NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Transition from children’s to adults’ services

NICE quality standard

Draft for consultation

21 December 2016

28 September 2023

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| **This quality standard covers** the period before, during and after a young person moves from children’s to adults’ services in all settings where transitions from children’s to adults’ health or social care services take place. It covers all young people (aged up to 25) using children’s health and social care services who are due to make the transition to adults’ services. This includes young people with mental health problems, disabilities and long-term, life-limiting or complex needs, rare diseases and those in secure settings or under the care of local authorities. It describes high-quality care in priority areas for improvement.  This quality standard will update the existing quality standard on transition from children’s to adults’ services (published December 2016). The quality standard was identified for update following stakeholder feedback. New and updated quality statements You are invited to comment on a new and updated statement. We have added a new statement on having a transition plan (statement 2) and amended the statement on missed appointments after transfer to adults’ services (statement 6). Please note that statement numbers have been updated to incorporate the new statement.  We have not updated statements 1, 3, 4 and 5 (shaded in grey) and cannot accept comments on them. In some cases, we have made minor wording changes for clarification.  For more information see [update information](#Update_info).  This is the draft quality standard for consultation (from 28 September to 26 October 2023). The final quality standard is expected to publish in December 2023. |

# Quality statements

[Statement 1](#_Quality_statement_1:_1) Young people who will move from children’s to adults’ services start planning their transition with health and social care practitioners by school year 9 (aged 13 to 14 years), or immediately if they enter children’s services after school year 9. **[2016]**

[Statement 2](#_Quality_statement_1:_2) Young people who will move from children’s to adults’ services have a co-ordinated transition plan. **[new 2023]**

[Statement 3](#_Quality_statement_23:) Young people who will move from children’s to adults’ services have an annual meeting to review transition planning. **[2016]**

[Statement 4](#_Quality_statement_34:) Young people who are moving from children’s to adults’ services have a named worker to coordinate care and support before, during and after transfer. **[2016]**

[Statement 5](#_Quality_statement_4:) Young people who are moving from children’s to adults’ services meet a practitioner from each adults’ service they will move to before they transfer. **[2016, updated 2023]**

[Statement 6](#_Quality_statement_56:) Young people who have moved from children’s to adults’ services but do not attend their initial meetings or appointments are contacted by adults’ services and given further opportunities to engage. **[2016, updated 2023]**

In 2023 this quality standard was updated and some statements prioritised in [2016] were updated [2016, updated 2023]. A new statement was also added [new 2023]. For more information, see [update information](#Update_info).

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| Questions for consultation **Questions about the individual quality statements**  **Question 1** For draft quality statement 2: Does this quality statement accurately reflect a key area for quality improvement?  **Question 2** For draft quality statement 2: Can data for the proposed quality measures be collected locally? Please include in your answer any data sources that can be used or reasons why data cannot be collected.  **Question 3** For draft quality statement 2: Do you think this statement would be achievable by local services given the net resources needed to deliver it? Please describe any resource requirements that you think would be necessary for this statement. Please describe any potential cost savings or opportunities for disinvestment.  **Question 4** For draft quality statement 6: We have suggested that this statement could be measured based on attendance at any of the first 3 meetings or appointments in adults’ services. Is this a helpful definition of initial appointments? If not, please suggest an alternative.  **Question 5** For draft quality statement 6: Can structure measure a) on arrangements to monitor and assure transitions from children’s to adults’ services be measured in practice? If so, how? Please let us know of any examples where this is already collected.  **Question 6** For draft quality statement 6: Is it helpful to include the new outcome measure b) to capture ongoing engagement with adults’ services (1 year after transfer) for this statement? Implementing NICE guidelines and quality standards **Question 7** Please let us know about any practical resources that have been developed to improve awareness of this quality standard among young people and their families and carers.  **Question 8** What are the challenges to implementing the NICE guidance underpinning this quality standard? Please say why and for whom. Please include any suggestions that could help users overcome these challenges (for example, existing practical resources or national initiatives). |

# Quality statement 1: Planning transition

## Quality statement

Young people who will move from children’s to adults’ services start planning their transition with health and social care practitioners by school year 9 (aged 13 to 14 years), or immediately if they enter children’s services after school year 9. **[2016]**

## Rationale

Starting to plan their transition as early as possible can lead to a better experience for young people moving from children’s to adults’ services. Early planning allows a more gradual process. A sudden move to adults’ services with no time for preparation or support can lead to young people, and their families and carers, losing confidence and disengaging with services. Early planning, led by the health and social care practitioners but with full involvement from the young person and their families and carers, allows them more time to be involved in decisions and to adjust to changes to their future care. It is recognised that for some young people, those covered by health and social care or education legislation, early transition planning is already a legal requirement.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

### Process

a) Proportion of young people in school year 9 (aged 13 to 14 years) who will move from children’s to adults’ services who have started planning their transition.

