediatric Care

In the instance that a **new referral** is received for an inactive case and the young person is **aged 15 years or above** * and eligible to receive health and/or disability funded services, the following process will apply.

Step	Action
1	The receiving referral coordinator will contact referral coordinator counterpart in the other service to discuss referral and decide appropriate action within three (3) working days.
2	• If referral coordinators are unable to reach a decision, this will be escalated to the team leader/charge nurse managers/relevant clinical leaders/ professional clinical leaders for both services (North, West or Rodney depending on referral address). • Team leader/charge nurse manager/professional clinical leader should consider whether the issues are closer aligned to those dealt with by the adult or paediatric service and what the skill mix of the team is. • A decision will be reached within five (5) working days.
3	Once agreement reached, the receiving service will accept the referral and prioritise according to their service prioritisation criteria.
4	Individual case to be placed on to agenda for quarterly service transition meeting if referral is accepted by CW&F services.

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Transition Pathway from Child Health to Adult Services

Appendix two

Transition steps
- Identifying patients for tx
- Assessing readiness for tx
- Completing tx handover

Supportive docs
- Summary of needs
- Title

Heading
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Info for patients/families
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Purpose:
This pathway has been developed to support a smooth and coordinated process for transition from care under Child Health Services to Adult Services, keeping the needs of the patient and family at the centre of the process.

Transition can be a stressful and scary process for young people, their families, as well as health care providers. Youth and families may be concerned about addressing health concerns under a new service, working with new health care providers, and learning to support the independence of the young person. In addition, health care providers may have developed relationships with their patients and families which can be challenging to handover.

We have the opportunity and responsibility to guide the process and prepare them to continue to address their health care needs effectively under the new service.

Using a structured approach, we can help to create a positive and empowering transition experience.

Who needs support with transition?

The Waitemata DHB Child Health Service aims to transition young people with stable but on-going health needs to adult care between the ages of 15 and 18 years old.

Young people with chronic medical conditions, high medical or disability support needs are likely to need support with transition to adult health services.

Chronic medical conditions
- *Diabetes*
- *Spina Bifida*
- *Epilepsy*
- *Down Syndrome*
- *Severe or poorly controlled asthma*
- *Bronchiectasis*
- *Cystic Fibrosis*
- *Cerebral palsy*
- *Neurological conditions*
- *Rheumatic fever*

Conditions which may affect the ability of the child or young person to function independently
- *Intellectual disability*
- *Developmental delay*
- *Autism*
- *Emotional or psychiatric conditions*
- *Severe behaviour problems*
- *Sensory impairment*

Palliative needs

Begin using pathway

Click Here

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Transition Pathway from Child Health to Adult Services

IDENTIFYING YOUNG PEOPLE NEEDING TRANSITION SUPPORT

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Child ≥ 14 years old under Child Health service, identified by
- Review at monthly cluster meeting of open referrals,
- Paediatrician, Children's Community Nurse and/or Children's Community team.

How to use QLIK *Click here*

Young person is reviewed at monthly Cluster meeting to evaluate whether transition support is needed.

Discussion will be recorded on the Cluster Case Discussions Spreadsheet.

Does child need transition process?

No

TRANSITION PROCESS NOT REQUIRED
- Manage health issues as needed.
- Discharge to GP at age 15 years when medically stable.
- Discharge letter to include:
  - Summary of assessments and care provided
  - Recommendations for on-going GP care.

Yes/ possibly

Develop plan to assess and meet transition needs.
- Identify Care Coordinator for transition process, who will coordinate meeting with involved health care providers and complete the Summary of Needs form. How can this be saved to medical record?
- Determine best way to involve youth & family in transition planning.
- Record on Cluster Case Discussions Spreadsheet (NHI, staff involved, date for next discussion)

Summary of Needs

Age 14-15

Age 15+

Discussion with family re: transition needs and goals
- Introduce topic of transition to family.
- Provide information outlining transition process.
- Information websites, written info needed. Link to family info sheet

Assess readiness for transition of care.

