

TRUST CORPORATE POLICY TRANSITION OF YOUNG PEOPLE FROM CHILDREN'S TO ADULT SERVICES
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APPROVING COMMITTEE(S)	Trust Policies Committee	Date approved:	13/12/21
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DISTRIBUTION	Trust Wide		
RELATED DOCUMENTS	<p>Barts Health Admission policy for children and young adults COR/POL/191/2021-001</p> <p>Observation and Escalation Policy – Adult Patients (Applies to over 16 years old) CLI/POL/198/2018-01</p> <p>Safeguarding Children Policy COR/POL/044/2021-001</p> <p>Supported Decision Making and Informed Consent for Investigations and Treatment COR/POL/046/2021-001</p> <p>Access and Management – Referral to Treatment (RTT) COR/POL/123/2015-001</p> <p>Discharge policy cli-pol-237-2018-001</p>		
STANDARDS			
OWNER	Chief Nursing Officer		
AUTHOR/FURTHER INFORMATION	Roald Dahl CNS for teenagers and young adults		
SUPERCEDED DOCUMENTS	CLI/POL/223/2017/001 Transition Of Young People From Children's To Adults' Services		
REVIEW DUE	Usually 3 years after approval		
KEYWORDS	Adolescent, Adolescence, Young People, Transition, Transfer to adult care		
INTRANET LOCATION(S)	https://weshare.bartshealth.nhs.uk/download.cfm?doc=docm93jjm4n2184.pdf&ver=34194		

CONSULTATION	<i>Barts Health</i>	Barts Health Teenage and Young Adult Group Barts Health Children's Clinical Health Board Barts Health Medical Board Distribution across adult and children services within Barts Health Barts Health Youth Empowerment Squad (YES) Barts Health Children's Safeguarding Team St Bartholomew's Safeguarding Committee
	<i>External Partner(s)</i>	East London Foundation Trust – community services North East London Foundation Trust – community services

		<p>East London Foundation Trust – mental health services</p> <p>North East London Foundation Trust – mental health services</p> <p>Local children’s hospices</p>
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SCOPE OF APPLICATION AND EXEMPTIONS	<p>Included in policy: <i>For the groups listed below, failure to follow the policy may result in investigation and management action which may include formal action in line with the Trust's disciplinary or capability procedures for Trust employees, and other action in relation to organisations contracted to the Trust, which may result in the termination of a contract, assignment, placement, secondment or honorary arrangement.</i></p>
	All Trust staff, working in whatever capacity
	Other staff, students and contractors working within the Trust
	<p>Exempted from policy: <i>The following groups are exempt from this policy</i></p>
	[Specify exempted staff groups or enter “No staff groups are exempt from this policy.”]
	[Private sector partners (or seconded to them under the Retention of Employment arrangement): providing Facilities Management services (Capital Hospitals Limited and its Service Providers)]

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TRANSITION OF YOUNG PEOPLE FROM CHILDREN'S TO ADULT SERVICES

1 INTRODUCTION

- 1.1 Transition is a key element of any healthcare service. It is defined as 'a purposeful, planned process that addresses the medical, psychosocial and educational/vocational needs of adolescents and young adults with chronic physical and medical conditions as they move from child-centred to adult-oriented health care systems.' (Together for Short Lives: Stepping Up, 2015). The transition pathway is a process that takes place over a minimum of 3-4 years. The pathway should begin no later than 13 years of age. The age of transfer into adult care is variable and can happen any age between 16 -18. However it is recognised that this pathway will be shorter for young people who receive a diagnosis at a later age and this will require careful planning.

Adolescence is a key period of development for individuals with their needs often changing during this period. Issues such as consent, competency and mental capacity need to be considered and addressed alongside the changing roles of parents (and carers) during this period. Nearly three quarters of children and young people with a mental health condition also have a physical health condition or developmental problem (Local Govt Association website – accessed 4.10.21)

With development in medicine many young people with long term health conditions that were previously confined to childhood are now surviving into adulthood. A multi-agency approach needs to be taken to enable young people to live their lives to the fullest extent, with a greater focus on the need for parallel planning for on-going care and support needs as well as their plans for end of life care. A multi-agency approach should include health, education and social care.