Numerator – the number in the denominator who have started planning their transition.

Denominator – the number of young people in school year 9 (aged 13 to 14 years) who will move from children’s to adults’ services.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

b) Proportion of young people entering children’s services after school year 9 and who will move to adults’ services who started planning their transition immediately.

Numerator – the number in the denominator who started planning their transition immediately.

Denominator – the number of young people entering children’s services after school year 9 and who will move to adults’ services.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

### Outcome

a) Proportion of young people (and their family and carers), who have transferred from children’s to adults’ services, who were satisfied with planning for transition and transfer.

Numerator – the number in the denominator who were satisfied with planning for transition and transfer.

Denominator – the number of young people (and their families and carers) who have transferred from children’s to adults’ services.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from a patient survey. Resources to support this include the [TIER Ready, Steady, Go programme](https://www.readysteadygo.net/rsg.html) which includes feedback on transition planning in its questionnaires for young people and their families and carers. Also, the [National Confidential Enquiry into Patient Outcome and Death transition from child into adult healthcare young person and parent carer survey](https://www.ncepod.org.uk/2023transition.html) includes questions on transition planning.

b) Proportion of young people who have transferred from children’s to adults’ services, who do not attend their initial meetings or appointments with each adults’ service.

Numerator – the number in the denominator who do not attend their initial meetings or appointments with each adults’ service.

Denominator – the number of young people who have transferred from children’s to adults’ services.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. For measurement purposes this could be defined as any of the first 3 meetings or appointments in each adults’ service.

c) Proportion of young people attending adults’ services after transfer from children’s services who continue to engage with services.

Numerator – the number in the denominator who continue to engage with services.

Denominator – the number of young people attending adults’ services after transfer from children’s services.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. For measurement purposes this could be defined as engagement at 1 year after transfer.

## What the quality statement means for different audiences

**Service providers** (children’s and adults’ health, mental health and social care providers) ensure that systems are in place to identify young people who will move from children’s to adults’ services and to start involving them and their families and carers in planning their transition by school year 9 (aged 13 to 14 years), or immediately if they enter children’s services after school year 9.

**Health and social care practitioners** (such as hospital consultants, nurses, social workers and mental health workers) involve children and young people, and their families and carers, in planning their transition from children’s to adults’ services by school year 9 (aged 13 to 14 years), or immediately if they enter children’s services after school year 9.

**Commissioners** ensure that they commission services that identify young people who will move from children’s to adults’ services and start planning their transition by school year 9 (aged 13 to 14 years), or immediately if they enter children’s services after school year 9. Commissioners should ensure that the planning involves the young person and their families and carers, as well as the practitioner.

**Young people who will move from children’s to adults’ services** work with their health or social care practitioners to start planning for the move by school year 9. For young people who enter children’s services after year 9, planning for the move should start immediately. Early planning gives young people time to be involved in decisions and to understand and adapt to changes in their future care.

**Families and carers of young people** **who will move from children’s to adults’ services** are involved from the start in planning for the move. This gives them time to understand and to adapt to changes in the young person’s future care. Their level of involvement will depend on the needs and preferences of the young person.

## Source guidance

[Transition from children’s to adults’ services for young people using health or social care services. NICE guideline NG43](https://www.nice.org.uk/guidance/ng43) (2016), recommendation 1.2.1

## Equality and diversity considerations

It will be important to adapt the timing and approach to transition to reflect the needs of young people with learning disabilities or developmental needs. Health and social care professionals should ensure that the starting point for transition planning is developmentally appropriate and considers each young person's capabilities, needs and hopes for the future, addressing their biological, psychological and social development in the broadest terms.

Transition support should take into account the young person’s maturity, cognitive abilities, psychological status, needs in respect of long-term conditions, social and personal circumstances (including culture and beliefs), caring responsibilities and communication needs.

