Policy Document

Reference: C71

University Hospitals of North Midlands NHS Trust

Acute Assessment and Management of 16-17 year olds and Transition of Young Adults from Children's Services to Adult Services, Inpatients/Outpatients

Version:	**2**
Date Ratified:	**July 2024 by the Quality & Safety Oversight Group**
To Be Reviewed Before:	**July 2027**
Policy Author:	**Chief Clinical Information Officer, Senior Matron - Child Health, Consultant Paediatrician**
Executive Lead:	**Chief Nurse**

Version Control Schedule

Version	Issue Date	Comments
1	May 2022	The purpose of this Policy is to provide guidance and principles of good practice in relation to the assessment on acute presentation and transition of young people from paediatric to adult services within the University Hospital of North Midlands at both Royal Stoke University Hospital and County Hospital.
2	July 2024	Minor change only to a telephone number for the Children's Safeguarding team

Statement on Trust Policies

The latest version of 'Statement on Trust Policies' applies to this policy and can be accessed here

NHS
University Hospitals of North Midlands
NHS Trust

Equality Impact Assessment (EIA)

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. The Equality Impact Analysis Form is designed to help consider the needs and assess the impact of each policy. To this end, EIAs will be undertaken for all policies.

Does this policy have the potential to affect any of the groups listed below differently - please complete the below. Prompts for consideration are provided, but are not an exhaustive list

Group	Is there a potential to impact on the group? (Yes/No/Unsure)	Please explain and give examples	Actions taken to mitigate negative impact
Age (e.g. are specific age groups excluded? Would the same process affect age groups in different ways?)	No		
Gender (e.g. is gender neutral language used in the way the policy or information leaflet is written?)	No		
Race (e.g. any specific needs identified for certain groups such as dress, diet, individual care needs? Are interpretation and translation services required and do staff know how to book these?)	No		
Religion & Belief (e.g. Jehovah Witness stance on blood transfusions; dietary needs that may conflict with medication offered)	No		
Sexual orientation (e.g. is inclusive language used? Are there different access/prevalence rates?)	No		
Pregnancy & Maternity (e.g. are procedures suitable for pregnant and/or breastfeeding women?)	No		Any CYP would be supported within maternity services as a speciality service.
Marital status/civil partnership (e.g. would there be any difference because the individual is/is not married/in a civil partnership?)	No		
Gender Reassignment (e.g. are there particular tests related to gender? Is confidentiality of the patient or staff member maintained?)	No		Trust policies would be followed
Human Rights	No		Trust policies would be followed

Group	Is there a potential to impact on the group? (Yes/No/Unsure)	Please explain and give examples	Actions taken to mitigate negative impact
(e.g. Does it uphold the principles of Fairness, Respect, Equality, Dignity and Autonomy?)			
Carers (e.g. is sufficient notice built in so can take time off work to attend appointment?)	No		
Socio/economic (e.g. would there be any requirement or expectation that may not be able to be met by those on low or limited income, such as costs incurred?)	No		
Disability (e.g. are information/questionnaires/consent forms available in different formats upon request? Are waiting areas suitable?) Includes hearing and/or visual impairments, physical disability, neurodevelopmental impairments e.g. autism, mental health conditions, and long term conditions e.g. cancer.	No		Trust policies would be followed
Are there any adjustments that need to be made to ensure that people with disabilities have the same access to and outcomes from the service or employment activities as those without disabilities?			**Yes/No**
			No - Trust policies would be followed
Will this policy require a full impact assessment and action plan?			**Yes/No**
			No

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1. INTRODUCTION

Acute assessment

The young people who are aged between 16- 17 should be cared for in a suitable environment keeping in mind the child's clinical needs and where they are best met. If a young person aged 16 years and above presents to the hospital, she/he should be offered care where their clinical needs are best met. The referring team should make a full clinical assessment and direct whether young person's needs are best met by the Paediatric services or adult services.

Transition

Transition is recognised as a gradual process of empowerment that equips young people with the skills necessary to manage their own healthcare as they move towards and into adult services and lifestyles. It is a carefully planned process undertaken over time which includes (but is more than) a planned transfer to adult services.