Physical health does not exist in isolation. Mental health, social relationships, lifestyle behaviours, family context and education are critical during this phase of life. Each of these domains impact each other, urgent work is needed to deliver age appropriate care to meet the needs of this patient group (Royal College of Physicians, 2015). Adolescence can be a challenging time for all young people but it can be especially hard for young people with long term health conditions who are at higher risk of social isolation, depression and ultimately suicide in some cases. It is crucial that health care providers are able to support them through this time (Ref: Facing the future standards for children with on-going health needs, RCPCH 2018).

Transition happens across a range of health, social care, education and other statutory and non-statutory bodies and the relationship and links between these are critical. Poor or inadequate transition from children's services can have serious impact on young people, due to lack of continuity or potential loss to follow up. This could have an impact on the life course or disease process. Additional health service costs may also be incurred due to poor transition. The children's and young people's health outcomes forum (2012) found that poor

transition can lead to disastrous health outcomes for both physical and mental health.

Advice and guidance in relation to transition pathways can be sought via the bartshealth.bartshealthtransitionnursespecialist@nhs.net email address.

1.2 Objectives

- To achieve a seamless transition from children's to adult services for young people in a coordinated manner which is developmentally appropriate and accessible
- To encourage self-management, self-advocacy, personal health decision-making and independence in young people
- To reduce unplanned hospital admissions
- To reduce loss to follow up
- To enhance patients', parents' and carers experience during, and after, their transition journey
- To ensure both patient, parents' and carers have access to appropriate support during their transition journey
- To make staff aware of the need for effective transition between children and adult services
- To ensure responsibility for funding is agreed early in the transition process
- For staff to consider mental health and physical health equally

Definitions

Adolescent/Young person	This phrase does not have any legal meaning but is commonly used to refer to older children. This guideline assumes that all young people are aged between 12 -18 years old (i.e. up to 18th birthday)
Adult	Anyone who is 18 years of age or older (i.e. from their 18th birthday)
Child	Legal term for anyone who is 18 years old (i.e. up to their 18th birthday) and up to 19 years old living with a disability
Transition	Transition from children's to adult healthcare is defined as the purposeful and planned process of supporting young people with long term conditions as they move from child-centred to adult orientated health care systems (Healthcare Quality Improvement Partnership 2018)
Parent	Takes into consideration parent or legal guardian
Professional Leading Care	Individual responsible for coordinating transition process within children's and adult services
NICE	National Institute for Health and Care Excellence
CQC	Care Quality Commission

2 EXECUTIVE SUMMARY

2.1 This Policy sets out the standards expected by Barts Health NHS Trust with regards to the transition pathway of all young people. This includes young people with long term physical, mental, emotional health conditions, learning disabilities and/or autism and children in care. This outlines specific practical steps which should be carried out before, during and after transition to encourage self-management into adulthood.

Currently within Barts Health there are 4 transition pathways:

1. Internal transition pathway within Barts Health
2. Pathway from other providers into Barts Health
3. Pathway from Barts Health into other providers
4. Transition from Barts Health to Primary Health Care

Young people may fall into 1 or more of these pathways, therefore it is important that young people have a clear and robust transition pathway in place.

Person-centred planning is key to ensure a smooth transition journey with these prerequisites being upheld:

The young person is at the centre of the process.

The young person is consulted throughout the process.

Young people may not have capacity to consent to care and treatment, so whilst ensuring they remain in the centre of the process, parents (or legal guardian) need to continue to be seen as partners in care. Reference should be made to government guidelines around any changes in the age of mental capacity.

Planning should begin no later than the age of 13.

Young people may be known to a number of professionals which requires close communication to all involved.

Where possible young people are involved in choosing the setting and timings of appointments e.g. young people may prefer early evening clinics so they don't miss morning or afternoon sessions of education or employment. The young person should also be able to choose who is present with them during consultations which may be offered face-to-face or virtually.

There should be a designated professional (Professional Leading Care) who leads the transition process for the young person and their family. It is recognised that this role may be difficult to implement but consideration should be given for one lead professional to oversee the transition pathway.