[[NICE’s guideline on transition from children’s to adults’ services](https://www.nice.org.uk/guidance/ng43), recommendations 1.1.2 and 1.2.3, terms used in this guideline and expert opinion]

# Quality statement 2: Co-ordinated transition plan

## Quality statement

Young people who will move from children’s to adults’ services have a co-ordinated transition plan. [**new 2023**]

## Rationale

Having a transition plan that is co-ordinated across all services will make it clear when the care and support provided to a young person will move from children’s to adult services and how it will be delivered. Services should work together to develop a coordinated transition plan that is practical to implement and avoids creating gaps in services due to variation in the age for transition between different services. This will help young people and their families and carers to know what to expect and reduce uncertainty and stress.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

### Process

Proportion of young people from school year 9 and above, who will move from children’s to adults’ services, who have a co-ordinated transition plan.

Numerator – the number in the denominator who have a co-ordinated transition plan.

Denominator – the number of young people from school year 9 and above, who will move from children’s to adults’ services.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. From school year 9 and above is included for measurement purposes, although it is recognised that the starting time may vary in different services. Data on a personalised transition plan and coordination of age of start of transition is included in the [National Confidential Enquiry into Patient Outcome and Death transition from child into adult healthcare audit toolkit](https://www.ncepod.org.uk/2023transition.html) which can be implemented locally.

### Outcome

a) Proportion of young people (and their families and carers) who have transferred from children’s to adults’ services, who were satisfied with planning for transition and transfer.

Numerator – the number in the denominator who were satisfied with planning for transition and transfer.

Denominator – the number of young people (and their families and carers) who have transferred from children’s to adults’ services.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from a patient survey. Resources to support this include the [TIER Ready, Steady, Go programme](https://www.readysteadygo.net/rsg.html) which includes feedback on transition planning in its questionnaires for young people and their families and carers. Also, the [National Confidential Enquiry into Patient Outcome and Death transition from child into adult healthcare young person and parent carer survey](https://www.ncepod.org.uk/2023transition.html) includes questions on transition planning.

b) Proportion of young people who have transferred from children’s to adults’ services, who do not attend their initial meetings or appointments with each adults’ service.

Numerator – the number in the denominator who do not attend their initial meetings or appointments with each adults’ service.

Denominator – the number of young people who have transferred from children’s to adults’ services.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. For measurement purposes, this could be defined as any of the first 3 meetings or appointments in each adults’ service.

c) Proportion of young people attending adults’ services after transfer from children’s services who continue to engage with services.

Numerator – the number in the denominator who continue to engage with services.

Denominator – the number of young people attending adults’ services after transfer from children’s services.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. For measurement purposes, this could be defined as engagement at 1 year after transfer.

## What the quality statement means for different audiences

**Service providers** (children’s and adults’ health, mental health and social care providers) work together to develop and agree a co-ordinated transition plan with young people who will transition from children’s to adults’ services, and their families and carers.

**Health and social care practitioners** (such as hospital consultants, nurses, social workers and mental health workers) involve young people, and their families and carers, in developing a transition plan for the move to adults’ services. They read the sections of the plan produced by other practitioners, to make sure the plan works as a whole.

**Commissioners** ensure they commission services that work together, and with young people, and their families and carers, to develop and agree a co-ordinated transition plan for the move to adult services.

**Young people who will move from children’s to adults’ services** are involved in developing a plan for moving that covers all the services they use. This will set out what changes there will be, as well as when and how those changes will happen.

**Families and carers of young people who will move from children’s** **to adults’ services** are involved in developing the plan for the move. This will set out future changes to services and care that the young person will receive.

## Source guidance

* [Disabled children and young people up to 25 with severe complex needs: integrated service delivery and organisation across health, social care and education. NICE guideline NG213](https://www.nice.org.uk/guidance/ng213) (2022), recommendations 1.8.5, 1.8.6 and 1.8.7
* [Transition from children’s to adults’ services for young people using health or social care services. NICE guideline NG43](https://www.nice.org.uk/guidance/ng43) (2016), recommendations 1.1.6 and 1.2.4

## Definitions of terms used in this quality statement

### Co-ordinated transition plan

Children’s and adults’ services should work together to develop a transition plan for each young person. Planning should include all services and interagency teams providing support to the young person. The transition plan should:

* coordinate the age of non-statutory transitions to adults’ services, to ensure a consistent approach
* include the services that are available locally to support transition
* be agreed with the young person and their family and carers (for example, by including a section for their comments and views)
* link to other plans the young person has in respect of their care and support.