More children with long-term conditions now live into adulthood. There is a growing need for health services to ensure a seamless transition of young people to adult health care services. This is achieved by maintaining good liaison between Paediatricians, Physicians, General Practitioners (GP), Nurses, Allied Health Professionals (AHP), and external agency professionals.

Inadequate transitional care impacts long-term health outcomes for children and young people.

The purpose of this Policy is to provide guidance and principles of good practice in relation to the assessment on acute presentation and transition of young people from paediatric to adult services within the University Hospital of North Midlands at both Royal Stoke University Hospital and County Hospital.

2. STATEMENT

UHNM set out to provide a service that is:

Assessment on acute presentation

- Centered on young people and placed in the context of young people's lives and their changing circumstances.

- All patients aged less than 16 years should be admitted to paediatric wards under paediatric services. All the patients aged 18 years and above should be admitted to adult wards under adult services.

- The decision to admit young person between 16- 18 years to either paediatric or adult services should be purely based on the clinical condition and where the young person's clinical needs are best met. Please refer to Appendix 1 for further guidance.

- Whether the child is in fulltime school education/ working or not has no bearing on the decision. Young person's wishes should be taken into consideration wherever possible but clinical need should override the individual wishes.

- In exceptional circumstances if the young person needs treatment under adult clinical teams but is deemed unsuitable to be in adult wards, as an exception the young person can be admitted to paediatric ward with clinical care provided by adult clinical teams.

- If the young person who is admitted to the adult ward wishes one of the parents to be present during clinical consultation, his/her wish must be facilitated wherever possible.
- Young person with mental health problems, a risk assessment should be undertaken to see whether he/she poses risk to other children in paediatric ward.

Transition to adult services

- Age and developmentally appropriate and takes into account the young person's maturity, cognitive ability and specific needs with respect to their long - term condition in addition to their social/personal circumstances and psychological status. Inclusion of the whole family in decision making about appropriate care for the young person is essential.

- A streamlined progression from paediatric to adult services.

- A multidisciplinary, multi-agency approach with involvement from professionals in primary, secondary and tertiary care alongside those in education and social care.

- Transition needs to address the medical, psychological and educational/vocational needs of the young person and the needs of their parents/carers

- Every young person with any long-term condition should have a planned transition of care evident within their health care records – identified by the trust alert system.

- Most patients identified as eligible for transfer to adult medical services will be transferred following the 'Ready Steady Go' transition pathway.

- The Trust recognises that the ready steady go program may not meet the needs of all patients and in this situation, an alternative, individualised transition pathway may be used which shares the same philosophy.

- A named lead professional (Consultant or CNS) who offers support around the transition should be identified for each young person within the specialty they are currently supported in.

- Some young people will require multi-disciplinary team (MDT) meetings, which should ideally include the GP in complex care cases. The lead professional can be any member of the MDT

- The MDT will ensure that the young person, and their carers, are appropriately supported and engaged with throughout the transition process.

- Every young person transitioning from Paediatrics to adult services will have 3 alerts placed into Careflow to alert all professionals of this significant time within the young person's healthcare journey.

    1. Alert one – entering transition
    2. Alert two – midway following the first joint appointment/first MDT meeting in the case of a complex patient under multiple professionals and specialties.
    3. Alert three – full transition. This alert assists young adults and professionals on admission via an emergency portal to understand who has current responsibility in the delivery of care. This alert will stay in place for one year post transition.

       In the background of all alerts will be clinical notes detailing the progression of the young person's transition.

- Every patient transitioning to adult services with a known learning disability will have a patient passport in place to support their own going health care in adult services. Any CYP (Child, Young Person) with a learning disability passport will have a flag annotated on their personal electronic patient record.

3. SCOPE

This policy applies to all paediatricians and adult physicians', Paediatric and Adults CNS's (Clinical Nurse Specialist's) and Allied Health Professionals involved in Acute assessment and in the transition of young

adults from Children's Services to Adult Services. Most importantly all young person's currently under the care of a paediatrician at UHNM requiring transfer to an adult based service.

