A significant number of interruptions were noted. This revealed the need to revisit protocols with other medical teams to ensure protected handover time.

A variety of locations for handover were recorded. A static/designated location would contribute to reducing interruptions.

**Huddles and Handovers**

As a result of the concerns highlighted around the afternoon handover, it was agreed to pilot an early afternoon ‘huddle’, between the junior team and the consultant, to discuss patient status and referrals. This less formal interaction, in the early afternoon, would allow time for troubleshooting ‘in-hours’ to address issues and improve patient safety.

Pre-handover Huddle – a new model?

The concept of huddles in health care is well documented and advocated by many practitioners. I feel there is merit in exploring the use of huddles as a ‘default practice’ in front of all handovers to ‘hone’ the critical information that is to be shared at handover and to confirm priorities.

In essence this reimagining of the huddle is where teams come together to review earlier planned actions ahead of formal handover.

This use of a huddle would ensure that the handover is ‘factual’, not ‘opinion seeking’, and could minimise out-of-hours avoidable decision making, e.g. referral for scans or other specialist teams input. The use of a huddle pre-handover would allow the ‘in-hours’ team to initiate actions that could allow the next team to ‘hit the ground running’.

### ACHIEVING NICE TRANSITION-RELATED STANDARDS OF CARE FOR YOUNG PEOPLE WITH LONG-TERM CONDITIONS – A QUALITY IMPROVEMENT PROJECT

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**Aim**

Moving from paediatric to adult services is a worrying and challenging time for young people with long-term conditions. Evidence suggests that effective transition between services can improve long-term outcomes, yet national data highlights that transition is often overlooked with little recognition as an area of importance within healthcare. However, there has recently been a drive to refine and improve the transition process through the NHS long term plan. This quality improvement project aimed to achieve the NICE Quality Standards for transition for 6 sub-specialties in one paediatric department, across a nine-month period.

**Methods**

An initial gap analysis was undertaken using 11 NICE quality transition-focused standards of care to demonstrate current performance of services for transition for 6 sub-specialties: allergy, asthma, diabetes, epilepsy, HIV, and sickle. Diagnostic tools including a process map, fishbone diagram, histogram and RAG rating were completed to help define the problem further. Following this, change ideas were generated and several PDSA cycles were conducted through transition workshops, regular progress meetings and implementation of individualised action points for each subspecialty.

**Results**

Baseline measurement following the initial gap analysis showed that only 18% of standards were partially met and 45% of standards were met across the 6 sub-specialties.

Diabetes, HIV and Sickle showed better performance, meeting at least 6 out of 11 standards of care for transition. Following the implementation of individualised action points and transition workshop meetings, the baseline measurement for partially meeting and meeting standards increased to 30%, and 58%, respectively. Standards 1 and 2 still require improvement across all specialties. Importantly, specialties such as asthma and epilepsy showed significant changes in partially meeting or meeting standards.

**Conclusion**

This quality improvement project has enabled one paediatric department to better achieve the NICE standards of care for transition for young people with long-term conditions. Highlights during the process included: external talks from a transition improvement manager and a transition nurse consultant, regular transition workshop meetings and successfully obtaining funding for a new epilepsy transition specialist nurse through Roald Dahl’s children’s charity. In addition, there was implementation of the Ready, Steady, Go, paperwork, joint clinics between paediatric and adult services for asthma and epilepsy, along with asthma transition clinics within the local community.

Measurable progress has been made in implementing transition-related standards of care, however; further work is needed to ensure young people and their families are actively involved in the design, delivery, and evaluation of transition services. Importantly, ongoing work is required to ensure that transition-related standards of care are met and provided for young people when moving from paediatric to adult healthcare services.

1. Implementing Transition: Ready Steady Go, Arvind Nagra
2. From the pond into the sea, children’s transition to adult health services, CQC
3. Transition from children’s to adults’ services, NICE Quality Standards

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**PEDIATRICS EPILEPSY TRANSITION SERVICE IN LUTON AND DUNSTABLE: A SERVICE REVIEW**

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**Aims**

Introduction Effective transition is a gradual process of empowerment that equips young people with the skills necessary to manage their own healthcare in paediatric and adult services. NICE guideline recommends that the transition should be a joint clinical action between paediatric and adult service, with at least 1 joint consultation and a clear action plan for conducting a review after the young person has transferred into the adult service.