[[NICE’s guideline on disabled children and young people up to 25 with severe complex needs](https://www.nice.org.uk/guidance/ng213), recommendations 1.8.5, 1.8.6 and 1.8.7 and [NICE’s guideline on transition from children’s to adults’ services](https://www.nice.org.uk/guidance/ng43), recommendation 1.2.4 and expert opinion]

## Equality and diversity considerations

It will be important to adapt the transition plan to reflect the needs of young people with learning disabilities or developmental needs. Health and social care professionals should ensure that transition planning is developmentally appropriate and considers each young person's capabilities, needs and hopes for the future, addressing their biological, psychological and social development in the broadest terms.

Transition support should take into account the young person’s: maturity; cognitive abilities; psychological status; needs in respect of long-term conditions; social and personal circumstances (including culture and beliefs); caring responsibilities and communication needs. The plan should ensure that the point of transfer is not based on a rigid age threshold and takes place at a time of relative stability for the young person. [[NICE’s guideline on transition from children’s to adults’ services](https://www.nice.org.uk/guidance/ng43), recommendations 1.1.2 and 1.2.3 and terms used in this guideline]

## Questions for consultation

Does this quality statement accurately reflect a key area for quality improvement?

Can data for the proposed quality measures be collected locally? Please include in your answer any data sources that can be used or reasons why data cannot be collected.

Do you think this statement would be achievable by local services given the net resources needed to deliver it? Please describe any resource requirements that you think would be necessary for this statement. Please describe any potential cost savings or opportunities for disinvestment.

# Quality statement 3: Annual meeting

## Quality statement

Young people who will move from children’s to adults’ services have an annual meeting to review transition planning. **[2016]**

## Rationale

Transition is a lengthy process that starts early, by school year 9 (aged 13 to 14 years) and continues past the point of transfer. Regular review of transition planning ensures that a young person’s changing needs are taken into account. Transition planning should be reviewed at least annually, but for some young people, and their families and carers, the meetings may need to be more frequent, depending on their individual needs.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

### Process

Proportion of young people older than school year 9, who will move from children’s to adults’ services, who have had a meeting in the previous 12 months to review transition planning.

Numerator – the number in the denominator who have had a meeting in the previous 12 months to review transition planning.

Denominator – the number of young people older than school year 9 who will move from children’s to adults’ services.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

### Outcome

a) Proportion of young people (and their families and carers) who have transferred from children’s to adults’ services, who were satisfied with planning for transition and transfer.

Numerator – the number in the denominator who were satisfied with planning for transition and transfer.

Denominator – the number of young people (and their families and carers) who have transferred from children’s to adults’ services.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from a patient survey. Resources to support this include the [TIER Ready, Steady, Go programme](https://www.readysteadygo.net/rsg.html) which includes feedback on transition planning in its questionnaires for young people and their families and carers. Also, the [National Confidential Enquiry into Patient Outcome and Death transition from child into adult healthcare young person and parent carer survey](https://www.ncepod.org.uk/2023transition.html) includes questions on transition planning.

b) Proportion of young people who have transferred from children’s to adults’ services, who do not attend their initial meetings or appointments with each adults’ service.

Numerator – the number in the denominator who do not attend their initial meetings or appointments with each adults’ service.

Denominator – the number of young people who have transferred from children’s to adults’ services.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. For measurement purposes, this could be defined as the first 3 meetings or appointments in each adults’ service.

c) Proportion of young people attending adults’ services after transfer from children’s services who continue to engage with services.

Numerator – the number in the denominator who continue to engage with services.

Denominator – the number of young people attending adults’ services after transfer from children’s services.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. For measurement purposes, this could be defined as engagement at 1 year after transfer.

## What the quality statement means for different audiences

**Service providers** (children’s and adults’ health, mental health and social care providers) ensure that systems are in place for young people who will move from children’s to adults’ services, and their families and carers, to have an annual meeting to review transition planning with all practitioners providing support.

**Health and social care practitioners supporting transition** (such as hospital consultants, nurses, social workers, mental health workers GPs, care coordinators or named workers) take part in an annual meeting to review transition planning for young people who will move from children’s to adults’ services. They ensure that they share the updated plan with young people and their families and carers after the meeting.

