2023

APCP Guidance for Good Practice: Physiotherapists Supporting Transition

Association of Paediatric Chartered Physiotherapists

APCP Guidance for Good Practice:

Physiotherapists Supporting Transition

Introduction

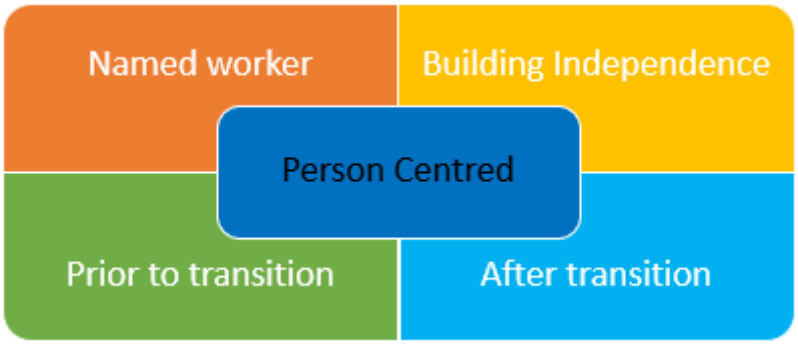
This ***Guidance for Good Practice*** document provides expert consensus on good practice for physiotherapists working with older children and young people (age 13/14+), with the aim of supporting their transition into adult services. This guidance is based on the best available evidence in combination with clinical expertise, shared by members of the Association of Paediatric Chartered Physiotherapists (APCP). Five key themes have been considered to inform good practice, based on the NICE Guidelines 'Transition from Children's' to Adults' Services for Young People Using Health or Social Care' (2016)

This document is supported by the **APCP Understanding Transition Leaflets** that can be provided to any young person and their carer, to start their understanding of transition.

Purpose

The purpose of this guidance document is to support paediatric physiotherapists and other allied health professionals working with older children and young people approaching transition. Document content can be used as a learning resource, to guide clinicians in the assessment and tailoring of transitional care for this population of interest.

Key themes to inform Practice



Theme 1: Person Centred

- Transition should be based on **developmentally appropriate** needs of the young person. Do not base transition on a rigid age threshold. For example, take into account their cognitive ability, maturity, personal circumstances, psychological status. This should be completed in collaboration with a multidisciplinary team where available (Marani et al. 2020)
- The young person should have **equal partnership in their transition** and their views and needs must be taken into full account.
- Transition support should be **strength based**, focusing on agreed goals.
- **Involve parents/carers** and ask the young person how they would like them to be involved. Please consider the Children's Act (1989) and where a child is over the age of 16, a young person's competence and capacity should be reviewed under the Mental Capacity Act (2005).
- Have open discussions with the young person and parent/carer about their **expectations of transition**, recognising that the young person's preferences may be different to the parent/carer. Take into account the young person's capacity (Hislop et al. 2016)

Checklist may include:

- ☐ **Have you assessed, in partnership with the MDT, that the young person is developmentally appropriate for transition? Where appropriate, has the young person been involved in this assessment?**
- ☐ **Have parents/carers been invited to be involved in transition and has the young person agreed to this where able?**
- ☐ **Have you discussed what transition is with the young person, involving parents/carers where appropriate?**
- ☐ **Have you agreed goals in partnership with the young person, involving parents/carers where appropriate?**
- ☐ **Have you discussed expectations with the young person, involving parents/carers where appropriate**

Useful resources and evidence:

Marani H, Fujioka J, Tabatabavakili S, Bollegala N, (2020) Systemic Narrative Review of Pediatric-to-aduly Care Transition Models for youth with Pediatric-onet Chronic Conditions. Children and Youth Service Review 118 (2020) 105415

Hislop J, Mason H, Parr JR, Vale L, Colver A, (2016) Views of young People with Chronic Conditions on Transition From Pediatric to Adult Health Services. Journal of Adolescent Health 59 (2016) 345-353

Theme 2: Named Worker

- A named worker should be identified to lead/ assist the young person with transition planning and liaison with the MDT. (McCallum et al. 2017)
- The young person should be involved in identifying who will coordinate their transition care and support.
- The named worker should be someone whom the young person has a meaningful relationship with and can act as an advocate or signpost them to an independent advocate if the young person lack capacity to make choices regarding their own future.

Checklist may include:

- ☐ **Does the young person have an identified key worker?**
- ☐ **Has the young person been involved in identifying a key worker?**
- ☐ **Does the key worker have a meaningful relationship with the young person?**

Useful resources and evidence:

McCallum C, (2017) Supporting Young People's Transition from Children's to Adult Services in the Community. British Journal of Community Nursing Vol 22 No 1.

