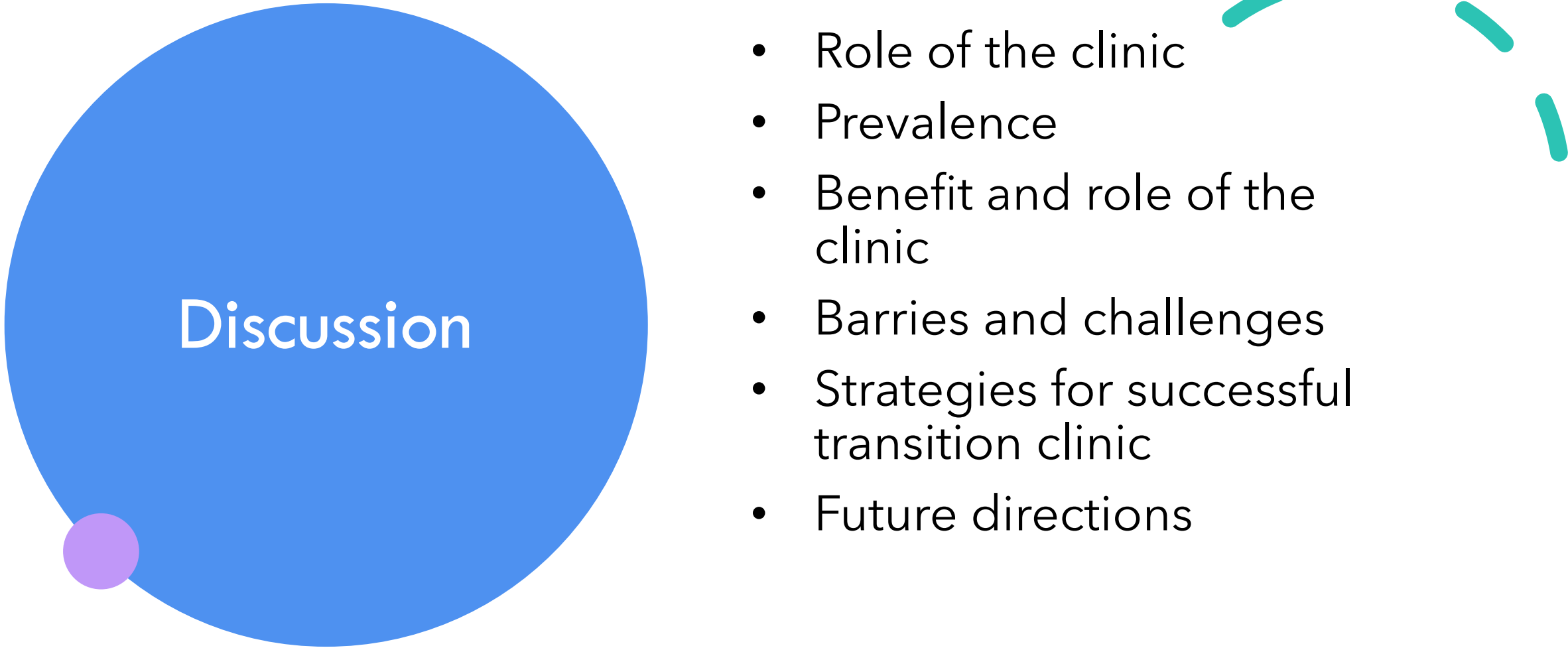


The background features several abstract geometric elements: a large blue circle on the right side, a purple circle in the upper left, an orange square outline on the left, and an orange L-shaped line in the top center. There are also several teal-colored lines, including two vertical ones on the far left and a cluster of four short, angled ones in the lower left. A small teal circle is partially visible in the top right corner.

Bridging the gap: The role of transition clinics in headache care



Discussion

- What is a transition
- Role of the clinic
- Prevalence
- Benefit and role of the clinic
- Barriers and challenges
- Strategies for successful transition clinic
- Future directions

Transition is defined as a multi-faceted, active process that attends to the medical, psychological and educational/vocational needs of adolescents as they move from child to adult centred care

- share information effectively between adult and Paediatric services
- 'importance to on-going engagement' (CQC 2014)
- empowering the young person in leading on their care. Such as, appointment times, knowing their medications, communication with professionals
- 'A pivotal moment in the lives of young people living with long term health conditions' (QNI 2018)



Why are transition clinics so important?