**Commissioners** ensure that they commission services that arrange an annual meeting with all practitioners to review transition planning for young people who will move from children’s to adults’ services.

**Young people who will move from children’s** **to adults’ services** have a meeting each year to talk about planning for the move and check that the plans are still suitable for them. The meeting should involve all practitioners supporting the young person, and parents and carers.

**Families and carers of young people who will move from children’s** **to adults’ services** are involved in a meeting each year to review planning for the move. The meeting ensures that parents and carers feel involved and know about future changes to services and care that the young person will receive.

## Source guidance

[Transition from children’s to adults’ services for young people using health or social care services. NICE guideline NG43](https://www.nice.org.uk/guidance/ng43) (2016), recommendation 1.2.4

## Definitions of terms used in this quality statement

### Annual meeting

The annual meeting should involve the young person, their parents or carers and input from all practitioners providing support.

The meeting can take place either in person or via teleconferencing or video.

The meeting should identify what is working well in the transition planning and what can be improved. The young person should be treated as an equal partner and their views taken into account. They should be supported to make decisions and build their confidence to direct their own care and support over time. At the meeting there should be a review of the young person’s current:

* clinical needs
* psychological status
* social and personal circumstances
* caring responsibilities
* educational and vocational needs
* cognitive abilities, and
* communication needs.

[[NICE’s guideline on transition from children’s to adults’ services for young people using health or social care services](https://www.nice.org.uk/guidance/ng43), recommendations 1.1.2, 1.1.4, 1.2.4 and expert opinion]

## Equality and diversity considerations

Service managers should ensure a range of support is available, and used, to help young people communicate effectively at the annual meeting. This could include having a written record of how a young person communicates, such as a communication passport or 1-page profile, and different ways to help the young person communicate, such as communication boards and digital communication tools. [[NICE’s guideline on transition from children’s to adults’ services for young people using health or social care services](https://www.nice.org.uk/guidance/ng43), recommendation 1.2.12]

Service providers should consider the best way to ensure that young people, especially those with complex needs, do not have to re-tell their story at each transition meeting. This could include making sure the same practitioners attend each meeting and/or developing and sharing a personal folder that includes key information about the young person. [[NICE’s guideline on transition from children’s to adults’ services for young people using health or social care services](https://www.nice.org.uk/guidance/ng43), recommendation 1.3.3]

# Quality statement 4: Named worker

## Quality statement

Young people who are moving from children’s to adults’ services have a named worker to coordinate care and support before, during and after transfer. **[2016]**

## Rationale

Transition can be a difficult time for young people and their families, because it is a lengthy process and involves various professionals and sometimes, several services with different timescales. A single point of contact – preferably a person that the young person knows and trusts – can coordinate care and signpost to appropriate support. This can increase attendance in adult services and lead to a better experience of care and better outcomes.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

### Process

Proportion of young people who are moving from children’s to adults’ services who have a named worker to coordinate care and support before, during and after transfer.

Numerator – the number in the denominator who have a named worker to coordinate care and support before, during and after transfer.

Denominator – the number of young people who are moving from children’s to adults’ services.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. Data on having a key worker before, during and after transition is included in the [National Confidential Enquiry into Patient Outcome and Death transition from child into adult healthcare audit toolkit](https://www.ncepod.org.uk/2023transition.html) which can be implemented locally.

### Outcome

a) Proportion of young people (and their families and carers) who have transferred from children’s to adults’ services, who were satisfied with planning for transition and transfer.

Numerator – the number in the denominator who were satisfied with planning for transition and transfer.

Denominator – the number of young people (and their families and carers) who have transferred from children’s to adults’ services.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from a patient survey. Resources to support this include the [TIER Ready, Steady, Go programme](https://www.readysteadygo.net/rsg.html) which includes feedback on transition planning in its questionnaires for young people and their families and carers. Also, the [National Confidential Enquiry into Patient Outcome and Death transition from child into adult healthcare young person and parent carer survey](https://www.ncepod.org.uk/2023transition.html) includes questions on transition planning.

b) Proportion of young people who have transferred from children’s to adults’ services, who do not attend their initial meetings or appointments with each adults’ service.

Numerator – the number in the denominator who do not attend their initial meetings or appointments with each adults’ service.

Denominator – the number of young people who have transferred from children’s to adults’ services.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. For measurement purposes, this could be defined as any of the first 3 meetings or appointments in each adults’ service.

c) Proportion of young people attending adults’ services after transfer from children’s services who continue to engage with services.

