INTERNAL REPORT

# Summary of ACI Transition Network Activity Jan 2011 – Dec 2015

## Transition Care Network

The information in this report has been obtained from data collected from the referral forms sent to the ACI Transition Care Coordinators (TCCs). This information is entered onto the ACCESS database used by the Coordinators.

Referral to ACI is not mandatory, so the data reflects the level of engagement with the Transition Care Network by individual clinicians, teams and young people rather than overall numbers of young people transitioning from paediatric to adult health services. Fluctuations need to be viewed in light of factors such as service gaps / staff changes and changes in referral processes since the inception of Trapeze.

The number of referrals has generally increased since the Network commenced in 2004 (appendix 1) as has the number of specialties who refer to ACI although not all specialities utilise the service. Details of referral diagnoses are available in the individual yearly reports.

**Referrals received by each Area Jan 2011- Dec 2015**

| Area | 2011 | 2012 | 2013 | 2014 | 2015 | Total |
|---|---|---|---|---|---|---|
| **Northern** | 140 | 139 | 100 | 138 | 177 | |
| **Southern** | 215 | 128 | 112 | 101 | 147 | |
| **Western** | 125 | 134 | 150 | 60 | 139 | |
| **NSW total** | 480 | 401 | 372 | 299 | 463 | 2015 |

- A total of 2015 referrals have been made to ACI Transition Care Coordinators over the past 5 years. The majority (on average 75%) were from the 3 tertiary paediatric hospitals and the remainder were from other sources such as adult clinicians, Disability and Home Care, the Department of Education, paediatric units, self-referrals from young people and families.

- Trapeze, which commenced in 2013, is now fully operational and is referring the majority of patients from Sydney Children's Hospitals Network (SCHN).

- The decrease in referrals in Western Area in 2014 (60%) needs to be interpreted within the context of the processes implemented by Trapeze.

- Trapeze now tracks and supports all young people who are current or ex patients of SCHN to primary health services. They also support all patients up to age 25 transitioning to adult tertiary services with a diagnosis of diabetes and chronic respiratory. ACI supports the remainder. This should not impact significantly on numbers of young people referred to ACI as diabetes services have never referred in large numbers, nor have CF and other chronic respiratory conditions such as asthma, mainly because they had well established transition services prior to the establishment of the Transition Network.

- The Children's Hospital at Westmead is in Western Area and has twice the number of patients with chronic complex illness than does the Sydney Children's Hospital at Randwick (South Eastern Area). Since Trapeze commenced in 2013, ACI Transition Coordinators have been 'notified' of impending referrals and these were not recorded on ACI databank until 'activated'. This process has changed so that now all patients are entered onto the ACI database as soon as they are referred so 2015 data should reflect previous trends.

- Identification of referring specialties has shown little general consistency although there are now a large number of sub specialities who refer. Only rehabilitation services at all sites have consistently referred since the inception of the program.

**Appendix 1: Referrals to ACI: Jan 2006 – Dec 2010.**

| Area | 2006 | 2007 | 2008 | 2009 | 2010 | |
|---|---|---|---|---|---|---|
| Northern | 15 | 54 | 44 | 76 | 93 | |
| Southern | 54 | 83 | 147 | 154 | 182 | |
| Western | 96 | 127 | 108 | 42 | 133 | |
| NSW total | 165 | 264 | 299 | 272 | 408 | 1408 |