	Framework point	**Facilitating transition of young people with long-term health conditions from children's to adults' healthcare services – implications of a 5-year research programme**	**NICE 2016 [26]**	**National Policy and Strategy for the Provision of Neuro-Rehabilitation Services in Ireland**	**A National Model of Care for Paediatric Healthcare Services in Ireland**
1	A named worker	'key worker'[25]	Section: 1.2.5 – 1.2.10	'Case management/key worker' (pg79)[21] 'A case manager ' (pg52)[28]	-
2	Appropriate parental involvement	' appropriate parent involvement'[18 25]	Section:1.2.19 -1.2.22	'Involvement of family and friends' (Fig 17; 8, pg55[28])	parents or guardians who will likely support and guide them through the process (pg7)[22]
3	Information provision which describes the transition process	'a written transition plan'[25]	Section:1.2.4, 1.2.14, 1.3.4, 1.3.8	'effective communication and the provision of information, particular attention is needed during transition phases' (pg79) [21] 'a written rehabilitation plan' (pg92)[21] 'Information and education' (Fig 17; 8, pg55)[21]	Effective information transfer (pg 6)[22] Appropriate planning to ensure seamless transition to adult services (pg 13,16)[27]
4	Promotion of health self-efficacy	' promotion of health self-efficacy'[18 25]	Section 1.1.4, 1.2.17, 1.2.21	'Supporting self-care'(pg 39)[21] 'increase service users' skills and confidence in managing their health problems' (pg 61) [28]	-
5	Promote opportunities for self-management	-	Section: 1.1.4, 1.2.17, 1.3.5-1.3.7	Promotes opportunities for 'self-management', where the individual is directly involved in planning and decision-making around their needs and takes responsibility for maintaining optimal health, functioning and participation (pg20)[21] Empowering and enabling people to have an active role in the management of their condition (pg 60) [28]	'coaching patients and family members in disease self-management' (pg7)[22] 'more responsibility for their own health care' (pg 6)[22] 'encourage independence and reassess their understanding of their condition' (pg 7)[22]

6	A health professional from the relevant adult services or primary care meets the young person before they transfer from child services.	' meet the adult team before transfer of care' [18 25]	Section: 1.3.1	-	-
7	A senior manager with with responsibility for championing, implementing, monitoring and reviewing effectiveness of transition strategies and policies.	'Transition manager for clinical team. '[25]	Section 1.5.1-1.5.3	'Rehabilitation Coordinator' (pg 52)[28]	-
8	Where there is no adult service for a young person to transfer to, a detailed discharge letter is sent to the young person's GP.	-	Section 1.1.8; 1.1.9; 1.3.9	'Role of GP, as the first point of contact for medical services and in linking to care pathways' (pg84)[21]	'GPs may be consulted by young people during transition and asked to take on a wider role'. (Pg 6)[22]
9	Formal life skills training relevant to health condition, in wider life skills - education, relationships, health maintenance etc.	'holistic life-skills training'	Section: 1.2.8; 1.2.13, 1.2.15, 1.3.3	'Access to supports' (pg 47)[28] 'Social prescribing' (pg 61)[28] 'Vocational support' (pg 90)[28]	'help with self-care and in developing their communication and decision making skills, to manage social, educational and employment opportunities and challenges as part of independent living' (pg 6) [22]