4. DEFINITIONS

- **Transition:** a purposeful, planned process to firstly prepare young people moving from a child-centered to adult-orientated service and secondly addresses the medical, psychological and educational/vocational needs of adolescents and young adults with chronic physical and medical conditions as they move from child-centered to adult-oriented health care systems

- **Clinician:** the professional responsible for the young person's care i.e. Doctor, Nurse Specialist or Allied Health Professional.

- **Key Worker:** a professional who has the responsibility for collaborating with professionals from their own and from other services and developing good working relationships to ensure co-ordination of care for the young person.

- **Parent/or carer:** a mother, father, close relative or close friend who are adults (older than 18 years) and who have been closely involved in caring for the child or young person.

- **Young person**: For the purpose of this Policy the term is used to describe young people between the ages of 13 – 17 years.

- **Complex** patients": usually **defined** as patients with **complex care needs**, with a combination of **multiple** chronic conditions, mental health issues, medication-related problems, and social vulnerability.

  Children who are born too early may have the long-term consequences of extreme prematurity; others have inherited conditions, chronic illness or sustain life changing injury. The spectrum of conditions includes cerebral palsy with significant disability, intractable epilepsy, autism, chromosomal and genetic conditions, chronic lung disease, complex metabolic disease, complicated cardiac disease, oncology or post-transplant. There are children who are oxygen dependent, have tracheostomies and need regular suction. Some require enteral feeding, either nasogastric or by a gastrostomy or jejunostomy. Poly-pharmacy with unfamiliar medication is not unusual. New technologies such as vagal nerve stimulators, deep brain stimulators or intrathecal baclofen pumps are increasingly frequent. Palliative and end of life care plans may be in place. Children with complex medical needs can present as an emergency with a complication of their condition or with childhood illness or injury. This presents a number of challenges in assessment and management.

5. ROLES AND RESPONSIBILITIES

- **The Chief Executive / Chief Nurse** has responsibility for ensuring that appropriate processes are in place for the transition of young people (13-18yrs) from child-centered to adult orientated services.

- **The Paediatric and Adult Care Consultants** have a responsibility for ensuring that the process agreed within this Policy is followed robustly to ensure effective transition between the services.

- **The Lead Clinician, Lead Clinical Nurse Specialist, the Paediatric Liaison and or Transition Nurse,** acts as a communication lead between all the individuals involved in effective transition.

- **The Director of Nursing and Paediatric Matrons for Children's Women's and Diagnostic Centre** have a responsibility for taking action on any non-compliance from the identified measurement tools that monitor compliance against this guidance.

- The receiving specialties have the responsibility to ensure that they have capacity within their OPD settings to support transferring patients.

- **Clinical Nurse Specialists Nurses** have a responsibility to ensure this Policy is championed and followed robustly when transitioning children to adult services within a specialist service framework.

- **Paediatric Governance Group, CWD Clinical Excellence** has the responsibility to ensure that standards are met, actions are carried out and areas of concern are raised and escalated appropriately.

- **The Children's Hospital Board at UHNM** is responsible for developing the transition service, ensuring that this transition Policy is followed accurately, and that it is revised as practice evolves.

Three Main Stages of Transition

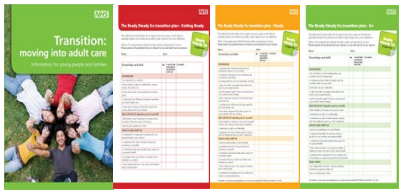
Getting Ready
The aim is to introduce the concept of transition to the young person and family/carer early; it allows the young person to develop their autonomy whilst being supported by their family. The young adult needs to become aware of their own health care needs, and the implications of their medical condition

Steady
The young person and their family develop an understanding of the transition process and what to expect from the adult services. The young person should gain an appropriate understanding of their condition and practice skills relevant to their needs and begin to set their own goals. Facilitating self-medication, self-care and 'parent free' consultations can help young people begin to take responsibility for their own health care needs.

Go
By this stage the young person and their family should be feeling confident about leaving the Paediatric system and the young person should have a considerable degree of autonomy over their own care.

Transition Process

- Young people and carers are introduced to Ready Steady Go through the 'Transition: moving into adult care' information leaflets, Or documentation developed by the specialty and supported via the Trust's governance process.