Numerator – the number in the denominator who continue to engage with services.

Denominator – the number of young people attending adults’ services after transfer from children’s services.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. For measurement purposes, this could be defined as engagement at 1 year after transfer.

## What the quality statement means for different audiences

**Service providers** (children’s and adults’ health, mental health and social care providers) ensure that systems are in place for young people who are moving from children’s to adults’ services to have a named worker to coordinate care and support before, during and after transfer. To support this, service providers could consider joining up services for young people involved with multiple medical specialities, for example, by having a single physician, such as a rehabilitation consultant, taking a co-ordinating role. [[NICE’s guideline on transition from children’s to adults’ services for young people using health or social care services](https://www.nice.org.uk/guidance/ng43), recommendation 1.5.10]

**Health and social care practitioners** (such as hospital consultants, nurses, youth workers, social workers, mental health workers and transition workers) work with the young person who is moving from children’s to adults’ services to identify a named worker and then work with this practitioner to coordinate care and support before, during and after transfer.

**Commissioners** ensure that they commission services that work with young people who are moving from children’s to adults’ services to identify a named worker to coordinate care and support before, during and after transfer.

**Young people** **who are moving from children’s to adults’ services** should be helped to choose a single worker – preferably someone that they know and trust – to act as a named worker who coordinates care before, during and after transfer. The named worker acts as a link with staff providing support, including the young person’s GP. The named worker should arrange appointments, as well as providing support to the young person and their family.

**Families and carers of young people** **who are moving from children’s to adults’ services** can contact the named worker for information and support for themselves. If appropriate, they can also ask the named worker for extra support for the young person to help with the move.

## Source guidance

[Transition from children’s to adults’ services for young people using health or social care services. NICE guideline NG43](https://www.nice.org.uk/guidance/ng43) (2016), recommendations 1.2.5 and 1.2.9

## Definitions of terms used in this quality statement

### Named worker

The named worker is a role rather than a job title. This should be one of the people from among the group of workers providing care and support to the young person, who has been designated to take a coordinating role. The young person should help decide who this person should be. It could be, for example, a support planner, a nurse, a youth worker, an allied health professional or another health or social care practitioner. It could also be someone who already has the title keyworker, transition worker or personal adviser. The transition process is lengthy and it would be expected that the named worker may change over time.

A named worker should oversee, coordinate and deliver transition support. They should be the main link with other practitioners, particularly if a young person receives care from more than one service. They should arrange appointments for the young person, act as their representative, direct them to other services and sources of support, and support the young person’s family if appropriate.

The named worker should be involved throughout transition, supporting the young person before and after transfer until a time agreed with the young person and their family or carers. The named worker should hand over responsibilities to a practitioner in adults’ services (if the named worker is based in children’s services) and give the practitioner’s details to the young person and their family or carers.

The named worker should ensure that support with education and employment is offered. For disabled young people in education, the named worker should liaise with education practitioners to ensure comprehensive student‑focused transition planning is provided.

[[NICE’s guideline on transition from children’s to adults’ services for young people using health or social care services](https://www.nice.org.uk/guidance/ng43), recommendations 1.2.5 to 1.2.10 and [NICE’s guideline on disabled children and young people up to 25 with severe complex needs](https://www.nice.org.uk/guidance/ng213), recommendation 1.8.12]

## Equality and diversity considerations

Service managers should ensure a range of support is available, and used, to help young people communicate effectively with the named worker. This could include having a written record of how a young person communicates, such as a communication passport or 1-page profile, and different ways to help the young person communicate, such as communication boards and digital communication tools. [[NICE’s guideline on transition from children’s to adults’ services for young people using health or social care services](https://www.nice.org.uk/guidance/ng43), recommendation 1.2.12]

# Quality statement 5: Meeting a practitioner in adults’ services

## Quality statement

Young people who are moving from children’s to adults’ services meet a practitioner from each adults’ service they will move to before they transfer. **[2016, updated 2023]**

## Rationale

Young people, and their families and carers, may feel unsure about moving to adults’ services, especially if they have been with children’s services for a while. Meeting a practitioner who will take a lead role in their future care, at least once, from each of the adults’ services they will move to can help build a young person’s confidence, reduce their concerns and increase their willingness to have new practitioners involved in their care. This can lead to a smoother transition for the young person and more regular attendance at appointments in adults’ services, with better outcomes.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

### Process

Proportion of young people who moved from children’s to adults’ services who met a practitioner from each adults’ service they moved to before they transferred.