3 AT THE BEGINNING OF THE TRANSITION PATHWAY

Information about the transition process, what to expect and the support available should be provided to young people and their parents/carers with sufficient time for them to reflect and discuss with the team if necessary. There is an expectation that patient information will be available summarising transition. In the absence of a recognised framework 'Ready, Steady, Go and Hello to adult services' should be the adopted framework. Relevant documentation can be found on the WeShare teenagers and young adults page <https://weshare.bartshealth.nhs.uk/young-adults>

The young person should be given information about the team they are transitioning to and the support available. This will allow the young person and their family to be equipped with realistic expectations and knowledge to ensure confidence in their care and support needs being met in the future.

Transition information should be developmentally appropriate and take into consideration their cognitive and physical development, emotional maturity and state of health. It should:

- be available in accessible formats, depending on the needs and preferences of the young person e.g. written, computer-based, audio, Braille formats or British Sign Language. Advice can be sought from the:
- Bartshealth.healthadvocacyenquiryonly@nhs.net or Advocacy availability line: 07 980 863 518
- be available as easy read versions
- describe the support available before, during and after transfer
- describe where they can get advice about benefits and financial support that they may be entitled to
- provide details of the team and where to access help and advice

4 DURING THE TRANSITION PATHWAY

4.1 Timing and review

Transition planning should begin by age 11, this links in to the age of moving to secondary school, and at the latest it should be started by 13. This should take into consideration the young person's maturity and readiness to begin transition planning and be delivered in a way that is appropriate to the individual. The process should take at least 3-4 years to complete. If the young person joins children's services after this age then it should be started immediately. 18 is the age by which transition to adult services is usually completed (unless the young person has individual needs e.g. special needs/complex health needs and has been negotiated with the lead professional).

Starting to plan for transition early can lead to a better experience for young people. A sudden move to adult services with no time for preparation or support can lead to young people and their families losing confidence and disengaging

with services and must not happen. Handover of care into adult services should not take place during a period of acute ill-health.

With the appropriate support and local agreement young people should be encouraged to have some of their appointments within the adult out-patient setting.

Transition plans should be reviewed regularly by the professional leading care to reflect the changing needs and wishes of the young person. Communication should be encouraged and shared between all key individuals in the transition pathway. Transition plans should include a recognised framework or a locally agreed framework and should incorporate health passports and education health care plans (EHCPs) where these are in use. Transition planning should be clearly documented and this can be done via a clinic proforma.

4.2 **Involvement of the young person**

The young person, with the support of their clinical team, should be supported to be involved in the completion of their transition documentation. It should ideally include clinical needs and how they are managed, alongside psychosocial factors with an emphasis on the young person's wishes and dislikes. Young people should be encouraged to express themselves in their own words in this document. Transition documentation may be in the form of paper, electronic or apps.

Young people from the age of 14 onwards with learning disabilities will be supported using the Hospital Passport, in addition to their transition pathway documentation.

[Hospital Passport](#)

4.3 **Information which should be discussed during the transition pathway includes:**

- Information about their health condition
- Information about their education and employment
- Health and wellbeing, emotional health, sexual health
- Their preferences about their parents/carers involvement, in the context of who has parental responsibility
- Independent living and housing preferences, and social care needs
- Emergency care plans
- History of unplanned admissions
- Their strengths, achievements, hopes for the future and goals
- Knowledge of their condition. Young people should be helped to understand and manage their own condition as part of the transition pathway.

- Provide details of the team and where to access help and advice

The transition plan should be formulated early in the transition process, so that it can be adapted throughout and to ensure that it plays a useful role in the transition process.

The transition plan should be brought to every transition meeting and clinic appointment to be updated accordingly. It will serve to avoid repetition of information by young people and their parent(s)/carers, encourage information sharing between children and adult services and prevent duplication of tasks by healthcare professionals.

Young people should be encouraged to make decisions and play an active part in their transition planning, as well as planning proactively for their future. They are involved in on-going assessments and developing a holistic plan that reflects their wishes for the future. Young people, where appropriate, should be offered the opportunity to be seen alone without their parent/carer and be encouraged to 'ask 3 questions'. <https://www.uhs.nhs.uk/Media/UHS-website-2019/Patientinformation/Visitinghospital/Ready-Steady-Go-Ask-3-questions.pdf>.

They should be encouraged to raise concerns of their own outside those of their parents and be made aware that the extent of their parents' involvement in their care is their decision once they complete transition into adult services (if they are deemed to have capacity). Refer to Barts Health NHS Trust Policy: [supported decision making and informed consent for investigations and treatment](#).