1. Continuity of care

Without a structured transition, patients may fall through the cracks leading to disrupted treatment or a complete loss to follow up.

2. Models of care

- **Paediatric** is often family centre, supporting and involves more guidance
- **Adult** expects self management, independence and self advocacy
- Transition involves teaching patients how to manage their condition effectively

3. Headaches begin young and can persist

- Symptoms often begin in childhood
- Effective early management improves quality of life and reduces long term disability
- Transition ensures patients stay on a consistent and effective treatment path into adulthood

4. Co-morbidities and psychological stressors

- Often coexisting anxiety, depression and sleep issues
- Impact of school, peer relationships and family expectations
- Transition clinics can help screen and address these issues early and ensure appropriate referrals for further support are made

5. Preventing medication overuse

- Without ongoing care, may use OTC or prescription medication incorrectly
- Adolescents at increased risk of MOH

6. Empowerment and self-management

- Promote autonomy
- Re-education around trigger management, lifestyle changes, medication timing and how to advocate for themselves within school and their workplace.

7. Improved outcomes and satisfaction

- Studies have shown patients in transition programs have better health outcomes, fewer complications and higher stratification of care
- Patient more likely to remain engaged in treatment and care decisions.

Headache is the most prevalent neurological manifestation in adults and one of the leading causes of disability worldwide

- Prevalence increases with age, for example 37- 51% at the age of 7 to 57%-82% by the age of 15 in European studies with similar patterns observed in the UK
- Globally, nearly 60% of children and adolescents experience significant headache, and 7.7% to 9.1% have migraine.
- Studies suggest that around 60 per cent of children aged between seven and 15 experience headaches, but a diagnosis of migraine may be delayed because tummy pain, vomiting, travel sickness, limb pain and episodic dizziness can all confuse the picture.
- Headache affect boys and girls equally before puberty, but migraine becomes significantly more common in females after puberty

Highlighting the need for transition:

- ✓ High prevalence in adolescents indicates the need for effective transition and ongoing care
- ✓ Gender difference emerge during puberty making tailored intervention and management essential
- ✓ Frequency of headache and migraines disrupts schooling, social development and quality of life

The benefit and role of transition clinics in Headache care

Continuity: Maintains therapeutic relationships and care plans.

Education: Empowers patients to understand and self-manage their condition.

Monitoring: Ensures appropriate medication use and follow-up.

Psychosocial support: Addresses anxiety, depression, school/work stress.

Care coordination: Between family, school, and healthcare providers.

Decreased: healthcare costs long-term

Higher: patient satisfaction

Challenges and barriers to transition care

- Risk of loss to follow up
- Psychosocial and development factors (autonomy, medication adherence, mental health)
- Communication barrier between paediatric and adult health care providers
- Funding/resources
- Variations in models between regions/centres
- Difference in patient and parent expectations

Young Person

- A consistent lead (welcoming, available, supportive and communicate)
- Be involved
- Central to plan
- Regular discussions
- Empowerment
- Independence

VS

Parents

- A link person to contact
- Involvement and gradual relinquishing of responsibility
- Parents place adulthood at university leaving age, or when established at work
- Expect holistic, individualised transition for their child
- Should be an extended process from 16 - 21 years (QNI 2018)

Strategies for Successful Transition Clinics

- Early planning (start in early adolescence, not just at 18)
- Use of transition readiness tools (e.g. ready steady go, GUGI)
- Joint paediatric-adult clinic visits
- Digital tools (apps, virtual clinics)
- Feedback (QR code for patient feedback, continually reflection and improvement on service)