Theme 3: Building Independence

- Ongoing education should be provided to support the young person's understanding of their condition. This should be individualised and developmentally appropriate in line with their cognitive and communication needs, with opportunities for the young person to ask questions.
- Have a plan for the young person to start taking responsibility when accessing physiotherapy.
- Encourage them to know when appointments are and keep a record of this themselves, prompting parents when they need to attend.
- Discuss treatments and why they are used with them and ensure set treatment goals are joint with the young person this will help the young person to learn how to identify their physiotherapy needs and when to ask for help.
- Encourage self-management, where possible, such as self-directed stretches/exercises, or get the young person to be confident enough to direct parents/carers on how to assist with these.
- Start to introduce skills on how to maintain/identify issues with their own equipment and liaise with professionals if they have a problem.
- Empower the young person to start the process of managing their health needs (Colver et al. 2018)

Checklist may include:

- ☐ **Has the young person been offered education about their condition, their treatment and the role of professionals involved in their management, in a developmentally appropriate format that meets their individual needs?**
- ☐ **Has the young person been given the opportunity to ask questions about their condition, treatment or role of professionals involved?**
- ☐ **Has the young person been involved in their treatment plan?**
- ☐ **Does the treatment plan encourage independent strategies where possible?**
- ☐ **Does the young person have access to contacts of professionals involved in their care, to encourage self-management where appropriate?**

Useful resources and evidence:

Colver A, Pearse R, Watson RM, Fay M, Rapley T, Mann KD, Le Couteur A, Parr JR, McConachie H, (2018) How Well Do Services for Young People with Long Term Conditions Deliver Features Proposed to Improve Transition BMC Health Services Research 18: 337

Theme 4: Prior to Transfer

- Identify the young person's physiotherapy needs and get a named contact in adult services.
- If the young person does not meet the criteria for statutory adult services flag this to the GP as they will have an increased responsibility for ongoing management.
- Signposting: Ensure the young person knows how to self-refer for any area they may need as an adult; for example, physiotherapy, wheelchair services, orthotics, prescriptions, equipment.
- Inform the young person of the services they can access and how to do this. This may include financial support or accessing personal budgets.
- Try to set up a transition clinic or at least an opportunity for joint working with adult services.
- Educate the young person about any potential physical problems related to their condition that could occur and how to manage them and how to get appropriate help. (Marani et al. 2020)
- Personal Folder: encourage the young person to create a personal folder in their preferred format. This should include information about their health condition, their preferred involvement of the parent/carer, emergency care plans, previous management like admissions, planned and unplanned, strengths and achievement including future hopes or goals.

Checklist may include:

☐ **Has the young person been supported to create a personal folder or summary of needs, strengths, achievements and future goals?**

☐ **Has the young person been given a named contact in adult services?**

If yes,

☐ **Has the young person been offered a joint appointment with paediatric and adult services?**

☐ **Is there a plan to support the young person's attendance to planned health and social care appointments?**

If no adult service is involved,

☐ **Have you made the GP aware that no adult services will be involved?**

☐ **Has the young person been provided with contact details for adult services should they wish to self-refer?**

☐ **Has the young person been provided with the education to identify potential new problems or worsening problems related to their health/condition?**

Theme 5: After Transfer

- Make sure you complete a discharge report including a final assessment, any previous treatment and management, equipment, orthotics, medical interventions.
- Ensure the report is copied to the GP, consultants or future placements involving the young person. (McCallum et al. 2017)
- Where a young person is unable to attend appointments, or is unable to make decisions based in line with the Mental Capacity Act (2005), this needs to be flagged to the GP and adult services.

Checklist may include:

☐ **Has the young person been provided with a discharge report and final assessment?**

☐ **Has the GP and appropriate adult services been provided with a copy of the discharge report and final assessment**

Useful resources and evidence:

Marani H, Fujioka J, Tabatabavakili S, Bollegala N, (2020) Systemic Narrative Review of Pediatric-to-aduly Care Transition Models for youth with Pediatric-onet Chronic Conditions. *Children and Youth Service Review 118 (2020) 105415*

McCallum C, (2017) Supporting Young People's Transition from Children's to Adult Services in the Community. *British Journal of Community Nursing Vol 22 No 1.*

Special Considerations

Education, Health and Care Plans

If the young person has an EHCP transition support should be incorporated within their plan and must include joint working towards their outcomes.

If the young person does not have an EHCP consider a multiagency meeting including the young person and family, and the GP, to discuss their future needs.

Financial support

Remember those in receipt of high-rate mobility can learn to drive at 16.

Emotional wellbeing

Transition can be daunting for the young person and their family. Signposting to counselling services or support groups may be beneficial.

Gap Analysis

If the young person cannot access statutory services consider doing a 'gap analysis' in order to inform local planning and commissioning of service gaps and risk.

Additional Resources to support Transition

This ***Guidance for Good Practice*** document should be used in combination with the following key documents to ensure safe and effective transitional care:

NICE (2016) Transition from children's to adults' services for young people using health or social care services
This guideline covers the period before, during and after a young person moves from children's to adults' services. It aims to help young people and their carers have a better experience of transition by improving the way it's planned and carried out. It covers both health and social care
Overview | Transition from children's to adults' services for young people using health or social care services | Guidance | NICE

Department of Health: Transition: moving on well
A good practice guide for health professionals and their partners on transition planning for young people with complex health needs or a disability
Transition: moving on well (ioe.ac.uk)

Competency and Consent
Guidance on definitions of capacity and Gillick competence
https://www.cqc.org.uk/sites/default/files/Brief_guide_Capacity_and_consent_in_under_18s%20v3.pdf

The Children's Act (1989)
This guidance updates and consolidates The Children Act 1989 Guidance and Regulations

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1000549/The_Children_Act_1989_guidance_and_regulations_Volume_2_care_planning__placement_and_case_review.pdf

Mental Capacity Act 2005

The Mental Capacity Act 2005, covering England and Wales, provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they may lack capacity in the future

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/921428/Mental-capacity-act-code-of-practice.pdf

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