**Aims and Objectives**

To evaluate and provide recommendations to the Paediatric Epilepsy service regarding the smooth and efficient transition process to Adult Epilepsy service.

We assessed if an epileptic child with normal development completed the transition process by 17th birthday, whereas an epileptic child with neuro-disability and learning difficulty completed the transition process by 19th birthday.

We also determined the reason for the delay in transition and the number of patients in whom transition did not happen in ideal condition (seen by a specialist nurse and joint transition clinic).
Methods We conducted a retrospective study where case notes of all the patients in our epilepsy service between 15-20 years of age were reviewed between February and September 2021.

Results The total number of patients was 110, 56 were Females and 54 were Males.

8 patients were excluded from data who were nonepileptic and 1 patient unfortunately died during this period.

Out of 101 patients, 31 patients fully transitioned whereas 36 patients did not complete the process (5 patients commenced the transition but did not complete it). 23 patients were discharged to GP with good seizure control. 11 patients’ transition status was unknown due to either loss in follow up, or they did not attend a clinic (frequent DNAs) or there was no documentation in the notes.

Of those who completed the transition (31 patients) 14 patients had at least one joint clinic whereas 17 patients transitioned without a joint clinic.

We also assessed the time taken to transition; 12 patients transitioned in <6 months, 17 patients took 6-12 months, and 2 patients required 13-24 months to complete the process of transition (figure 1).

We also looked at stage of transition at various age groups and found that by 20 years of age all of them had fully transitioned (figure 2).

The reasons for the delay in transition were frequently DNAs, clinic cancellation due to COVID pandemic, and lack of availability of joint clinics with adult neurology service.

Recommendations Joint clinics with the adult team are ideal but the transition should not be delayed due to the non-availability of an adult team.

The young person and their carers should start the Ready Steady Go programme at around 11 years of age, if developmentally appropriate.

To consider the introduction of ‘Ready Steady Go programme’ through an introductory video and the ‘Transition: moving into adult care’ information leaflet.

Conclusion

Aims To review the spectrum of patients referred from primary care to secondary care respiratory clinics.

Methods General Practice referral letters to Sandwell and West Birmingham hospital asthma clinic, were assessed over 12 months. The letters were reviewed for the current management initiated by the GP and compared to the local Black Country and Sandwell & West Birmingham STP asthma treatment guidelines. Letters were reviewed to assess whether primary care treatment options were maximised prior to referral to secondary care. The letters were also assessed for mention of compliance and inhaler technique review. The clinical course and management was assessed 6-12 months following clinic review.

Results A total of 27 referrals to two paediatric asthma clinics were analysed. 55% of patients were not started on inhaled corticosteroid therapy in primary care as per the local guidelines despite features of asthma in the referral letter. 96% of referrals did not specify in the referral whether adherence or inhaler technique had been checked 67% of patients referred did not have a clinical history suggestive of asthma according to the referral letter. 2 patients were referred for spirometry testing but not commenced on inhaled corticosteroids despite having clinical features of asthma. 37% of patients were discharged from secondary care with the addition of very low/Low dose corticosteroids to their prescription. 2 patients were discharged from secondary care after addition of a spacer.

Conclusion A significant number of children were referred without treatment options and basic checks of inhaler technique being completed in primary care. A considerable number of patients were not adequately treated with inhaler therapy in primary care. This included not prescribing adequate doses and also not prescribing inhaled corticosteroids as per the local Black Country and Sandwell & West Birmingham STP asthma guidelines. These patients may suffer from significant morbidity related to their asthma if not prescribed the correct recommended medication. Furthermore, inappropriate referrals place considerable stress on secondary care resources which are already sparse. Appropriate referrals will lead to financial savings, shorter outpatient visiting times and better patient treatment and control of their asthma. It is recommended that these findings are dispersed to local GP practice. A referral proforma may improve the treatment and assessment in primary care.