



# Teenagers and Young Adults with Cancer

*Uniting professionals. Improving practice*



## Transition

TYAC best practice  
statement  
for health  
professionals

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# TRANSITION BEST PRACTICE STATEMENT

## Scope

This TYAC best practice statement discusses some of the key issues relating to transition and outlines principles for best practice that can be adapted to individual services and transition in all settings. These principles are set out against an assumption that all young people within the TYA age range will be discussed at a designated cancer MDT for both their age range and cancer type.

## Definition

The 2014 NHS England Generic specification for transition describes transition as “a developmentally mediated process which ensures optimal health and wellbeing outcomes for young people as they move, in partnership with their healthcare teams towards and into adult services and lifestyles”.

In cancer services transition may take place during or after treatment, and may be to a different team/setting within the same hospital, another hospital, or may be from hospital-based care to primary care, e.g. for ongoing follow up.

## Key principles

- Local transition policy and pathways
- Advance preparation and planning
- Partnership with patient
- Parent involvement where appropriate
- Key worker support
- TYA MDT handover
- Ensure ALL services are considered in the transition process
- Treatment summary and ongoing care plan
- Joint/transition clinic
- Professionals working across boundaries [paediatrics/TYA/adult]
- Health promotion/education role
- Effective communication and collaboration

## Introduction

Arrangements for transition of teenagers and young adults [TYA] within cancer services will vary across the country as service configuration is diverse, and the age criteria for paediatric and adult services are not standardised.

Cancer services for teenagers and young adults are increasingly recognising the importance of patient choice in negotiating complex care pathways in cancer care.

The growth of teenage and young adult teams, based around TYA Principal Treatment Centres, TYA Designated Hospitals and TYA multidisciplinary teams (MDTs), are providing young people with a genuine opportunity to transition from paediatric to adult services via a service that is designed for them.

However, development of discrete teenage and young adult services has created two points of transition, from paediatric to TYA services and TYA to older adult services.

## Planning

The TYA MDT should discuss all new TYA diagnoses within its catchment area [NICE 2005]. This discussion should raise the issue of transition if it can: **clearly be predicted that a young person, during the course of their treatment, will become of an age that would require them to move from one place of care to another.**

Transition planning will involve a wide range of different disciplines, depending on the individual patient's circumstances. The TYA MDT will identify a key worker who will take overall responsibility for guiding each young person through the transition process. This will often be the patient's existing cancer key worker.

The TYA MDT should discuss any future change to place of care and document any planned transition into or from another service.

Multidisciplinary team discussion to identify young people requiring transition at an early stage, and the identification of a key worker, means that a young person can be made aware that transition is planned for the future, at a safe and appropriate time and pace.

Patients and their families should be informed at the outset that there will be various transitional stages throughout their journey, and anticipated time points should be given.

Clear documentation and discussion at an MDT will help to ensure all key professionals are clear about planned transition for individual patients.



## Facilitating the process

Transition should, if possible, be progressed at a pace that suits the young person and their family. The patient's identified key worker for transition or appropriate professional (social worker, youth support worker, etc.) identified by the young person, should establish with the young person how they want to proceed and what information they require.

It is suggested that best practice is to offer an opportunity for the young person and their family to visit a new place of care well in advance of transition; this may be a ward, clinic or out-patient setting. This provides an opportunity for the young person and their family to become accustomed to the new environment, to meet a new team of staff and to ask questions. It is recognised that not all young people may wish to take up this opportunity, but as a minimum it should be offered and supported.

The involvement of the TYA team should be a constant for the young person as they transition, which will allow for a level of continuity. It may be appropriate for the same professional to remain as a key worker for an agreed period of time.

In facilitating transition to a new place of care, a young person and their family should be offered appropriate written information which can be read in their own time. Information provided should detail practices of the ward or hospital that may be different to their current place of care. It should also include topics such as directions, car parking, food, cash point, contact details for the new service and contact details for any new professionals involved in their care, etc.



## The point of transfer

Shortly before implementing transfer to a new place of care, the young person should once again be discussed at the TYA MDT. This discussion will provide an opportunity to clarify planned treatment, care or monitoring, and should be detailed in a summary outcome letter from the existing team to the new team. The young person and their family should be offered the opportunity to receive copies of correspondence.

The transition process should be supported by key documents that will help to facilitate the process, such as:

- Holistic Needs Assessment (appropriate to the local practice)
- Treatment Summary
- Future Care Plan
- Written and verbal information regarding all involved services (places of care and specific teams)

The TYA MDT should identify a key contact person in the new place of care; this may be a new identified key worker. The key person identified will act as the point of contact for professionals from the previous treatment setting regarding any information that may be relevant to ongoing treatment and support.

Ideally, a member of either the TYA team or site specific team, who is known to the young person, should be present at the new place of care for their first attendance. This may not be appropriate or possible in all instances but should be discussed and planned in advance with the young person.