4.4 **Transition outpatient clinics**

Young people transitioning into adult care should be seen in a transition clinic where they are seen jointly with members of the paediatric and adult teams present. The transition clinics should ideally be held face-to-face and the young person benefits from the opportunity to visit the adult clinics.

For young people under the age of 16 who are attending a transition clinic in the adult clinic area the following must apply:

The paediatric medical team should be present throughout

Clinical responsibility and care lead will remain with the paediatric team

Any necessary prescribing of medications will be done by the paediatric team

Any necessary invasive procedures such as blood tests will take place in paediatric environments. Post appointment care coordination will be led by paediatrics

4.5 **Involvement of parents(s)/carers**

Parents/carers should be involved in transition planning and should be given appropriate information and support about what to expect alongside potential issues they may face and how to deal with them.

Issues and changes regarding consent and the mental capacity of the young person between the ages of 14 to adulthood should be explained clearly. Refer to Barts Health NHS Trust supported decision making and informed consent for investigations and treatment.

It should be taken into consideration that transition can be a difficult time for parents/carers, who may need to give up a lot of control and adapt to the young person moving into adult life. Parents should also be offered appropriate support and their needs as carers (if they are the primary carer for the young person) should be assessed to determine if they need additional support as per the Care Act 2014 which gives carers the legal right to assessment and support. Support for carers is available through voluntary sector and local authorities. Refer to Barts Health NHS Trust Carers Policy

[Recognising and Supporting Carers as Partners in Care](#)

4.6 Role of the professional leading the transition of care

- The role of a professional leading care is to coordinate the healthcare of the young person during their transition journey and to determine the appropriate pathway for the young person e.g. children's clinic, transition clinic to adult clinic.
- The professional in children's services leading care will already be involved with the care of the young person and will understand their responsibility for the safe transition of care to adult's health services. For example, the paediatrician leading the care of the young person would be an ideal candidate to become the professional leading care.
- The professional leading care should be someone who is knowledgeable about the young person and is well versed with their medical history, needs and wishes alongside family needs and wishes. There should also be a named professional lead within adult services
- The professional leading care should support the young person in formulating their transition plan (see next section). This transition plan can then be shared with all relevant members of the team caring for the young person. For a number of young people who have an existing Education Health and Care Plan (EHCP) then the hospital transition plan could be incorporated into the EHCP.
- The professional leading care should communicate effectively with all members of the team i.e. the young person and their family, the healthcare professionals involved in the young person's care currently from children's services and their future healthcare professionals from adults' services including their GP and any community or social service agencies involved. Maximising the opportunity to use technology (email and text) is essential to engage young people, taking confidentiality factors into account.
- For young people with complex health needs the professional leading care should organise transition meetings where all the individuals mentioned previously (community care, primary care and secondary care) can meet to discuss the transition process. This should ideally involve the young person and their family. Video conferencing may be used to ensure that as many team members as possible can be involved in decision making.

- The professional leading care should recognise the importance of involving the GP and community health services in transition planning. This is especially important if the young person does not meet the criteria for specialist adults services input and the GP will have medical responsibility for the young person's care. Primary care should be involved throughout and as early as possible. Consider checking the young person is registered to a GP.
- The professional leading care, within childrens and adult services, should provide appropriate information of the young person's conditions to all involved and signpost to relevant services such as peer support groups and patient advocacy groups.
- Support should be provided to the young person for a minimum of 6 months before and after the point of transfer, with the young person able to negotiate a specific time period of support which they would prefer.
- Where possible, transition clinics with both paediatric and adult services present should be organised during the transition process. Whilst being mindful of the number of staff attending.
- From age 18 (or 19 for young people with a learning disability), adult clinicians and multidisciplinary services are responsible for the care of the patient (unless the patient has special needs/complex disability and a different transition timeline is agreed with the young person and/or their family). Paediatric advice and input can be requested if required with the professional leading the care being the main point of contact.

4.7 Admission

Emergency admission care plans should be considered in the case of an acute admission occurring during the transition period, especially with regards to where the young person would prefer to be admitted to e.g. a named adult ward (if possible) where the young person has visited when they are well. This links to the Trust admission policy for children and young people

[Admission Policy for children and Young People](#)

Appropriate flagging on electronic patient record of young people with a learning disability should be encouraged.