Click here

Review within 1 year

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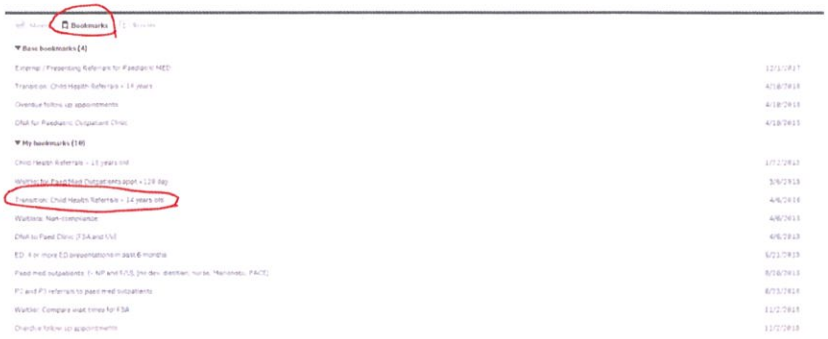
HOW TO USE QLIK SENSE TO FIND TRANSITION INFORMATION

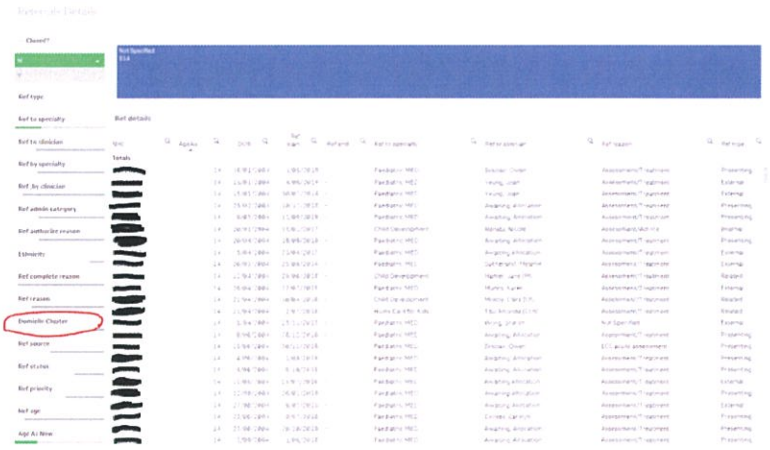
1. Open "QLIK sense-Data Discovery" from A-Z directory and follow prompts log on.

2. Open "Paediatric Dashboard"

3. Open the "Bookmarks" tab, and select "Transition: Child Health Referrals >14 years old"



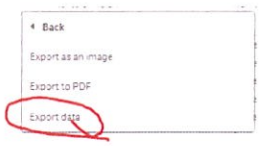
4. Select appropriate cluster under "Domicile Cluster" and confirm by clicking the green tick mark.



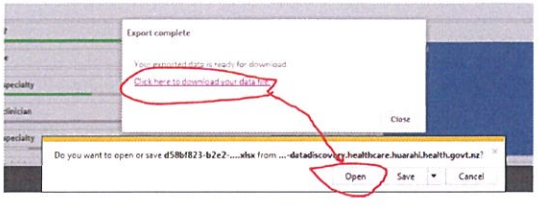
5. You may export the spreadsheet to a file on your computer:

Right click on the spreadsheet

Click "Export"→ then click "Export data"



Follow prompts to download and open the file



Back to **identifying transition patients**

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Transition Pathway from Child Health to Adult Services

ASSESSING READINESS FOR TRANSITION OF CARE

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Young person over 15 years requires transition, with aim to transition by 18 years.

- Ensure Care Coordinator has liaised with family and health care team to update Summary of Needs. Where to save doc?
- Ensure details and follow up discussion have been entered on Cluster Case Discussions spreadsheet

Summary of Needs

Has the family received appropriate support to prepare for transition?

No
- Provide family info sheet link
- Coordinator reviews transition checklist to identify areas of need, organises support accordingly.
- Consider joint appointment with young person, family, paediatric and adult care providers.
- If difficulty preparing family, consider referral to Youth Clinic for transitional care.
- Review at MDT meeting in 3 months

Yes

Is the child's medical condition stable for safe transfer of care?

No
- Continue under paediatric care to stabilise medical condition.
- Review at MDT meeting in 3 months.

Yes

Have plans for on-going care been clarified with GP and relevant specialists?