- If there are any concerns with a child's or young person's ability to give informed consent refer to the Trust's Consent for Examination or Treatment Policy available here

- At the next consultation the young person completes a 'Getting Ready' questionnaire. Through a series of structured questions, a personalised transition programme is designed to meet their individual needs. The issues are addressed over the following 1- 2 years and not in a single consultation.

- As young people gradually develop the confidence and skills to take charge of their own healthcare, the ‘Steady’ questionnaire is completed. This builds on the young person’s knowledge and skills around their condition.

- Finally the ‘Go’ questionnaire ensures that the young person has all the necessary skills and knowledge to transfer safely and confidently to adult services.

- The young person should be introduced to the adult team – ideally at least a year prior to transfer.

- Young people should be given the opportunity of being seen on their own. This can be offered, depending upon the emotional maturity of the young person, from around the age of 13 years. All children being seen on their own should be chaperoned during the consultation, in line with safeguarding policies. (Trust Policy 44 Chaperoning)

- The parent or carer should complete a parent/carers transition plan. This is designed to help parents and carers feel confident about their knowledge and skills during the period of transition.

- The point of transfer to adult services for both outpatient and inpatient is mutually agreed by the young person, parents or carers, and professionals.

- Any issues, concerns, and progress are documented in the transition plan by the healthcare team/lead professional.

- On transfer to adult services, the young person will begin the “Hello to Adult Services” programme and complete the ‘Hello to Adult Services’ questionnaire.

- Intermittently, the ‘Hello to Adult Services’ questionnaire should be reviewed, in order to maintain the young person’s knowledge and skills around their condition.

- Those young people or adults whose first presentation with a long term condition is in adult services should be started on the ‘Hello to Adult Services’ programme. It can be used for all young people and adults regardless of age or sub-specialty.

Timing

The process of transition from paediatric to adult medical services should commence at approximately 13 years of age (as deemed appropriate developmentally).

- Not all young people will be ready to move into adult healthcare at the same time. The young person’s maturity, cognitive ability and specific needs with respect to their long term condition in addition to their social circumstances and psychological status need to be taken into account. Every effort should be made to put the young person and their family/carers at the Centre of this process.

- The timing of transfer should be tailored to individual patient’s needs depending upon their emotional maturity and cognitive and physical development. It normally occurs around the time of the young person’s 18th birthday but for those with complex needs the process may take longer.

- Young adults who are supported with a complex care pathway and receiving care from a number of pediatrician’s and have a named community pediatrician should with their parents be invited to an MDT meeting with all pediatrician attendance to commence the transition process this should continue during the transfer to adult services so that a seamless transition occurs for all specialties.

Communication

- Copies of key letters and summaries should be given to the young person during transition. This may be kept in a Personal Health Record.

- Communication between paediatric and adult teams should be accurate and relevant and facilitate a smooth and safe transfer.

- Clear, concise, and useful information needs to be shared with the patient's GP at all key points in the Ready, Steady, Go process

Communication to health professionals via Care flow

- Every young person transitioning from Paediatrics to adult services will have 3 alerts placed into Careflow to alert all professionals of this significant time within the young person's healthcare journey.

    1. Alert one – entering transition
    2. Alert two – midway following the first joint appointment/first MDT meeting in the case of a complex patient under multiple professionals and specialties.
    3. Alert three – full transition. This alert assists the young adult and professional on admission via an emergency portal to understand who has responsibility in care. This alert will stay in place for one year post transition.

       In the background of all alerts will be clinical notes detailing the progression of the young person's transition.

Safeguarding

Any concerns raised during the transition process that the young adult's need will not be fully met should prompt early involvement of appropriate support services. If there are specific safeguarding concerns, then guidance outlined in the Trust's safeguarding policies should be followed closely (C23 Children Protection Policy).

For children with complex needs who are already known to social care, their named social worker will also need to be involved during the process of the transition.

Transition for young people with a learning disability

- All young people with a learning disability who have started on the Ready Steady Go pathway should be referred to the Adult Learning Disability Liaison Nurse at UHNM. A Learning Disability Liaison nurse will attend a joint appointment with the receiving and referring teams to support the young person, ensuring reasonable adjustments are made.