## After transfer

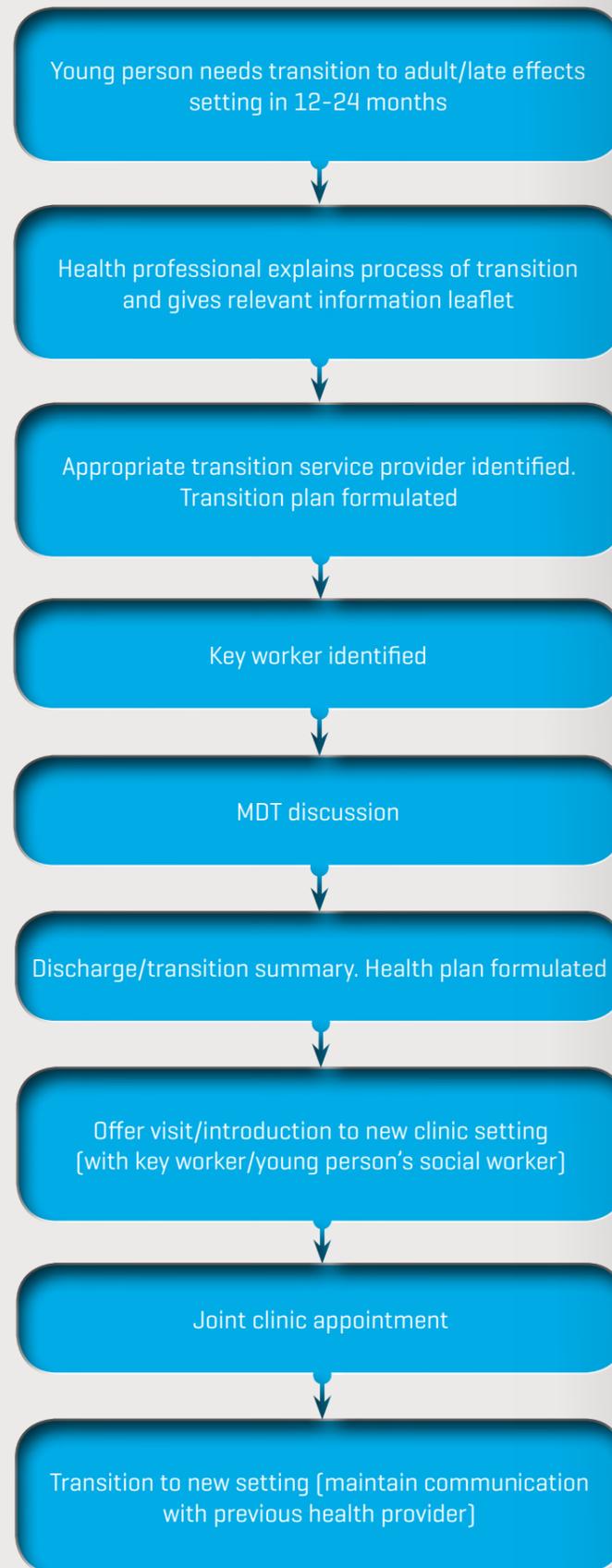
After a young person has transferred to a new place of care or team, it is important that contact is maintained by the key worker for a short period of time, agreed by all parties. This enables any emerging queries or issues to be solved quickly. An open process from the outset should mean that this time is short. The treatment and care summary provided at the time of transition can then be maintained and added to by the team in new care setting so that all involved know what treatment the young person has received, any future treatment planned as well as psychosocial assessment and ongoing support needs.



## Top Tips

- Transition should be a gradual process facilitated by healthcare professionals and preferably coordinated by an identified key worker in partnership with the young person.
- Allow for flexibility within policy/practice for transition to ensure it is at an appropriate and safe point in the patient's cancer pathway. For example: maturity of patient, stage of treatment palliative phases, relapses.
- Do not transition a patient between services/place of care at times of relapse or in palliative care unless absolutely necessary. Engage the young person and their family consistently through the transition process in order to empower and increase confidence in the new care arrangements.
- Offer visits/introduction to new clinical settings [with key worker/ youth support worker/young person's social worker] prior to actual transition.
- Ensure agreed protocols and policies are developed to delegate roles and responsibilities across the MDT and both service providers.
- The potential for transition should be highlighted in patient literature that is produced by the TYA ward/service.

## EXAMPLE OF A TRANSITION PATHWAY [Ensure there is Transition – lead/policy/information]



"Transition is the purposeful, planned movement of adolescents and young adults with chronic physical and medical conditions from child-centred to adult-orientated health care systems." [Blum *et al*, 1993]



## Resources

- DoH 2006. Transition: getting it right for young people.
- RCN 2007. Lost in Transition
- DoH 2008. Transition: moving on well
- NCB 2010. VSS Briefing Policy - Transition to Adult Services
- NHS England 2014 Children and Young People Transition to adult services - Generic Specification. [not yet published]
- NIHR 2010. The transition from paediatric to adult diabetes services: what works, for whom and in what circumstances?
- Department of Health, 2011. You're welcome - Quality criteria for young people friendly health services
- Teenage Cancer Trust and TYAC 2012. A Blueprint of Care for Teenagers and Young Adults with Cancer
- Care Quality Commission 2014. From the pond into the sea - Children's transition to adult health services
- A good example of transition documentation has been developed by the University Hospital Southampton. The 'Ready, Steady, Go' package can be viewed at: [www.uhs.nhs.uk/OurServices/Childhealth/TransitiontoadultcareReadySteadyGo/Transitiontoadultcare.aspx](http://www.uhs.nhs.uk/OurServices/Childhealth/TransitiontoadultcareReadySteadyGo/Transitiontoadultcare.aspx)





## About TYAC

Teenagers and Young Adults with Cancer is a registered charity and the UK's only membership body open to all professionals involved in the care of teenagers and young adults with cancer. By providing information on best practice and new developments, training and support to our members, we aim to improve the quality of life and likelihood of survival for young people with cancer.

Our vision is that all teenagers and young adults with cancer in the UK receive the best possible treatment and support.

For more information on membership

**Visit:** [www.tyac.org.uk](http://www.tyac.org.uk)

**Email:** [info@tyac.org.uk](mailto:info@tyac.org.uk)

**Call:** 0115 9033 033

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