Developing a transition toolkit – the process and outputs

Jane Edmunds, Sue Greenhalgh, Sarah Ghezaiel, Ruth Gordon

In this article, the authors highlight how sharing current practice via a clinical network has led to the development of a suite of tools to help teams develop transition policies. They describe the products of the transition work as well as how this was achieved through efficient and effective working within a clinical network. A subgroup of the North West Paediatric Diabetes network undertook the provision of guidance for individual teams to develop their own transition policies to improve the experience for young people with diabetes. The guidance aimed to meet one of the standards in the new best practice tariff (BPT) for paediatric diabetes, set up in April 2012, as well as meeting the network's aims. The subgroup worked together effectively to produce a suite of tools designed to help units and trusts develop their local policy and assess their own transition process as well as meet the BPT. The subgroup's working methods made efficient use of time and can be easily replicated.

The process of transition varies across the country from a one-off transfer process to a service in which a young person is taken from paediatric care through to a teenage clinic then into a young adult clinic before finally moving into an adult service at the age of 25 years. Many young people are lost to follow-up when transferred to an adult system, increasing the already significant risk of premature morbidity and mortality. The documents *National Service Framework for Diabetes: Standards* (Department of Health [DH], 2001) and *Growing Up Ready for Emerging Adulthood: An Evidence Base for Professionals Involved in Transitional Care for Young People with Chronic Illness and/or Disabilities* (McDonagh, 2006) highlight transitional care as an integral component of care for all young people, and stress the importance of smooth, effective transition organised in partnership with the young person.

A smooth transition is further supported by the documents *Bridging the Gaps: Health Care for Adolescents* (Royal College of Paediatrics and Child Health, 2003), *Adolescent Transition Care: Guidance for Nursing Staff* (Royal College of Nursing, 2004) and *You're Welcome: Quality Criteria for Young People Friendly Health Services* (DH, 2011a), and is in keeping with the objectives of the Department for Education and Skills (2004) and the DH (2007).

Article points

1. In 2011, a subgroup of the North West Paediatric Diabetes (NWPD) network created a toolkit to help units assess their current transition arrangements and develop their own policies.
2. The NWPD network subgroup included people from different areas that have different transitional arrangements.
3. There are four documents included in the suite of tools: *How to Use Guide, Transition Best Practice Guidance, Paediatric and Adolescent Diabetes Transition Policy* and *Individual Transition Plan.*
4. Combining the expertise of clinicians with the support of the coordinator was agreed to be an effective way of working that could be easily replicated.

Key words

- Best practice tariff
- Paediatric diabetes
- Transition process

Authors' details can be found at the end of this article.

Page points

1. In 2011, a subgroup of the North West Paediatric Diabetes (NWPD) network met to undertake a piece of work on transition.
2. The NWPD network subgroup aimed to create a toolkit to help units assess their current transition arrangements and develop its own transition policy in a structured and organised way to be compliant with the best practice tariff.
3. Volunteers with an interest in transition from within the NWPD network were brought together by the network coordinator (who is funded by NHS Diabetes), through email contact, a telephone conference and follow-up by a face-to-face meeting.

The North West Paediatric Diabetes (NWPD) network brings together specialists in paediatric diabetes across the North West region to share good practice and work together on key areas to improve standards of care. In 2011, a subgroup of the NWPD network met to undertake a piece of work on transition. The group developed a series of key workstreams, each with clearly defined objectives. One of these workstreams focused on transition, with the following aim: to develop a transition toolkit to assess, with young people, their competency in areas of transition.

In addition, since April 2012 the best practice tariff (BPT) has been available for all paediatric diabetes units and provides trusts with the opportunity to claim an annual tariff per patient if they meet 14 quality standards. Included in the standards is one focusing on transition:

> *"Each provider unit must have a clear policy for transition to adult services" (DH, 2011b).*

The NWPD network subgroup aimed to create a toolkit to help units assess their current transition arrangements and develop their own transition policies in a structured and organised way to be compliant with the BPT.

How the subgroup worked

The NWPD network subgroup included people from different areas that have different transitional arrangements. These include people from provider units that transfer young patients aged 16 years and those from a service that held a young person's clinic for patients up to the age of 25 years.