Numerator – the number in the denominator who met a practitioner from each adults’ service they moved to before they transferred.

Denominator – the number of young people who moved from children’s to adults’ services.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. Data on attendance at a joint transition clinic is included in the [National Confidential Enquiry into Patient Outcome and Death transition from child into adult healthcare audit toolkit](https://www.ncepod.org.uk/2023transition.html) which can be implemented locally.

### Outcome

a) Proportion of young people (and their families and carers) who have transferred from children’s to adults’ services, who were satisfied with planning for transition and transfer.

Numerator – the number in the denominator who were satisfied with planning for transition and transfer.

Denominator – the number of young people (and their families and carers) who have transferred from children’s to adults’ services.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient survey. Resources to support this include the [TIER Ready, Steady, Go programme](https://www.readysteadygo.net/rsg.html) which includes feedback on transition planning in its questionnaires for young people and their families and carers. Also, the [National Confidential Enquiry into Patient Outcome and Death transition from child into adult healthcare young person and parent carer survey](https://www.ncepod.org.uk/2023transition.html) includes questions on transition planning.

b) Proportion of young people who have transferred from children’s to adults’ services, who do not attend their initial meetings or appointments with each adults’ service.

Numerator – the number in the denominator who do not attend their initial meetings or appointments with each adults’ service.

Denominator – the number of young people who have transferred from children’s to adults’ services.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. For measurement purposes, this could be defined as the first 3 meetings or appointments in each adults’ service.

c) Proportion of young people attending adults’ services after transfer from children’s services who continue to engage with services.

Numerator – the number in the denominator who continue to engage with services.

Denominator – the number of young people attending adults’ services after transfer from children’s services.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. For measurement purposes, this could be defined as engagement at 1 year after transfer.

## What the quality statement means for different audiences

**Service providers** (children’s and adults’ service managers) ensure there are systems in place for young people to meet a practitioner from each adults’ service they will move to before they transfer from children’s to adults’ services. These may include joint appointments, joint clinics, virtual meetings, and pairing of a practitioner from adults’ services with one from children’s services. Children’s services should consider ensuring that practitioners work with the young person to create a personal folder with key information to help with their introduction to adult’s services.

**Health and social care practitioners** **from adults’ services** (such as hospital consultants, nurses, social workers and mental health workers) meet the young people who will move into their service before they transfer. This meeting should help them to identify the support the young person will need to prepare for adult life and maximise their independence.

**Commissioners** ensure that they commission adults’ services in which practitioners meet young people before they transfer from children’s services.

**Young people** **who will move from children’s** **to adults’ services** meet someone from each of their new adults’ services before they transfer, to help them feel more confident about the move.

## Source guidance

[Transition from children’s to adults’ services for young people using health or social care services. NICE guideline NG43](https://www.nice.org.uk/guidance/ng43) (2016), recommendation 1.3.1

## Equality and diversity considerations

Health and social care practitioners should consider the young person’s communication needs and preferences when deciding on the format for the introductory meeting with adults’ services.

Service managers should ensure a range of support is available, and used, to help young people communicate effectively when they meet practitioners from adults’ services. This could include having a written record of how a young person communicates, such as a communication passport or 1-page profile, and different ways to help the young person communicate, such as communication boards and digital communication tools. [[NICE’s guideline on transition from children’s to adults’ services for young people using health or social care services](https://www.nice.org.uk/guidance/ng43), recommendation 1.2.12]

# Quality statement 6: Missed initial appointments after transfer to adults’ services

## Quality statement

Young people who have moved from children’s to adults’ services but do not attend their initial meetings or appointments are contacted by adults’ services and given further opportunities to engage. **[2016, updated 2023]**

## Rationale

Young people need to engage with adults’ services so that they continue to receive the care and support they need. When young people disengage from services during transition it can affect their future health, mental health and social care needs.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

### Structure

a) Evidence of local arrangements to monitor and assure transitions from children’s to adults’ services.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, such as local protocols, governance structures and reporting arrangements.

b) Evidence of local processes in adults’ services for follow-up arrangements for young people who have moved from children’s to adults’ services but do not attend their initial meetings or appointments.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from service protocols.

