
Developmentally Appropriate Healthcare for Young People Aged 11-25 Years

(including transition and transfer of young people with long-term conditions and disabilities, from children’s to adult services)

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Purpose of Agreement	This policy is for all employees who are working with and in contact with young people aged 11 – 25, in all settings across the Trust and for All Managers that support employees who work with young people aged 11 – 25
Document Type	<input type="checkbox"/> Policy
Reference Number	Solent NHST/Policy/ CF02
Version	Version 1
Name of Approving Committees/Groups	Transition Group, Policy Steering Group, Trust Management Team Meeting
Operational Date	March 2020
Document Review Date	March 2023
Document Sponsor (Job Title)	Chief Operating Officer Southampton and County Wide
Document Manager (Job Title)	Transition Lead for Solent NHST, Head of Quality an Professions – Child and Family East
Document developed in consultation with	Adult services, Child and Family Services, Therapists, Paediatricians
Intranet Location	Business Zone > Policies, SOPs and Clinical Guidelines
Website Location	Publication Scheme
Keywords (for website/intranet uploading)	Transition, Young People, Children, Transfer, Policy, CF02

Amendments Summary:

Please fill the table below:

Amend No	Issued	Page	Subject	Action Date

Review Log:

Include details of when the document was last reviewed:

Version Number	Review Date	Lead Name	Ratification Process	Notes

1. SUMMARY OF POLICY

- 1.1 This policy outlines required standards to support the provision of developmentally appropriate healthcare for all young people (aged 11-25), and the transition and transfer to adult services of young people with long-term health conditions (LTHC) and disabilities, across the Trust.
- 1.2 The policy adheres to the following framework and outlines required standards within each domain:
- Developmentally Appropriate Healthcare for young people aged 11 – 16/18
 - Developmentally Appropriate Healthcare for young people aged 16/18 - 25
 - Commencing Transition – from age 14/15 - for young people with a LTHC / disabilities
 - Transfer between child and adult service(s) – around age 16-18 (flexible)

Transfer can occur as follows:

- Community care (children's) to Community Care Adult teams
 - Child and Adolescent Mental Health Teams to Adult Mental Health
 - Child and Family Community Services (including CAMHs) to Primary Care
 - Child and Family Community Services to Secondary Care
- 1.3 Developmentally-appropriate healthcare requires children's and adult teams to engage with the needs of the young people they see to provide care that is personalised to the individual's needs. Employees will work with young people to achieve healthcare goals and help minimise the impact of health needs upon other areas of their lives (e.g. social; vocational; educational; emotional; leisure; and the move towards independent living).

Acknowledgement and Thanks:

This Policy has been written following receipt of Northumbria healthcare NHS Foundation Trust Policy, thank you to the author Dr Gail Dovey-Pearce for sharing their current policy with Solent NHST. Northumbria healthcare NHS Foundation Trust have a leading role nationally in working towards improved services for young people and they are the lead Trust and sponsor for the recently completed 5 year research programme 'Transition', funded by the National Institute of Health research.

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Developmentally Appropriate Healthcare for Young People Aged 11-25 Years

1. INTRODUCTION & PURPOSE

This policy outlines required standards to support the provision of developmentally appropriate healthcare for all young people (aged 11-25), and the transition and transfer to adult services of young people with long-term health conditions (LTHC) and disabilities, across the Trust.

1.2 Policy Summary

The policy adheres to the following framework and outlines required standards within each domain:

- Developmentally Appropriate Healthcare for young people aged 11 – 16/18
- Developmentally Appropriate Healthcare for young people aged 16/18 - 25
- Commencing Transition – from age 14/15 - for young people with a LTHC / disabilities
- Transfer between child and adult service(s) – around age 16-18 (flexible)

Transfer can occur as follows:

- Community care (children's) to Community Care Adult teams
- Child and Adolescent Mental Health Teams to Adult Mental Health
- Child and Family Community Services (including CAMHs) to Primary Care or GP
- Child and Family Community Services to Secondary Care

2. SCOPE & DEFINITIONS

2.1 This policy applies to locum, permanent, and fixed term contract employees (including apprentices) who hold a contract of employment or engagement with the Trust, and secondees (including students), volunteers (including Associate Hospital Managers), bank staff, Non-Executive Directors and those undertaking research working within Solent NHS Trust, in line with Solent NHS Trust's Equality, Diversity and Human Rights Policy. It also applies to external contractors, agency workers, and other workers who are assigned to Solent NHS Trust

2.2 Solent NHS Trust is committed to the principles of Equality and Diversity and will strive to eliminate unlawful discrimination in all its forms. We will strive towards demonstrating fairness and Equal Opportunities for users of services, carers, the wider community and our employees.