Future Directions

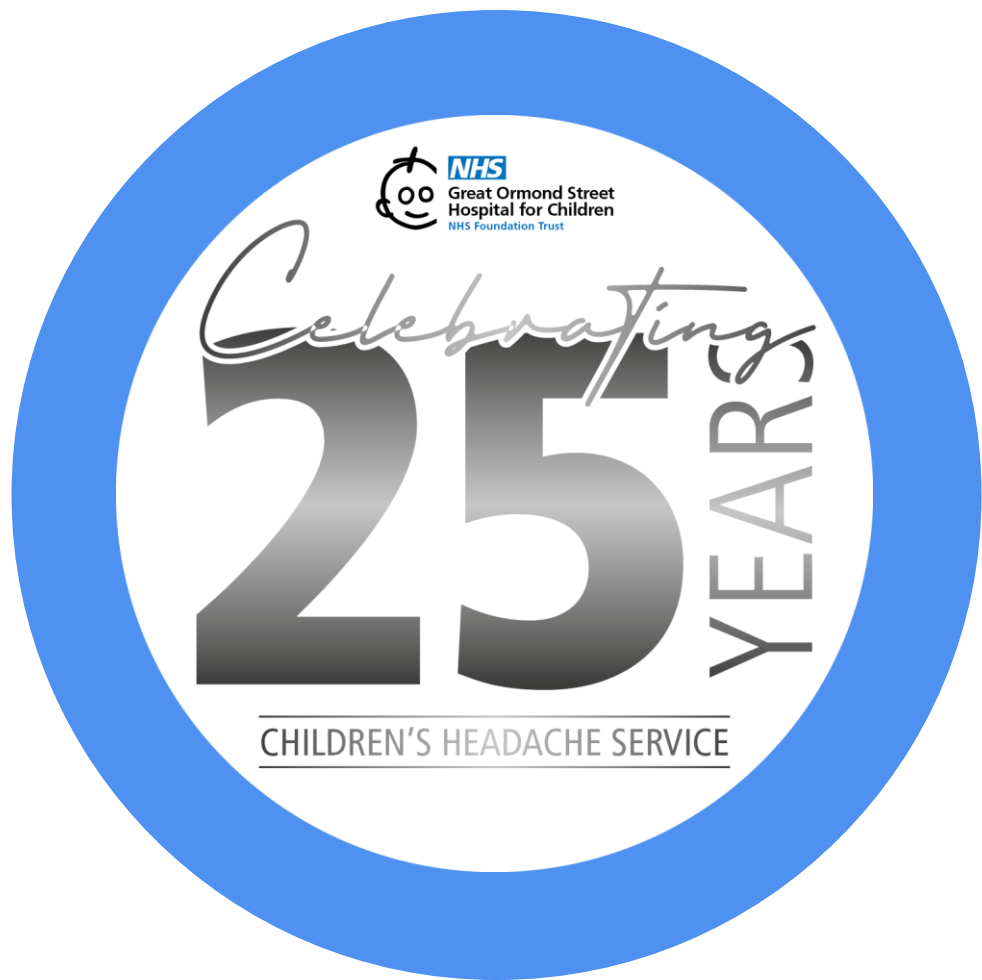
- Patient-led transition plans
- Expanding to underserved areas
- Research and standardisation of care models

Summary

- Transition clinics are key to ensuring seamless, effective headache care across the lifespan
- They empower patients, reduce healthcare burden, and improve outcomes
- Emphasis on the need for institutional support and tailored implementation

References

- Care Quality Commission (2014) From The Pond Into The Sea: Children's transition to adult health services. Available at: https://www.cqc.org.uk/sites/default/files/CQC_Transition%20Report.pdf (accessed on 29th July 2024).
- National Institute for Health and Care Excellence (2023) Transition from children's to adults' services. Available at: <https://www.nice.org.uk/guidance/qs140/resources/transition-from-childrens-to-adults-services-pdf-75545472790213> (accessed on 29th July 2024)
- Queen's nursing Institute (2018) Transition of Care Report. Available at: <https://www.qni.org.uk/wp-content/uploads/2018/07/Transition-of-Care-Programme-Final-Report-2018-online.pdf> (accessed on 29th July 2024).
- [Primary headache epidemiology in children and adolescents: a systematic review and meta-analysis - PubMed](#)
- [Headache in Children and Adolescents - PMC](#)
- [Migraine information for schools - National Migraine Centre](#)