- All young people with a learning disability should be simultaneously referred to the adult learning disability services either directly or via the known keyworkers within the Integrated Services for Children.

Transition for young people accessing emergency portals of entrance

Young people aged between 13-17yrs whilst in transition access services via the emergency portals of entrance of the Accident and Emergency department and require an inpatient spell are admitted under their paediatrician to the Children's Unit.

Young people aged 16-17yrs who have fully transitioned and access services via the emergency portal of entrance and require an inpatient admission are admitted to the relevant adult specialty and ward.

Young people aged 16-17 yrs access services via emergency portals should be managed as per guidance outlined in appendix 1

Key documents:

- **Transitional Care Plan**. This document is a checklist to ensure the patient has all the skills necessary for a successful transfer to adult services
- **Patient information leaflet on transition**. This describes the transitional care process
- **Parent/Carer Transition Plan**. This helps parents and carers develop their confidence to empower them with the knowledge and skills to enable them to support their child during the transition to adult services.
- **Hello to Adult Services Questionnaire.** This is the key tool for identifying the extent to which the patient is ready for transition to adult services. It identifies which skill sets/knowledge base require further development before successful transfer to adult services can be undertaken, and the young person has the confidence and skills to take charge of their own healthcare
- **Moving Through the Programme Flow Chart.** This provides clear guidance on how to use the Ready Steady Go programme

6. NEW REFERRALS TO UHNM FOR YOUNG PEOPLE AGE 16-17YRS

Any young person referred to the UHNM for a secondary opinion will be triaged and the decision to admit to Children or adult services should be based on where the clinical needs are best met – there will be exceptions to this. (Please see appendix 1)

Any young person aged between 16-17years attending the Accident and Emergency department (A&E) and requires admission should be assessed at emergency portal and decision to admit to Children or adult services should be based on where the clinical needs are best met – there will be exceptions to this. (Please see appendix 1)

7. EDUCATION/TRAINING AND PLAN OF IMPLEMENTATION

Professionals may need to consider further development of their knowledge and skills in working with young people, including: the biology and psychology of adolescence; communication and consultation strategies; multi-disciplinary and multi-agency teamwork; and an understanding of the relevant individual conditions and disorders and their evolution and consequences in adult life.

All professionals who have regular involvement in transitioning children to adult services should complete this training.

This policy will be disseminated via the following governance meetings:

- Children’s Women’s and Diagnostic Division
- Medical Division
- Surgical Division
- Specialised Surgical Division

It is the responsibility of the Directors of Nursing, Associate Chief Nurses’ and Matron’s to ensure that all staff are familiar with the policy.

8. MONITORING AND REVIEW ARRANGEMENTS

8.1 Monitoring Arrangements

Adherence of the policy will be monitored on a quarterly basis and presented to the Child Health Quality Safety and Risk meeting and the Children's Hospital Board

- A selection of patients that are currently in the transition phase from children's to adult services will be randomly selected from differing specialities and the following elements reviewed
  - Did Not Attend (DNA) to transition appointments
  - Number of emergency admissions during transition
  - Completion of a patient feedback questionnaire.

- A selection of patients that have transitioned during a calendar year April to April will be selected randomly from differing specialities and following elements reviewed.
  - Did Not Attend (DNA) to appointments within adult services post transition
  - Number of emergency admissions post transfer
  - Completion of a patient feedback questionnaire.

- A selection of patients attending the adult emergency department at UHNM and requiring onward admission, patients within the following age range of 16-18years will be randomly selected.

- Attendance due to long term condition – e.g. Respiratory, Complex Care, Diabetes, Haematology, gastroenterology via an emergency portal of entrance.

- If the young adult is in on-going transitional care admitted to children's services?

- If the young adult has completed transition admitted to adult services.
  - Completion of a patient feedback questionnaire.

8.2 Review

Children's Women's and Diagnostic are responsible for the review of this policy within the first year.