4.8 Funding

To ensure that young people and their families are not left without equipment, services, respite care or other requirements during transition, responsibility of funding needs to be agreed upon early in the process.

- Changes in funding from children's to adult services need to be clear and explained to families
- Assessments to allocate funding for continuing health care needs to be completed by professionals who understand the needs of the young person and family to ensure no key information is missed

5 SUPPORT AFTER MOVING INTO ADULT SERVICES

If logistically possible, the young person should have the opportunity to see the same healthcare professional for the first two attended appointments after transition. Medical responsibility should be clearly articulated to ensure that clinical decision making is not blurred between adult and paediatric teams.

If a young person does not attend meetings or appointments after moving to adult services, efforts should be made by the adult healthcare professional to contact the young person and their family and include other relevant professionals such as their social worker and GP, while working within safeguarding protocols. If the patient is under the age of 18, this must be in line with child safeguarding protocols whereas if the patient is over 18, safeguarding of vulnerable adult protocols should be followed. (refer to access and management policy – referral to treatment COR/POL/123/2018-001 policy).

Where a young person does not have capacity to make decisions about their care and treatment eg learning disability then particular consideration needs to be made around decision making. This is especially relevant around appointments and the need to involve parents/carers in planning for a young person's care in adult health services.

Between the ages of 16 to 18, there is provision, if required, for the young person to be referred back to the paediatric team. If this happens, the paediatric team should review the health plan of the young person and work with them to identify better, alternative ways for them to engage with adult services alongside meeting their health care needs. This is done with the aim of ensuring transition is completed by age 18 and is in agreement of the young person that this is a time - limited period.

There will be local discussions to discuss any young person who is one year above the age of transfer.

6 DUTIES AND RESPONSIBILITIES

All staff working in the Trust who are involved in transition pathways	To facilitate the smooth transition of young people from children's to adults' services
Professional leading care	To coordinate health care of young people during their transition journey and determine appropriate funding
Managers	To be included in the transition pathway particularly when questions around funding are raised and service redesign
Local commissioners	May be involved in application for continuing care health plans
Primary health care	GP provider is the service who remains the consistent during the transition pathway
Mental health services	To be involved in the conversations to outline what services may be on offer particularly within adult services.

Social care	Young people may be known to children's social care services. It is important that they are involved in the conversations to outline what services may be available within adult social care.
Education	Education colleagues will be involved in contributing to the EHCP
Voluntary organisations	Can offer support for young people, families/carers
Committees	The Trust Teenager & Young Adults Steering Group is the lead group for this policy and which reports to the Children's Health Clinical Board. With additional reporting to the other relevant clinical boards.

7 POLICY CHANGE LOG

Substantive changes from previous version	Reason for Change	Author & Group(s) approving change(s)
Pg 3 – specific mention of considering the importance of mental and physical health as being seen as equal	A significant number of young people living with a physical health need will have an associated emotional, mental health need	Neil Fletcher; Roald Dahl Clinical Nurse Specialist for teenagers and young adults Children's Clinical Health Board Trust Teenage and Young Adult meeting who has representatives from children's and adult services
Pg 4 – in the absence of a recognised framework that the ready, steady, go, hello to adults framework should be adopted	This is a recognised framework that is currently supported by the Care Quality Commission	Neil Fletcher; Roald Dahl Clinical Nurse Specialist for teenagers and young adults Children's Clinical Health Board Trust Teenage and Young Adult meeting who has representatives from children's and adult services
Pg 6 – young people and clinical teams are encouraged to support clinic attendance within adult services where appropriate	A key point within the transition pathway is to empower young people and for them to have the opportunity to meet colleagues based within adult services and for them to become familiar with the adult clinical environment before they are transferred into their care	Neil Fletcher; Roald Dahl Clinical Nurse Specialist for teenagers and young adults Children's Clinical Health Board Trust Teenage and Young Adult meeting who has representatives from children's and adult services

