
SOUTHPORT &
ORMSKIRK HOSPITAL
NHS TRUST

Our Best Hopes:

- Share the pathway with you
- Discuss how it is psychologically informed
- Our best hopes for October-January before the 4th QI Event in January
- Q&A

Who Are We Connecting With To Improve Our Work?

1. MDT

"if we could have the best transition pathway of all time, what would that look like? What does *good* look like?"

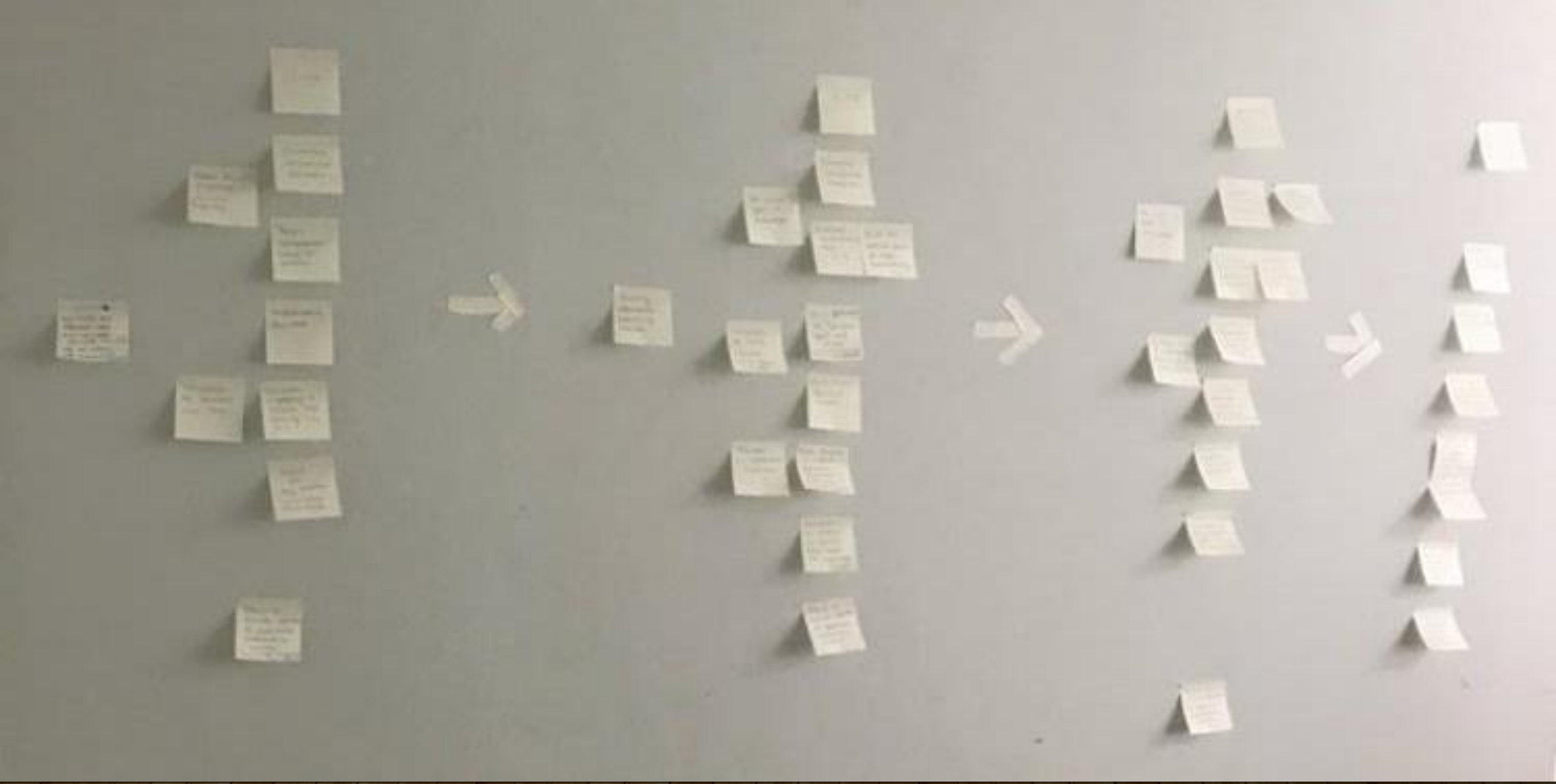
2. Expert Patients and their families

"if you could have had/are about to have the best transition, what would that look like?"