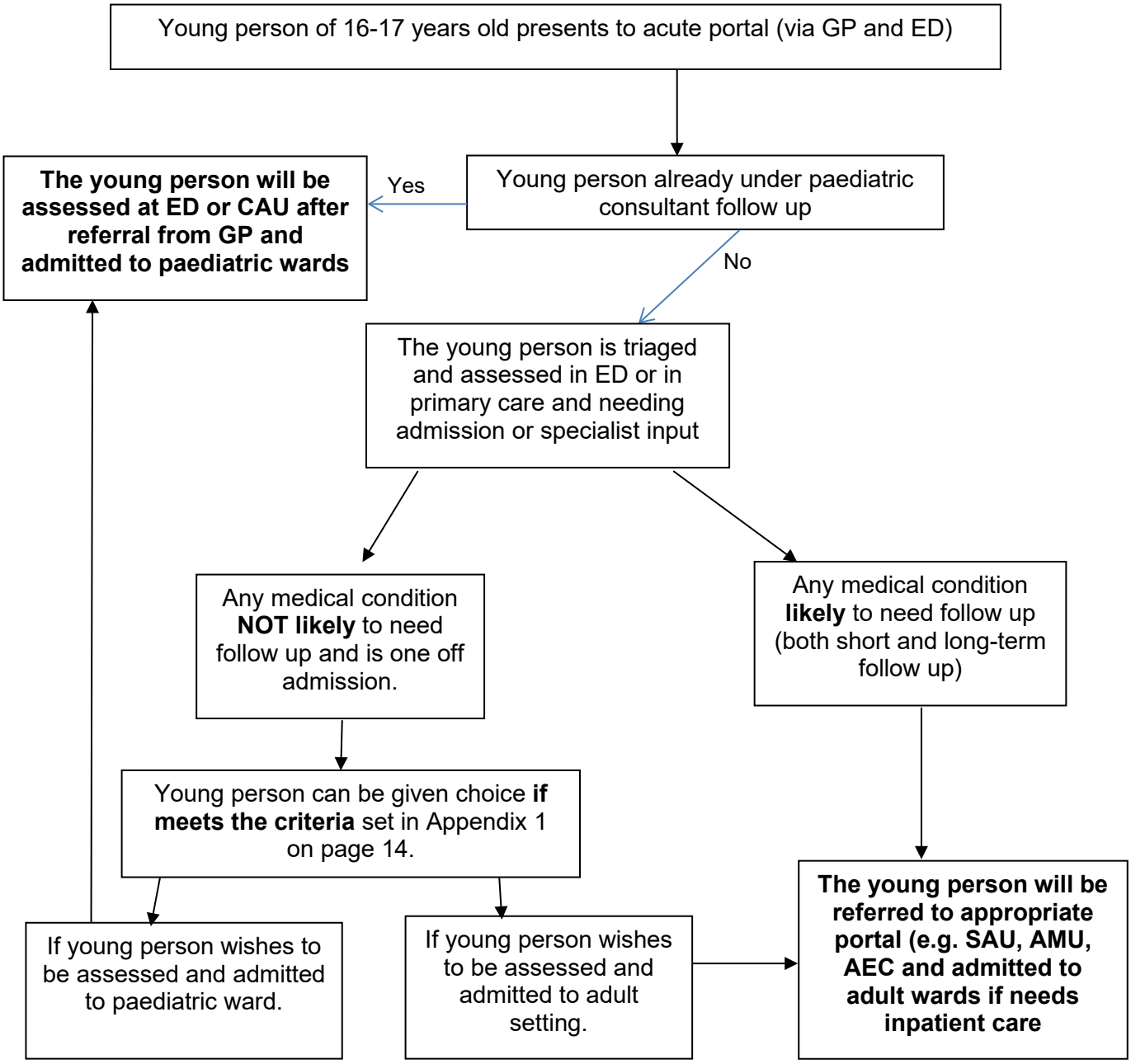
The policy after the first review will then be reviewed three yearly – unless we receive notification of a national change to the transitioning of young adults from Children's to Adult Services

Appendix 1

Table showing assessment /admission criteria for young person aged 16 and over.