2.3 The policy includes additional guidance for employees working with young people who have:

- A long-term condition
- A progressive, life-limiting condition

- Complex health care needs
Including: physical disabilities; learning disabilities; autism spectrum disorders; acquired brain injury; sensory impairments; mental health conditions; palliative care needs; long-term health conditions, such as diabetes, asthma, arthritis etc.

2.3 Definitions of Terms Used

‘Young People’ (YP) – in this document, is a term for those aged 11-25, that encompasses: Adolescence – a developmental stage when YP are developing their sense of self, steadily acquiring autonomy in all areas of life and beginning to broaden their focus from salient tasks of childhood to include emerging tasks of adulthood.

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Young adulthood – a developmental stage, from around age 16 to around age 25, that overlaps with and follows on from adolescence.

Developmentally appropriate healthcare requires individualised and flexible approaches, responding to the multiple and changing impacts of health and healthcare, upon the young person’s needs and developmental goals (e.g. school attendance; body image; sustaining peer relationships). The aim is for healthcare professionals (HCPs) to provide high quality clinical care and also to support the young person’s ability to reach their own health and wellbeing goal(s), using approaches such as identifying the young person’s goals; breaking goals up into manageable steps; helping a YP to problem-solve and set themselves targets; and signposting the YP to available support outside of the consultation, as appropriate. Within the Trust, a range of goal setting and care planning approaches are being used (e.g. motivational interviewing; shared decision-making; Making Every Contact Count (MECC); person-centred care). YP may need adapted versions of existing approaches or may be able to receive care within current models of care.

It also requires an integrated approach to care, based on working relationships between HCPs and patients and also across services and agencies. Linking with families, schools, voluntary agencies and Children’s Services etc. may also be helpful / required at times, to be able to facilitate the network of support needed by YP.

Overall, the aim of developmentally appropriate healthcare for YP is to minimise potential negative interactions between health / healthcare and developmental tasks and experiences. It should be the approach for all YP seen within the Trust and not just for those with a long-term health condition. It is a key principle underlying ‘adolescent medicine’ and is closely related to other concepts in healthcare, such as transition, transfer, realistic medicine, health literacy and preventative healthcare.

Transition (in healthcare) is the purposeful, planned process that addresses the medical, psychosocial, educational and vocational needs of adolescents and young adults with long-term health conditions, as they progress through child-centred to adult-oriented healthcare system.

Transfer is the brief, organisational shift from children's services to adult teams, for those YP with long-term health conditions.

Involvement, in this document, means the direct and active involvement of YP in decision-making about matters relevant to their lives, whether individually or collectively, and it centres upon them having power to influence the decisions and outcomes being considered. This can take the form of being engaged in 1:1 discussions with HCPs; taking part in good quality service user consultation exercises, working in partnership with professionals, and up to YP having responsibility over organisational decisions, as is most applicable to the given situation. YP can be involved in many ways in shaping and supporting healthcare services, from service user feedback to large-scale research projects, and it is considered that an organisational strategy for a multi-layered approach to gaining the views of YP is required.

3. PROCESS/REQUIREMENTS

National guidance, including *You're Welcome* standards and the Care Quality Commission (2014) report *From the Pond to the Sea: Children's Transition to Adult Healthcare Services*, highlight the need to improve acute and long-term healthcare services for young people (YP).

YP are going through a period of rapid bio psychosocial change. The tasks of childhood (e.g. sustaining friendships and achieving academic success) are continuing, tasks of adolescence (e.g. developing the sense of self and acquiring autonomy) are central and certain tasks of adulthood (e.g. focusing on career, intimate relationships and future health) are emerging.

Health issues, acute and long-term, occur during this period and healthcare organisations need to understand how these fit with the other demands upon YP, to be able to tailor their services to them, to be most effective. For example, for YP with a long-term health condition, this rapid period of change and development coincides with the move from paediatric to adult healthcare systems. It is a time when the risk of being lost to follow-up rises significantly.

3.1 Purpose

The policy is relevant for all employees providing services for any young person (aged 11-25) seen within the Trust and captures national guidance and local imperatives, in order to support the provision of developmentally appropriate healthcare to all YP who access our services.