3. The adult diabetes team

This pathway is the best!

Work Backwards



Change the colour of our files

Age 12-13 ⇨

Begin the conversation informing children and young people of the process of transition

Referral to outside agencies for additional independent support, early help and other teams if necessary.

They need to be aware of their key worker, the child and the PDSN and vice versa.

Invitation to contact with PDSNs so CYP can contact via text message whenever they would like.

Independent download

Complete structured education

Children engaging in problem-free talk at the start of appointments

Two Ticks Every 6 Months

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Age 14-15 ⇨

Complete structured education, continue conversations that will have been had in clinic from 12 to 13 years old but what we would be expecting or inviting children and young people to do is to attend the clinic for longer independently, so i.e. they might be encouraged to discuss their checking with the consultant – their blood results after they have downloaded.

Invitation to parents to discuss best hopes of transition that would be with **psychology team**.

The child encouraged to set their own goals and targets

Invite CYP to independently have conversations about their health needs, school included.

Revisit any gaps in knowledge.

promotion of independence *in* school,

promotion of independence *with* school

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Age 16-17 ⇨

Continue conversations regarding transition, encouraging ongoing independence in clinic.

Complete structured education

completing structured education specific to the young person's role so at this stage looking at if they are going to work or college or university or what they will be doing at that point – tailoring the education for that.

Conversation regarding continued education, GCSEs and A-Level through to university.

Invitation/continued conversations for parents to discuss best hopes or transition, this would be invited.

Continue download & independently meeting with the PDS team.

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Continue download & independently meeting with the PDS team.

✓ ✓

Age 17+ ⇨

Every young person to be offered and encouraged to attend a "**progress appointment**" 6 – 12 months before transition.

Leaflet about registration with GP but also a conversation that needs to be ticked off about registering with a new GP if people are going to university.

Young person to work with Psychology for a solution focused transition letter that will take the form in the progress appointment. CC: GP/new team/consultant

Pack containing self-help leaflets for example, alcohol, pregnancy: reflective of NICE guidelines

Invitation to group sessions. Best hopes and expectations of the services and more broad conversation of what they would like as well, which can be added to the letter

Attendance to joint adult paediatric clinic.

Appropriate housing accommodation for university, there is a fridge there, if there is someone who is a wellbeing lead for the university

Consolidation of knowledge: frameworks/policies that might be useful to the young person to know to empower them even more at this time.

Provide key information in relation to adults services, so contact numbers, names and venues, clinics, what is expected of them at those appointments in addition

who the team are, what they will look like and very much doing a "all about me"!

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Outcomes:

- Collecting qualitative data
- Conversations – suppose today is your last appointment with us, what would you like to be telling us? What would you notice? On a scale of 0_____10...
- PEDSQL
- HbA1c

Team Changes ➡

More communication with the adult team

Continued development for the team, training etc.

Training the adult team in psychological approaches

All about me leaflet peadiatric and adult team

Best Hopes October - December:

- Keep doing that we are doing (!)
- Continue to give people a good listening to. In our thoughts at all times is how best can we support our CYP? How can we empower them as best as possible?
- Develop transition age yearly prompt/activity sheets (similar to the ones that we do for newly diagnosed – it works very very well for us!)
- Education, education, edu... (*here*, *there* and *everywhere*!)
- The CYP is the expert in their condition – after all they have got this far without us...
- Outcomes