Pg 8 – specific mention of the important role of the GP	The GP is the service that continues throughout the entire transition pathway and they are often not involved/included in conversations around transition planning and preparation. They may be the care provider that young people are referred to in adulthood. Involving GPs along the pathway is vital and their valuable contribution should be recognised.	Neil Fletcher; Roald Dahl Clinical Nurse Specialist for teenagers and young adults Children’s Clinical Health Board Trust Teenage and Young Adult meeting who has representatives from children’s and adult services
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8 MONITORING THE EFFECTIVENESS OF THIS POLICY

Issue being monitored	Monitoring method	Responsibility	Frequency	Reviewed by and actions arising followed up by
Effective transfer of care	Audit of lost to follow up	Trust Teenager & Young Adults Steering Group	Yearly	Children’s Clinical Health Board
Patient satisfaction	Feedback from patients	Trust Teenager & Young Adults Steering Group	Yearly	Children’s Clinical Health Board
Staff satisfaction	Feedback from professionals leading the care and health practitioners	Trust Teenager & Young Adults Steering Group	Yearly	Children’s Clinical Health Board

9 REFERENCES

NICE (NG43) Transition from children's to adults' services for young people using health or social care services 2016

<https://www.nice.org.uk/guidance/ng43>

CQC From the Pond Into The Sea: Children's transition to adult health services 2014

https://www.cqc.org.uk/sites/default/files/CQC_Transition%20Report_Summary_lores.pdf

Mental Capacity Act: Care Quality Commission Brief guide: capacity and competence in under 18s Review date: July 2020

https://www.cqc.org.uk/sites/default/files/Brief_guide_Capacity_and_consent_in_under_18s%20v3.pdf

Transforming children's and young people's mental health provision: a green paper 2018

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/664855/Transforming_children_and_young_people_s_mental_health_provision.pdf

NICE (NG204) Babies, children and young people's experience of healthcare August 2021

<https://www.nice.org.uk/guidance/ng204>

Public Health England (2015) Improving Young People's Health and Wellbeing –

A Framework for Public Health. <https://www.gov.uk/government/publications/improving-young-peoples-health-and-wellbeing-a-framework-for-public-health>

Impact assessments

Pragmatic Equality Analysis

1. Document Details	
Name and brief description of the policy, guideline or SOP:	Transition of young people from children's to adult services
Date of this version:	
Is it a new or existing process?	new
Author(s):	Neil Fletcher, Roald Dahl Clinical Nurse Specialist for teenagers and young adults
Approving Board/governance group:	
Expected Impact:	High/Medium/Low
Date of completion:	

2. Evidence Gathering and Engagement		
<p>a. List all the evidence that you used to complete this analysis, using the table below:</p> <p><i>Note, publicly available equality analysis documents from other NHS trusts may provide a helpful start point when seeking evidence. See these examples. As well as literature, you are encouraged to use data in your analysis. This can include the staff survey results , WRES, WDES, gender pay gap reporting, PHE fingertips or workforce data, national and local statistics, complaints, incidents, patient and staff surveys, focus groups, interviews. Two examples are included below for reference:</i></p>		
Finding	Source	Relates to...
<p>Young adults and adolescents (YAA) aged between 16 and 25 years are no longer among those considered to be the healthiest alive. Enormous improvements in health for children and young people have been achieved over the past 50 years, but the health of adolescents has shown significantly less improvement than that of any other age group. Mortality among adolescents is now higher than that for all other stages of childhood, except for infants aged under 1 year. Over 20% of YAA aged 13–24 years rate themselves as having a long-standing illness. Failure to recognise and meet the health needs of YAA has both immediate and long-term consequences for this group, for their families or carers, and for</p>	<p>Davies SC (ed). <i>Chief Medical Officer's annual report 2012. Our children deserve better: prevention pays</i>. Department of Health, 2013. www.gov.uk/government/publications/chief-medical-officers-annual-report-2012-our-children-deserve-better-prevention-pays [Accessed 24 August 2015].</p> <p>Hargreaves DS, Djafari Marbini A, Viner RM. Inequality trends in health and future health risk among English children and young people, 1999–2009. <i>Arch Dis Child</i> 2013;98:850–5.</p>	

<p>society: poor healthcare outcomes incur considerable personal costs in this age group with regard to employment, personal wellbeing and quality of life. YAA have the same rights to good healthcare as any other age group, yet health outcomes and reported experiences suggest that they have not been provided with the care and thought afforded to other age groups. Healthcare commissioners, providers and regulators should work to improve healthcare for this group of people. YAA need special consideration as a patient group that has unique needs and particular vulnerabilities.</p>	<p>Other guidelines and publications are available on request</p>	

b. Who have you **engaged and consulted with specifically around this equality analysis?**