No
- Continue under paediatric care while paediatrician clarifies on-going care plans with GP and relevant specialists.
- Review at MDT meeting in 3 months.

Yes

Can nursing, allied health and dietitian needs be met by adult services?

No/ uncertain
- Discuss at joint meeting with paediatric and adult allied health and district nursing services.
- Review at MDT meeting in 3 months.

Yes

Complete the transition handover to adult services
Click Here

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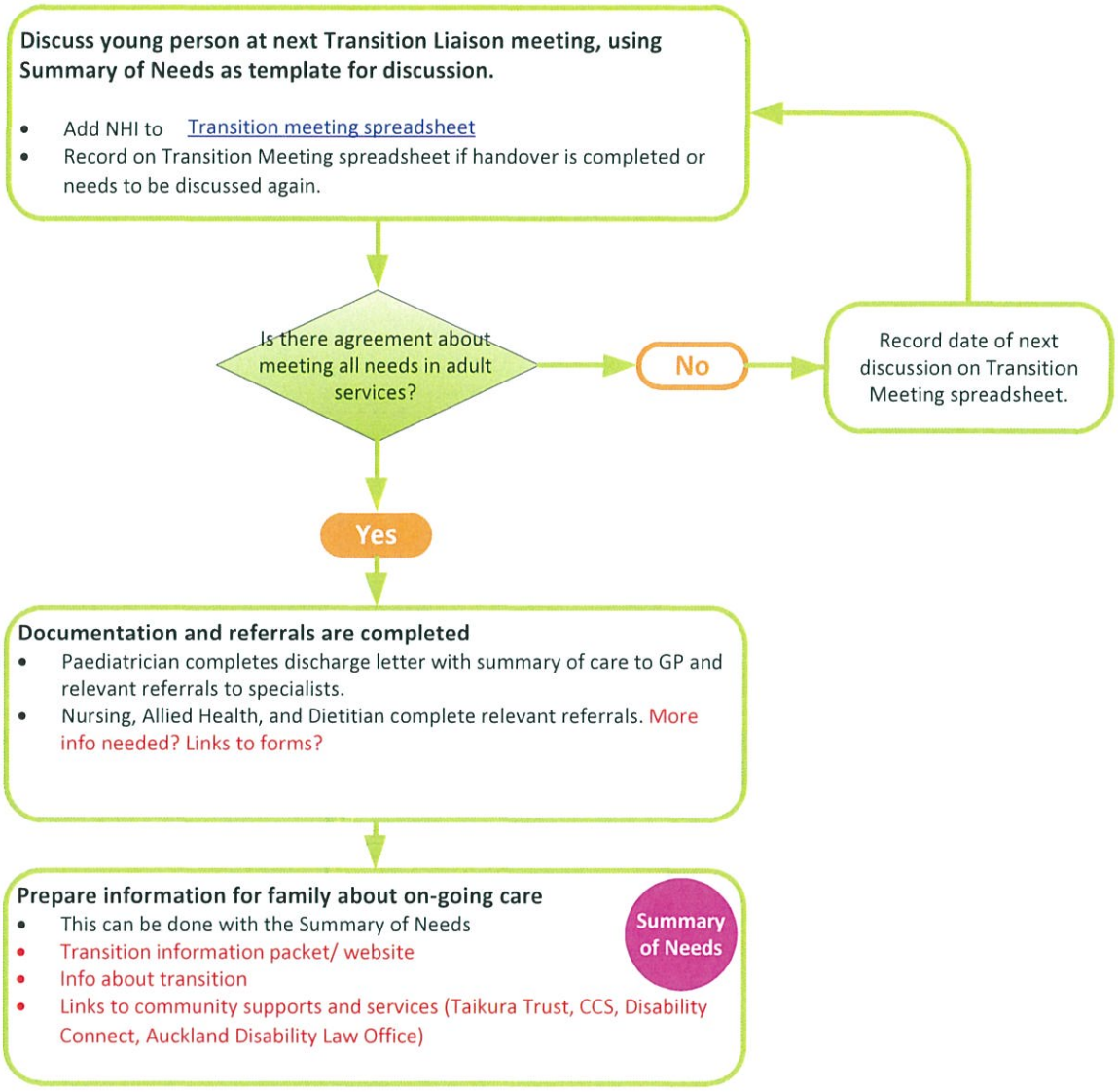
COMPLETING THE TRANSITION HANDOVER