### Process

Proportion of young people who have moved from children’s to adults’ services but did not attend their initial meetings or appointments who were contacted by adults’ services and given further opportunities to engage.

Numerator – the number in the denominator who were contacted by adults’ services and given further opportunities to engage.

Denominator – the number of young people who have moved from children’s to adults’ services but did not attend their initial meetings or appointments.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. For measurement purposes, this could be defined as any of the first 3 meetings or appointments in each adults’ service.

### Outcome

a) Proportion of young people who transferred from children’s to adults’ services who are discharged from each adults’ service without attending a meeting or appointment.

Numerator – the number in the denominator who are discharged from each adults’ service without attending a meeting or appointment.

Denominator – the number of young people who transferred from children’s to adults’ services.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

b) Proportion of young people attending adults’ services after transfer from children’s services who continue to engage with services.

Numerator – the number in the denominator who continue to engage with services.

Denominator – the number of young people attending adults’ services after transfer from children’s services.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. For measurement purposes, this could be defined as engagement at 1 year after transfer.

## What the quality statement means for different audiences

**Service providers** (adult health, mental health and social care services) ensure that systems are in place, so they know who is transferring from children’s services, and that a young person is contacted and given further opportunities to engage if they do not attend their initial meetings or appointments in adults’ services.

**Health and social care practitioners from adults’ services** (such as hospital consultants, social workers, mental health workers) ensure that they work with children's services to identify young people who have moved to adults’ services but did not attend their initial meetings or appointments. They ensure that the young people are contacted and given further opportunities to engage.

**Commissioners** ensure that they commission adults’ services that contactyoung people who have moved to their services but do not attend the initial meetings or appointments and give them further opportunities to engage (for example, other appointments).

**Young people** **who have moved from children’s** **to adults’ services but do not attend their initial meetings or appointments** are contacted by someone from adults’ services. They will check if the young person’s care and support plan is still right and whether they need any other help to get back in touch with the service.

**Families and carers of young people** **who have moved from children’s** **to adults’ services but do not attend their initial meetings or appointments** are contacted by someone from adults’ services to try to help the young person keep in touch with adults’ services.

## Source guidance

[Transition from children’s to adults’ services for young people using health or social care services. NICE guideline NG43](https://www.nice.org.uk/guidance/ng43) (2016), recommendations 1.4.1 and 1.4.2

## Definitions of terms used in this quality statement

### Opportunities to engage

If a young person does not attend meetings and appointments in adults’ services, the adults’ service should try to contact them and their family or carers and follow up with the young person, then involve other relevant professionals (including children’s services and their GP) if need be. If there is still no contact then the relevant provider should refer back to the named worker or the children’s service with clear guidance on re-referral, if applicable. The named worker should review the person‑centred care and support plan with the young person to identify how to help them use the service. If the young person does not want to engage in adults’ services, they should be offered alternative ways to meet their support needs by the named worker. [[NICE’s guideline on transition from children’s to adults’ services for young people using health or social care services](https://www.nice.org.uk/guidance/ng43), recommendations 1.4.1 to 1.4.3].

## Equality and diversity considerations

Service managers should ensure a range of support is available, and used, to help young people communicate effectively when adults’ services engage with them. This could include having a written record of how a young person communicates, such as a communication passport or 1-page profile, and different ways to help the young person communicate, such as communication boards and digital communication tools. [[NICE’s guideline on transition from children’s to adults’ services for young people using health or social care services](https://www.nice.org.uk/guidance/ng43), recommendation 1.2.12]

## Questions for consultation

We have suggested that this statement could be measured based on attendance at any of the first 3 meetings or appointments in adults’ services. Is this a helpful definition of initial appointments? If not, please suggest an alternative.

Can structure measure a) on arrangements to monitor and assure transitions from children’s to adults’ services be measured in practice? If so, how? Please let us know of any examples where this is already collected.

Is it helpful to include the new outcome measure b) to capture ongoing engagement with adults’ services (1 year after transfer) for this statement?

**Update information**

**September 2023:** This quality standard was updated following feedback from stakeholders.

Statements are marked as:

* **[2016]** if the statement remains unchanged
* **[new 2023]** if the statement covers a new area for quality improvement
* **[2016, updated 2023]** if the statement has been amended.

# About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

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## Diversity, equality and language

Equality issues were considered during development and [equality assessments for this quality standard](http://www.nice.org.uk/guidance/qs140/documents) are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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