3.2. Process

3.2 Developmentally Appropriate Healthcare for young people aged 11-16/18

3.2.1 Environment and Service Structure

- a) Services must consider the accessibility of their environments and service structures for young people.
- b) Services should consider and offer advocacy services to ensure YPs voices are heard when they feel unable to represent themselves.
- c) The appropriateness of all settings, waiting areas and information resources for young people must be determined and necessary changes resourced (see You're Welcome:www.gov.uk/government/publications/quality-criteria-for-young-people-friendly-health-services)
- d) Services should have a system for flagging up young people reaching age 11 and then age16/18. (E.g. administrative clinic preparation process).
- e) Consistency of team members should be considered when planning provision, as it improves a young person's engagement and facilitates rapport and participation.
- f) Basic service feedback mechanisms, gaining young people's views, must be facilitated by service managers.
- g) More advanced involvement of young people in service planning should be considered and planning to embed it within service design and development should take place.
- h) Age-banding (e.g. 0-11s / 11-16 / 16-25) would facilitate a consistent consultation style across each clinic and in services where this is not possible (e.g. lack of critical mass) clustering of young people's appointments should be arranged, with consideration of patient choice.
- i) Where possible, the choice of an appointment outside school hours should be provided and appointment times should be negotiated with young people and parent(s)/carer(s) to prevent 'Was Not Brought' (WNB) / 'Did not attend' (DNA).

3.2.3 The Consultation

- a) All employees working with young people must have a good working knowledge of the legislation around issues of privacy, young people's rights and confidentiality, in line with the Trust policy.
- b) Incrementally introducing some one-to-one time in consultation with young people is essential and must be documented within patient notes.
- c) All employees working with 11-16/18 year olds must consider copying letters to the young person, including a consideration of issues of confidentiality, privacy and consent.
- d) All employees working with young people must explore relevant and timely primary prevention and health promotion issues, in the context of the consultation (e.g. accident prevention; risk taking behaviours; etc).
- e) Services must select and make available age and developmentally appropriate privacy, consent and health promotion information for their 11-16/18 service users.
- f) Within the consultation, ideally with the YP alone, or with their chosen advocate, the young person's own individual goals for their health and wellbeing must be identified/reviewed

and clearly documented in the clinical notes and any relevant clinical correspondence, as appropriate and in agreement with the YP, in order to support the young person's self-confidence in achieving good health and wellbeing.

3.3 Developmentally Appropriate Healthcare for Young People aged 16/18-25

3.3.1 Environment and service structure

All points from section 3.1.1 apply to adult services working with young people.

3.3.2 Consultations / Clinics

Points 3.1.2 a-f plus:

- a) Employees must ensure compliance with the Mental Capacity Act for this age group.
- b) WNB/DNA and loss to follow-up if they are going to occur are likely to occur soon after the transfer to young adult care. Adult services must have clear mechanisms for recording WNB/DNAs and following-up young people/families.
- c) An automatic discharge after 1 WNB/DNA is not appropriate for this age group. Each team should consider more flexible arrangements to follow-up WNB/DNAs and make recommendations to their Service Line about how best to proceed. All employees must follow the Trust Policy for DNA and WNB.
- d) Teams must continue to offer to directly involve parents/carers, in line with the young person's preference.
- e) Young people expect their specialist team(s) to be aware of other health issues of relevance (e.g. longer-term implications / complications; drugs and alcohol; mental health; sexual health, fertility and pregnancy), so HCPs should develop such knowledge and know how to signpost to other health services.

3.4 Commencing Transition (age 14-15) for Young People Moving between Child and Adult Services

3.4.1 Individual Case Planning

- a) Transition planning must start by 14/15, to identify the impact of health issues on the young person's developmental goals and set out the support and services the young person and family/carers require in the period up to and including transfer: health services; voluntary sector support; education services; social services; support from family/community; etc.
- b) A mechanism should be implemented for monitoring attendance of those aged 14-18. It is a time when young people can become 'lost' to services.
- c) If attendance is poor, other appointment arrangements should be explored and documented in the patient notes (e.g. other more accessible settings; different times).
- d) Employees should take steps to involve the G.P. in transition planning – they are providing for the young person's primary care needs, are likely to have an holistic overview of the

young person's needs and may be able to take on an active role in supporting the transition process.

- e) Each children's team should establish a process so that a multi-disciplinary summary of the patient history is prepared in time for the young person's transfer in 1-2 years' time.
- f) The multi-disciplinary summary should include information from the referring service that is essential for the receiving service to provide continuity of care.
- g) In liaison with the young person and family/carers, teams should consider the need to identify a named worker from within the current care team. Their main role will be to be a named contact if the young person is struggling with any aspect of the transition process, and to help coordinate aspects of care for those young people with complex health and/or social care needs.
- h) Young person-centred checklists/planners should be considered as a useful way for identifying healthcare and developmental goals, to support planning for a comprehensive transition process.
- i) For some young people (e.g. with special educational needs; disabilities) this planning should feed into a broader, multi-agency transition planning process (person-centred plan; statutory 0-25 education, health and care (single) plan) and should be linked with social care and education planning, as required.