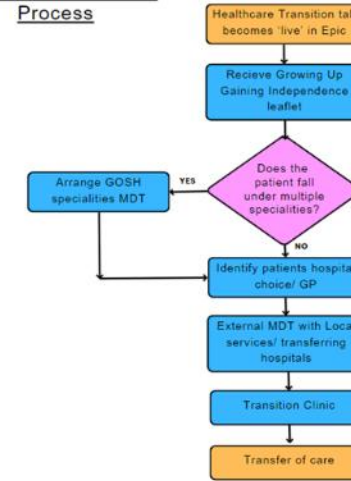


Thank
you

KHP/GOSH transition service

Healthcare Transition Process

Healthcare Transition Process



All clinical staff are responsible for a patients Healthcare Transition journey. Documentation should begin in the Healthcare Transition tab from:

- 10years onwards for young people transitioning to adolescent Services.
- 12 years onwards when transitioning to adult services.

'Ready, Steady, Go' should be provided to patients to complete at developmentally appropriate times within their Healthcare Transition process.

- Expected discussions usually commence at 12 years of age
- GUGI - influenced by GOSH Young people's forum
- Ready steady go
- Involving young people and families in their care decisions, our patients are encouraged to use 'My GOSH' to complete aspects of the 'Ready, steady, Go' document which can then be used in their clinical appointments to plan transition

Navigation: About | Ready Steady Go Programme | Specialities | Education | Shared Decision Making

The Ready Steady Go transition programme - Getting Ready

The medical and nursing team are to support you as you get older and help you gradually develop the confidence and skills to take charge of your own healthcare. **Ready Steady Go programme**

Fill in this questionnaire with the help of your medical professionals to help you. Please answer all questions that are relevant to you and ask if you are unsure.

Name: _____ Date: _____

Knowledge and skills	Yes	Need to be reviewed	Comments
KNOWLEDGE			
I can describe my condition			
I know where to get my medications, letters, tests, how often, etc.			
I know what roles in the medical and nursing team			
I understand the difference between children's and adult health care			
I know about resources that offer support for young people with my condition			
SELF ADVOCACY (speaking up for yourself)			
I feel happy to talk to people about my condition			
I feel happy to talk to people about my condition			
I feel happy to talk to people about my condition			
HEALTH AND LIFESTYLE			
I understand it is important to exercise for my general health and condition			
I understand the role of diet, exercise, sleep and smoking in my health			
I understand what appropriate looking means for my general health			
I can aware that my condition can affect how I think, e.g. anxiety			
I know when and how to access reliable information about health			

The Ready Steady Go transition programme - Steady

The medical and nursing team are to support you as you get older and help you gradually develop the confidence and skills to take charge of your own healthcare. **Ready Steady Go programme**

Fill in this questionnaire with the help of your medical professionals to help you. Please answer all questions that are relevant to you and ask if you are unsure.

Name: _____ Date: _____

Knowledge and skills	Yes	Need to be reviewed	Comments
KNOWLEDGE			
I understand the medical terminology and what it means for my condition			
I understand what each of my medications are for and their side effects			
I am responsible for my own medication at home and when I am in hospital			
I book my own appointments			
I call the hospital myself if I am a day or more away from my appointment			
I know what each member of the medical team can do for me			
I understand the difference between children's and adult health care			
I know about resources that offer support for young people with my condition			
SELF ADVOCACY (speaking up for yourself)			
I feel confident to go to see the doctor on my own			
I understand my right to confidentiality			
I understand my role in my own health and how to access reliable information about health			
HEALTH AND LIFESTYLE			
I exercise regularly as an active lifestyle			
I understand the role of diet, exercise, sleep and smoking in my health			
I understand what appropriate looking means for my general health			
I know when and how to access reliable information about health			
I understand the implications of my condition and medication on my general health and lifestyle			
DEAD LIVING			
I can recognise when I am feeling unwell, planning, coping, etc.			
I can be an active member of my community			

The Ready Steady Go transition programme - Go

The medical and nursing team are to support you as you get older and help you gradually develop the confidence and skills to take charge of your own healthcare. **Ready Steady Go programme**

Fill in this questionnaire with the help of your medical professionals to help you. Please answer all questions that are relevant to you and ask if you are unsure.