Sharing work from a variety of trusts, the subgroup was able to develop a suite of tools to reflect the different processes of transition. Different units have different types of transition clinics – some are for teenagers and some are for young adults up to the age of 25; other units run clinics in the evening or on Saturday mornings to try to ensure that appointments are at a time that are accessible to those who are working or who are at college. Taking this into account meant that all paediatric diabetes units represented could adapt the tools to reflect their own local practice.

Volunteers with an interest in transition from within the NWPD network were brought together by the network coordinator (who is funded by NHS Diabetes), through email contact, a telephone conference and follow-up by a face-to-face meeting. Documents were shared and formulated as an output from the telephone conference and the face-to-face meeting. The comments were incorporated into the suite of tools described below.

The outputs of the subgroup – the suite of tools

The suite of tools, or toolkit, was designed to help units develop their local policy and assess their own transition process, as well as to meet the BPT. There are four documents included in the suite of tools, which are described below.

How to Use Guide

The *How to Use Guide* describes the tools, and contains a case study that uses the self-assessment tool to critically analyse transition arrangements in a given service.

Transition Best Practice Guidance

The *Transition Best Practice Guidance* document highlights that transition is a process that must meet the needs of the individual young person; a checklist for transition is also provided. This part of the suite of tools enables units to identify, using a red–amber–green rating, how well their current transition process works. This is further broken down into the following different aspects of transition:

- The team.
- The young person.
- Family members and/or carers.
- Multidisciplinary team involvement.
- Monitoring of the transition process.

By using the self-assessment tool, teams can identify which aspects of their current arrangements are successful and which need to be improved.

Paediatric and Adolescent Diabetes Transition Policy

The *Paediatric and Adolescent Diabetes Transition Policy* provides a template that was developed for units and Trusts to use as the basis of their own policy. It is expected that each unit will use this and add their own logos and processes to develop a bespoke policy that meets the needs of the young person and requirements of the standard of the BPT.

Individual Transition Plan

The *Individual Transition Plan* is a document that is owned by a young person and allows clinicians to work with them to assess how competent they feel about managing their own diabetes at different stages through the transition process. The toolkit contains a worked example of the *Individual Transition Plan*.

Next steps

The suite of tools has been shared with all units and trusts regionally via the monthly NWPD network newsletter. The toolkit was shared nationally by asking the paediatric diabetes network coordinators (who are funded by NHS Diabetes across England) to circulate it via their paediatric diabetes networks.

The documents were piloted by two units from within the subgroup with different transition processes to ensure that they are applicable to practice. So far the pilot sites have found the suite of tools easy to use and helpful in describing their local processes for transition. In addition to recording what is in place at present, using the documents has challenged teams to look at their transition processes to see if they can be improved. Some teams are adapting the individual transition plan so that it fits into their notes and are also looking at how this can be expanded with reminders for electronic records.

The toolkit is now being further piloted by other units, and the feedback so far has been positive. The next step is to gather feedback from young people throughout the North West to identify whether transition processes developed from the suite of tools meets the needs of young people with diabetes.

Conclusion

The suite of tools was developed from work undertaken by a variety of trusts that was already available. The work undertaken by the NWPD network subgroup demonstrated that sharing good practice enables rapid development of documentation to meet the requirements of BPT and help trusts develop their own policies. The suite of tools has been made available nationally via distribution through other networks and they have been added to the NHS Diabetes website (www.nhsdiabetes.nhs.uk).

The approach used by the facilitator to ensure timely output of the documentation highlights ways of working that ensure work is completed quickly and efficiently using different communication methods. Combining the expertise of clinicians with the support of the coordinator was agreed to be an effective way of working that could be easily replicated. ■

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Authors

Jane Edmunds is a DSN, Diabetes and Endocrine Unit, Alder Hey Children's NHS Foundation Trust, Liverpool; Sue Greenhalgh is a Paediatric DSN, Salford Royal Foundation Trust, Salford; Sarah Ghezaiel is a Paediatric DSN, Stockport NHS Foundation Trust, Stockport; and Ruth Gordon is North West Paediatric Diabetes Coordinator, NHS Diabetes and works at Ruth Gordon Associates Ltd.

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