3.4.2 Organisational Planning

- a) There must be a clear demarcation of clinical accountability and service responsibilities between children's team(s) and adult team(s) / primary care team(s) during the transition process, and these should be documented within the transition pathway, where one exists.
- b) Where a number of young people with the same or similar health needs are moving to adult services, a transition pathway should be agreed between teams (i.e. children's teams, adult teams, representatives from primary care and other Local Authority (LA) agencies, as appropriate)
- c) Services have a responsibility to engage commissioners in transition discussions to ensure a smooth transition process and that the YP is able to transfer their care at the right time for themselves and their family.

3.5 Transfer (Around age 16 – 18: Flexible According to Young Person's Choice and Needs)

- a) The transfer between services is an administrative and organisational issue and all efforts must be taken so that this does not impact negatively on the young person's experience of care.
- b) The triad of communication between family/carer, young person and professional is key and discussions must acknowledge and address the loss of continuity of care and ensure that confidence for the move is fostered and new relationships are established.
- c) A clear administrative process to ensure successful transfer of patient information must be in place.

- d) A clear administrative process to ensure that the young person receives their first appointment in the adult service in a timely manner must be in place.
- e) A clear administrative process to check attendance in the adult service must be in place.
- f) The opportunity to visit the new clinic area and be introduced to key adult employees should be offered, if this is possible.
- g) Young people should receive a detailed outline / information leaflet about the service(s) they will be transferring to, prior to their move.
- h) It is best practice that young people moving away for a defined period of higher education are offered a choice between transferring to services in their place of study or maintaining care with their current local adult health care team. If the care cannot practically be delivered in this model it will be recommended that the YP transfer their care to a local team.
- i) The multi-disciplinary summary of the patient history should be completed and appropriately disseminated in a timely manner. The HCP who is transferring care has a duty to inform all involved HCPs, including primary care and social care (as appropriate).
- j) If issues linked to special circumstances around transfer (e.g. move from community paediatrics to multiple adult providers) have not been addressed in the transition phase, these should be addressed now and the transfer process should be delayed for a short period until they have been resolved, as far as current provision allows and in close liaison with the young person and family/carers.
- k) Extra attention should be paid to communication and planning when young people are moving to/from tertiary centres and other healthcare organisations.

4. ROLES & RESPONSIBILITIES

- 4.1 The Chief Executive has ultimate accountability for the strategic and operational management of the organisation, including ensuring all policies are adhered to.
- 4.2. **Policy Author** – is responsible for ensuring the policy is updated at the required intervals or when legislation or local policy changes need to be disseminated before being ratified by the Trust wide Policy Assurance Group.
- 4.3 **Managers/Supervisors** – are responsible for ensuring that arrangements are in place for this policy to be fully implemented at service level. This will include arrangements for employees attending training and using the appraisal system to promote skills development and outline roles/responsibilities. Managers/supervisors are responsible for ensuring adequate dissemination, implementation and monitoring of policy standards, as well as adopting the standards of practice for themselves.
- 4.4 **All Trust Employees who work with Young People** – are responsible for reading the new policy to maintain current awareness of changes which impact on their roles and follow as appropriate.

5. TRAINING

- 5.1 All HCPs working with YP require training in the developmental needs of adolescents and young adults. Managers must include training goals around developmentally appropriate healthcare, transition and transfer as part of the employee appraisal process, for employees working with YP. A bespoke package will be developed.
- 5.2 All employees working with young people must have the knowledge, skills and confidence to deliver developmentally appropriate healthcare to young people and the support of their managers (e.g. via the appraisal process) to develop and update their knowledge and skills.
- 5.3 Employees must have skills to be able to negotiate a suitable approach to care with parents/carers and young people, reflecting the standards in this policy, so that YP are able to choose an approach that suits their (changing) preferences, whilst the parent(s) / carer(s) needs are also met.
- 5.4 All employees working with young people must have access to the appropriate training and tools such as HEADSS, Disability Matters, Mental Capacity Act.
- 5.5 All employees working with young people must undertake mandatory safeguarding training in line with Trust safeguarding policies.
- 5.6 All employees working with young people should have an up-to-date overview of community and hospital-based services available to young people in the local area (e.g. schools-based sexual health services; drug and alcohol services) and be able to signpost young people, as appropriate.