The following patients should be admitted to paediatric ward under paediatric services.	The following patients should be given choice but clinical need can override the personal choice.	The following patient groups should be admitted to adult wards under adult services.
Any child /young person who is currently under the care of paediatrician with on-going medical problems. Any children/young person with significant safeguarding concerns. Any child under the care of CAHMS who doesn't pose risk to other Children.	Any child or young person presenting with acute medical/surgical condition which doesn't need follow up. Any patient with chronic condition who is in transition to adult services but also under paediatrician. Young person with mental health issues or Learning difficulties who doesn't pose risk to other Children.	Any acute clinical condition which needs long term follow up. Any new presentation of chronic medical or surgical condition. E.g.: Renal, Neurology, Endocrine, Cardiology, Haematology/Oncology etc. Any patient with chronic condition who is already transitioned to adult services. Young person under the care of CAMHS who pose risk to other children. Young person with mental health problem or Learning difficulties, who pose risk to other Children.

Young person's acute assessment flowchart



The decision to admit young person between 16- 17 years to either paediatric or adult services should be purely based on the clinical condition and where the young person's clinical needs are best met.

Whether the child is in fulltime school education/ working or not has no bearing on the decision. Young person's wishes should be taken in to consideration wherever possible but clinical need should override the individual wishes.

In exceptional circumstances if the young person needs treatment under adult clinical teams but is deemed unsuitable to be located in adult wards, as an exception the young person can be admitted to paediatric ward with clinical care provided by adult clinical teams.

If the young person who is admitted to adult ward wishes one of the parents to be present during clinical consultation, his/her wish must be facilitated wherever possible.

Young person with mental health problems, the risk assessment should be undertaken to see whether he/she poses risk to other children in paediatric ward.

Young adults > 16years cared for within either Children's Or Adult departments or wards should use the following supportive policies.

- C21 Transfer Discharge of Children
- C23 Child Protection Policy
- C38 Missing Absconded Children
- Appendix 2 (on page 17): Sop to be used to support young adults in adult wards and departments

Appendix 2

Standard Operating Procedure (SOP)

C71-SOP-1 Supporting young adults 16years of age who have chosen to follow an adult inpatient admission pathway

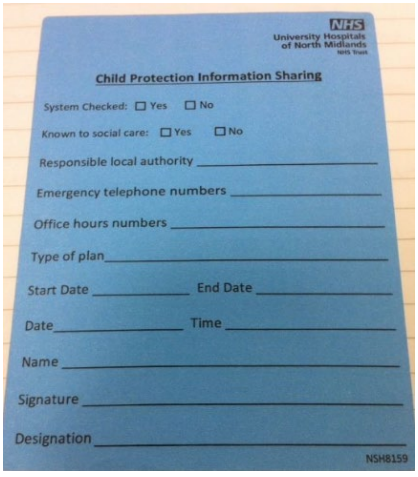
V2 July 2024

University Hospitals of North Midlands NHS Trust

The purpose of this SOP is to: Support young person from the age of 16-17years of age who have chosen to follow an adult inpatient admission pathway to any adult ward at RSUH/County Hospital.

This SOP links to Trust Policy C21, C23, C38

All person 16 years of age to those that have not reached their 18-birthday admitted to an adult ward.

No.	Description of Procedural Steps
1	When admitting a young person to an adult ward please ensure that a full social history is completed within the patient's health record. Please ensure that the following information is gained: Patient demographic information: (Is the young person still residing with their parents or at a differing address? Next of Kin – please be curious if the young person does not give parents as their next of kin. Social care involvement General Practitioner On- going education/school/university. Please ascertain who has accompanied the young person to hospital/ is with them. If admitted alone – please ascertain who they wish to be informed of their admission – please be curious if the response is not given as a parent.
2	If the young person is known to social care please ensure that a review of CP-IS has been undertaken when admission has occurred via an emergency portal of entrance. A CP-IS STICKER WILL BE PLACED WITHIN THE HEALTH RECORDS.  If the young person highlights, they have social care support please ensure that their social care team is informed of the admission. If required, please make a telephone contact to the local authority area from which the young person is from. If there isn't a completed review and CP-IS STICKER within the health records, please refer to the admitting portal if this is not completed.