NURSING AND ALLIED HEALTH DISCHARGE LETTER

- Discussion is held at joint meeting with paediatric and adult services to determine which service can best meet the needs of the young person.
- List of criteria which would determine which service is most appropriate. Is there a definite cut-off age for paediatric services? If receiving paed nursing or allied health services, does pt need to be under paediatrician?
- From this meeting, referrals are generated to adult allied health and district nursing services.
- Paediatric Nursing and Allied Health Discharge Letter
  - Medical condition(s)
  - Assessments done
  - Interventions
  - Equipment needed
  - Social issues and current status.
  - *Copies to young person/ family, GP, district nursing service, adult allied health service*

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INFORMATION FOR YOUNG PEOPLE AND FAMILIES

See RCH website

http://www.rch.org.au/transition/

http://www.rch.org.au/kidsinfo/fact_sheets/Transition_to_adult_health_services/

Who do I contact?

Differences between paediatric and adult medical care

Where do I get my needs met? Who do I contact

- **Medical care**
- **Emergencies**
- **Supplies (respiratory, feeding, continence, mobility, postural management)**
- **Behaviour support**
- **Financial supports**
- **Independent living**

How long will I still have contact with my paediatric team?

Transition steps

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AUDIT

The ___ pathway will be audited at __ monthly intervals using ____ criteria.

PUBLISHMENT AND REVIEW DATES

List dates of publishment, reviews and updates

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RESOURCES AND DEVELPOMENT TEAM

PATHWAY DEVELOPMENT TEAM

List names here

REFERENCES

List references here

Waitemata District Health Board
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[PLACE PATIENT LABEL HERE]

First Name: _____ Gender: _____
Surname: _____ Ph: _____
Address: _____
Date of Birth: _____ NHI#: _____
Ward/Clinic: _____ Consultant: _____

Child Health

Summary of Needs

Young Person and Family Goals:

-
-
-

Diagnosis/ Medical Issues:

-
-

Team currently involved:

-

Care co-ordinator:

Medical Care: *(Issues requiring ongoing input)*

Concerns	Action Required	Who will do it

Medications and Special Authority:

Medication	Special authority (if applicable)	Next review

Screening X-Rays and Blood Tests:

What is needed?	Who is responsible?	Next due

Special Immunisations:

What is needed?	Who is responsible?	Next due

Feeding Plan:

What is needed?	Who is responsible?	Next review

Advance Care Plan:

Resuscitation status	Definition of limited resuscitation (if applicable)	Date of discussion with family

Summary of Needs –Child Health WDHB

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[PLACE PATIENT LABEL HERE]
First Name: _____ Gender: _____
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Child Health

Summary of Needs

Equipment, Supplies and Home Environment Needs:

What is needed?	Summary and Plan
Self-Care	
Mobility	
Postural Management	
Home Environment	
Communication/Hearing	
Feeding	
Respiratory	
Continence	
Other	

Community Participation and Supports:

Current situation	Summary and Plan
Living situation and support	

Summary of Needs –Child Health WDHB

(***Note:*** *Trials must be no longer than 3 months. Complete Authorisation Form* ***after*** *the trial period*)

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[PLACE PATIENT LABEL HERE]

First Name: _____ Gender: _____
Surname: _____ Ph: _____
Address: _____
Date of Birth: _____ NHI#: _____
Ward/Clinic: _____ Consultant: _____

Child Health

Summary of Needs

- who I live with, - guardianship *Auckland Disability Law*	
Emotional/social supports	
Participation in community and family activities	
Needs Assessment	
- Personal care supports - Carer support - Respite *Taikura Trust*	
Financial supports	
WINZ	
Education, vocational training	
Contingency plan	
Medical Alert Bracelet *St. John's Membership*	

Plan:

Summary of Needs –Child Health WDHB

(***Note:*** *Trials must be no longer than 3 months. Complete Authorisation Form* ***after*** *the trial period*)

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[*PLACE PATIENT LABEL HERE*]

First Name: _____ Gender: _____
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Child Health

Summary of Needs

Summary of Needs –Child Health WDHB