6. EQUALITY IMPACT ASSESSMENT AND MENTAL CAPACITY

- 6.1 In line with Trust policy, an Equality Impact Assessment has been completed. It is understood that no employee will receive less favourable treatment on the grounds of disability, age, sex, race, religion or belief, gender reassignment, pregnancy or maternity, marriage or civil partnership, working patterns or Trade Union membership or non-membership in relation to the application of this policy. The Equality Impact Assessment is included in Appendix A.

7. SUCCESS CRITERIA / MONITORING EFFECTIVENESS

- 7.1 The Document Manager must be able to demonstrate the effectiveness of the document at the point of review, for example by; carrying out audits, reviewing incidents that may have occurred related to the document, discussing the document at team meetings. Any subsequent issues/findings resulting from the review should be incorporated in the new version of the document.
- 7.2 This section should include details of the following (in accordance with NHSLA best practice);
- When will implementation be reviewed
 - who will carry out the review
 - using what tool (attach as an appendix) and, where applicable, sample size
 - where will results be presented
 - how will actions be monitored

- how often will a review take place

7.3 State that non-compliance must be reported.

8. REVIEW

8.1 This document may be reviewed at any time at the request of either staff side or management, but will automatically be reviewed 3 years from initial approval and thereafter on a triennial basis unless organisational changes, legislation, guidance or non-compliance prompt an earlier review.

9. LINKS TO OTHER DOCUMENTS

9.1 This document is linked to Solent NHS Guideline for Family Disengagement and Children Not Brought for Appointments - [Guideline for WNB Disengagement](#)

Equality Analysis and Equality Impact Assessment

Equality Analysis is a way of considering the potential impact on different groups protected from discrimination by the Equality Act 2010. It is a legal requirement that places a duty on public sector organisations (The Public Sector Equality Duty) to integrate consideration of Equality, Diversity and Inclusion into their day-to-day business. The Equality Duty has 3 aims, it requires public bodies to have due regard to the need to:

- **eliminate unlawful discrimination**, harassment, victimisation and other conduct prohibited by the Equality Act of 2010;
- **advance equality of opportunity** between people who share a protected characteristic and people who do not;
- **foster good relations** between people who share a protected characteristic and people who do not.

Equality Impact Assessment (EIA) is a tool for examining the main functions and policies of an organisation to see whether they have the potential to affect people differently. Their purpose is to identify and address existing or potential inequalities, resulting from policy and practice development. Ideally, EIAs should cover all the strands of diversity and Inclusion. It will help us better understand its functions and the way decisions are made by:

- **considering the current situation**
- **deciding the aims and intended outcomes of a function or policy**
- **considering what evidence there is to support the decision and identifying any gaps**
- **ensuring it is an informed decision**
-

Equality Impact Assessment (EIA) *see supporting guidance on pg 3*

Step 1: Scoping and Identifying the Aims

Service Line / Department	Child and Family	
Title of Change:		
What are you completing this EIA for? (Please select):	Policy	<i>(If other please specify here)</i>
What are the main aims / objectives of the changes		

Step 2: Assessing the Impact

Please use the drop-down feature to detail any positive or negative impacts of this document /policy on patients in the drop-down box below:

Protected Characteristic	Positive Impact(s)	Negative Impact(s)	Action to address negative impact: <i>(e.g. adjustment to the policy)</i>
Sex	/		
Gender reassignment	/		
Disability	/		

Age	/		
Sexual Orientation	/		
Pregnancy and maternity	/		
Marriage and civil partnership	/		
Religion or belief	/		
Race	/		

If you answer yes to any of the following, you MUST complete the evidence column explaining what information you have considered which has led you to reach this decision.

Assessment Questions	Yes / No	Please document evidence / any mitigations
In consideration of your document development, did you consult with others, for example, external organisations, service users, carers or other voluntary sector groups?)	Yes	Engagement with service users
Have you taken into consideration any regulations, professional standards?	Yes	National recommendations
In drafting your document have you identified any discrimination issues, and if so how have they been mitigated?	Yes	

Step 3: Review, Risk and Action Plans

How would you rate the overall level of impact / risk to the organisation?	Low	Medium	High
	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
What action needs to be taken to reduce or eliminate the negative impact?			
Who will be responsible for monitoring and regular review of the document / policy?			

Step 4: Authorisation and sign off

I am satisfied that all available evidence has been accurately assessed for any potential impact on patients and groups with protected characteristics in the scope of this project / change / policy / procedure / practice / activity. Mitigation, where appropriate has been identified and dealt with accordingly.

Equality Assessor:	Stephanie Clark	Date:	4/2/00Eqwu
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This section is to be agreed and signed by the Head of Diversity and Inclusion in agreement with the Diversity and Inclusion Strategy Lead:

Diversity and Inclusion authoriser name:	
Date:	