Name: _____ Date: _____

Knowledge and skills	Yes	Need to be reviewed	Comments
KNOWLEDGE			
I am confident in my knowledge about my condition and its management			
I understand what is likely to happen with my condition when I am an adult			
I book after my own medication			
I make and follow my own decisions and book my own appointments			
I call the hospital myself if there is a problem about my condition and therapy			
SELF ADVOCACY (speaking up for yourself)			
I feel confident to go to see the doctor on my own			
I understand my right to confidentiality			
I understand my role in my own health and how to access reliable information about health			
HEALTH AND LIFESTYLE			
I exercise regularly as an active lifestyle			
I understand the role of diet, exercise, sleep and smoking in my condition and general health			
I understand what appropriate looking means for my general health			
I know when and how to access reliable information about health			
I understand the implications of my condition and medication on my general health and lifestyle			
DEAD LIVING			
I can recognise when I am feeling unwell, planning, coping, etc.			
I can be an active member of my community			

October 2025

Headache Academy Title

12

KHP/GOSH transition service

- As the school years are usually the trickiest for our headache patients, we usually wait to discuss transition after they've turned 16 years old
- Discussions in clinic/ GONI app
- Encourage families to use Migraine Trust map to see clinics in local area



KHP Consultant

Dr Diana Wei



GOSH Nurses

Jo Mortimer, ANP
Kate Crumpler, CNS

KHP/ GOSH Transition service

Establishing the service

1

Established service need
Created work group

2

Develop patient information sheets, clinic feedback QR codes and clinic design

3

Monthly MDT meeting to discuss referrals.
Monthly clinic held F2F at Guys Hospital

4

First Clinic August 2022
Patients first app after their 17th Birthday

5

Quarterly service reviews to establish what is working well and what can be improved

Referral Criteria

Inclusion:

- Chronic migraine with 3 failed preventatives
- TAC
- CSF related Headaches
- Other headache disorders requiring specialist headache care

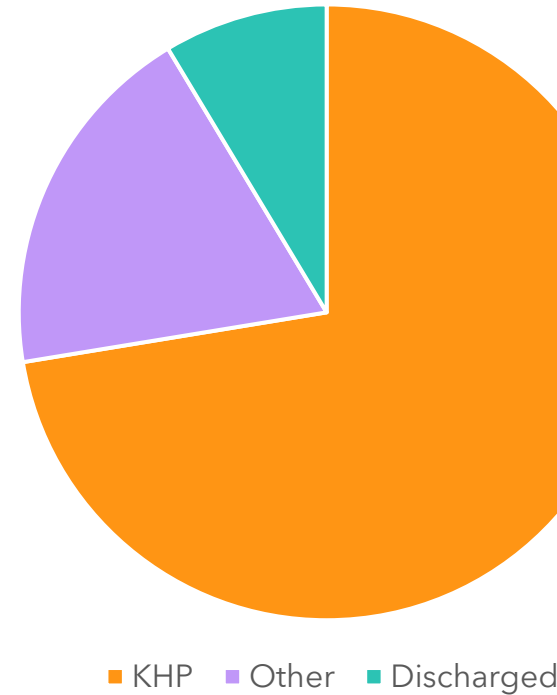
Tricky points

- Patients accessing MABS through clinical trials for episodic migraines.
- Patients under alternative specialities ensuring adult service care is under the most appropriate team
- Patient geographical location
- After being in specialist clinic patient (families) expect that to continue

Summary:

- Patients report they feel more supported
- Smoother process
- Greater working relationships between GOSH/ KHP teams
- Transition clinic/service is 'gold standard'

Transition Locations since commenced of KHP/ GOSH clinic



72% of our patients have opted to complete the KHP transition route instead of being referred locally through their GP