

Title	Transition
Version	2.0

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1. Introduction & Principles

- Transition from paediatric to adult CF care is an exciting opportunity for young people to gain independence and take control of the management of CF.
- The transition process needs to be planned well and started with enough time to allow young people to develop their independence in CF management before they begin to establish a trusting relationship with the adult team. Young people also need time to become familiar with the new adult outpatient/ inpatient environment.
- Good communication between the paediatric and adult CF team is essential to ensure a smooth and successful transition of care.

2. Transition Process

- Preparation for transition begins from age 11 and involves both the child and parents/caregivers.
- Patients can transfer to adult care between their 16th and 18th birthday: the decision to transition is made by the Paediatric Team, with the patient and their parents/caregivers.
- “Ready Steady Go” documents (Appendix 1) are introduced as a framework for the entire transition process. An individualised plan is made with each child and their family regarding their wishes for transition.
- Young people should have the opportunity to formally meet the adult CF team on more than one occasion (usually in joint clinics), and view the adult outpatient and inpatient ward areas.
- Parents will be offered meetings with the Psychologist from the Paediatric CF Team to support them in the next stage for their child. The Psychologist from the Paediatric CF Team will be available to support the parent post transition as they adjust to this change. Where ongoing work is required, they will be supported by the Psychologist from the Adult CF Team.
- RSUH Patients:
 - The adult CF Team will attend paediatric clinics regularly, so that they can introduce themselves to young people and their parents/ carers and become involved with clinical consultations.
 - The adult CF Team will be invited to lead some clinic consultations within the paediatric clinic.
 - A member of the Paediatric CF Team is available to support the young person at their first Adult CF clinic appointment.
- SaTH Patients:
 - Patients and parents/ carers meet the local and UHNM adult CF teams in the SaTH paediatric outpatient department, facilitated by the SaTH paediatric CF Team.
 - The patient subsequently attends the adult SaTH CF Clinic and paediatric CF Clinic alternately until transition is deemed appropriate by all parties.
- RWT Patients:
 - Patients and parents/ carers meet the local and UHNM adult CF teams in the RWT paediatric outpatient department, facilitated by the RWT paediatric CF team.
 - Further joint adult and paediatric CF clinics are arranged until transition is deemed appropriate by all parties. Paediatric CF team attends first adult clinic appointment to support patients and their families/ caregivers.
- BCH Patients:
 - Patients and parents/ carers meet the RWT and UHNM adult CF teams in the BCH paediatric outpatient department, facilitated by the BCH paediatric CF team.
 - Further joint adult and paediatric CF clinics are arranged until transition is deemed appropriate by all parties. Paediatric CF team attends first adult clinic appointment (delivered jointly by RWT and UHNM adult team) at RWT to support patients and their families/ caregivers.

3. Key Points

- Where required, a member of the paediatric CF team should accompany the patient to their first adult clinic appointment.
- It is the responsibility of the whole CF MDT to ensure that the transition process is as smooth as possible and to complete the relevant “Ready Steady Go” documentation.
- A formal handover discussion between the Paediatric and Adult CF Teams needs to occur prior to a patient’s first adult clinic appointment.
- Joint paediatric and adult nurse home visits prior to transition is beneficial for patients and CF teams, particularly with gaining trust around procedures e.g. Portacath access and venepuncture.
- Where patients have additional and/or complex needs (neurodiversity, learning disabilities, etc) the patient may require additional preparation for transition; this includes making changes specific to the young person’s needs. This may mean that transition is delayed until they are considered ready.
- It is important to engage with the parent of a person with CF at key points during and after transition.