No.	Description of Procedural Steps
3	If you have any safeguarding concerns in hours, please contact the Named Nurse for Child Safeguarding in hours on EXT 79839 for advice. Out of Hours please refer to Policy C23 and contact social care as appropriate. (See policy above.) When making contact with social care, please ensure that you have a resume of concerns to hand so that the appropriate support and direction can be given to the ward.
4	Please observe the behaviour of the young person during their hospital stay. A young person's behaviour is often a clue to what has brought them into a hospital setting and being curious regarding their behaviour is often the first step to gaining the correct support for the young person. Consider the potential for: Drug taking Alcohol Child Sexual Exploitation Gangs Domestic violence Physical and Sexual abuse Child trafficking Self-harming – mental health Please consider that they may be a carer for an adult family member.
5	Please be vigilant regarding visitors to the young person. Are they supporting the young person, not all visitors are appropriate if you are concerned regarding the young person, please consider the following: Delivery of drugs and alcohol – please be curious if they are leaving the ward frequently. Violence – physical and sexual Child Trafficking Child Sexual exploitation Gangs Be curious and watchful – please speak with the Named Nurse for Safeguarding for support
6	If the young person/parent admitted has a learning disability. Please refer to the hospital intranet where you will be able to source lots of supportive information in assisting you in support for your patient. See under section Clinical – Trust intranet. **OR IF FURTHER SUPPORT IS REQUIRED** Please contact the Trust Acute Liaison Learning Disability Nurse (ALN) EXT 71246. Please note this service is for Royal Stoke patients only although telephone advise can be offered for patients at County Hospital
7	If the young person is admitted following self –harm, overdose or with a mental health diagnosis. Please ensure that the young person had had a review by the Mental Health Liaison team (MHLT) Please source MHLT for support for the young person on the ward. UHNM Lead Nurse for Mental Health

No.	Description of Procedural Steps
	Contact details: Office 01782 671246 Or via the trust switchboard
8	If the young person within the care of the adult ward requires support to engage within invasive procedures due to fears and anxieties, Please contact the Child Health Hospital Play Team Coordinator, bleep via the Trust Hospital Switchboard.
9	If the young person is in continuing education and has a hospital inpatient admission greater than 3 days please contact the Child Health Matrons via the Hospital switchboard. The Child Health Directorate provider of hospital education, **MERIT** may be able to offer educational support during their hospital stay this maybe particularly important for a young person during exams – they may also qualify for their school mark.
10	If a young person goes missing or feared absconded or abducted during their hospital admission – then please utilise Policy C38 Management of Missing, Absconded or abducted child or adult up to 18years of age. (See policy above). This will trigger an alert to all child health professionals and the wider public sector – the police. However, at the time of instigating C38 and placing a call to the hospital switchboard at the point of contact with the operator you must also ask them to inform the Matron for your area and Directorate Manager.
11	On discharge, please ensure that the Trust discharge policy C21 Transfer, Discharge policy for Children and young adults is followed. (See Policy above) If a young person is reluctant to go home, please consider and be curious about the following: Drug taking Alcohol Child Sexual Exploitation Gangs Domestic violence Physical and Sexual abuse Child trafficking Self-harming – mental health If concerned or the young person makes a disclosure, please establish contact with: The Named Nurse for Child Safeguarding in hours on EXT 79839 for advice. Out of Hours please refer to Policy C23 and contact social care as appropriate
12	There are resources contained within the Trust intranet that maybe helpful to care for a young person within the ward environment: Hospital Intranet Clinicians: • Learning disabilities • Making every contact count • News/pews/sbar Clinical Services – Children's CT • Child Protection

No.	Description of Procedural Steps
	• Clinical Guidelines for paediatrics • Mental Health Leaflets – Top Tips for Nurses Clinicians- clinical guidance – outpatients' information
13	Please ensure that on discharge if social care is involved with your young person, they are made aware of the discharge. Please ensure within the discharge letter that it contains relevant information regarding mental health and social care engagement if relevant to your patient.
14	Additional support, advice and guidance can be obtained via the Matron's for Child Health Contactable via the Trust Switchboard.

Trust Contact: Head of Nursing – WCCSS
Date of Review: July 2027