*Engaging and consulting with different groups of patients, their families, staff and the community can be really important to understand the impact of this policy, guideline or SOP. **Include a bullet point list of engagement events/groups you have spoken to whilst considering equality in this policy/proposal:***

- Community Engagement Lead – Barts Health NHS Trust
- Head of Health Advocacy – Barts Health NHS Trust

3. Impact Analysis

This section makes up the core part of an equality analysis. The purpose is to consider:

- a) What positive and negative impacts might your policy or process change have?
- b) That we often have different needs depending on our background and situation, how can your policy accommodate this?
- c) If you identify negative impacts or unmet needs, what can you do to reduce any inequalities?

For point b, consider lifestyle (e.g. diet & nutrition, education, physical activity, alcohol/drug use, risk taking behaviour); the social environment (e.g. income, cultural awareness, social status, employment, social/family support, relationships between groups); the physical environment (e.g. living conditions, working conditions, transmission of infectious diseases, accidental injuries and public safety); access to services and opportunities (e.g. health care, transport, social, housing and education). Guidance from other NHS organisations outline potential questions to help investigate impact ([see page 9-14](#))

You may find that your intervention has no positive or negative impact on some groups, you may also

find that in some cases you uncover unmet need or inequalities that your policy cannot address. If this is the case, list them in section 4. The purpose is to encourage thinking on equality, spark a discussion in your team and adapt your work accordingly.

Group	Impact:
Minority ethnic people including gipsy/travellers.	What positive or negative impacts will your policy have, considering the needs of this group? All young people are covered within this guideline
	What changes can you make to your policy to reduce any negative impacts or better accommodate the needs of this group?
Older people, children & young people	What positive or negative impacts will your policy have, considering the needs of this group? This guideline directly relates to young people from the age of 11 onwards with the aim of transition pathways to begin no later than 13 years of age. However there is also recognition for those young people who may receive a diagnosis after their 13 th birthday.
	What changes can you make to your policy to reduce any negative impacts or better accommodate the needs of this group?
Women, men and non-binary people	What positive or negative impacts will your policy have, considering the needs of this group? This policy is relevant to all genders.
	What changes can you make to your policy to reduce any negative impacts or better accommodate the needs of this group?
People with a disability	What positive or negative impacts will your policy have, considering the needs of this group? Continuity of care can be a major concern as there may be gaps in the provision of parallel services in adult care. In young people with learning and/or autism the transition pathway has to be introduced sensitively. Parent (s)/carer (s) are advised that they will work the young person's pathway as the young person's voice/advocate. Some topics are especially difficult for healthcare professionals and parents(s)/carer(s) – sexual health, pregnancy and the future. It is recommended that the transition plans is completed with a healthcare professional expanding on the questions applicable for the young person and parent(s)/carer(s) and liaising with other teams where appropriate. Easy read version of the ready, steady, go, hello to adult services is available.
	What changes can you make to your policy to reduce any negative impacts or better accommodate the needs of this group? Liaising with the health advocacy service could help with discussions around sensitive topics and could consider the availability of an advocate who identifies as the same pronoun as the young person or of the same gender.
People with mental health	What positive or negative impacts will your policy have, considering the needs of this group? Parity of esteem should be considered. Young people often say 'there's more to me

problems	<p>than my condition' and thought should be given around their emotional and mental health wellbeing. This is particularly relevant when availability for psychological support or thresholds for adult mental health services may be different.</p>
	<p>What changes can you make to your policy to reduce any negative impacts or better accommodate the needs of this group? Access to voluntary organisations could be promoted depending on need and availability</p>
People in religious/faith or no faith groups	<p>What positive or negative impacts will your policy have, considering the needs of this group? This policy is relevant to all young people</p>
	<p>What changes can you make to your policy to reduce any negative impacts or better accommodate the needs of this group?</p>
LGBTQ+ people	<p>What positive or negative impacts will your policy have, considering the needs of this group? LGBTQ+ - developing a sense of identity is part of adolescence and additional thought should be given to support young people who may need communication aids to express their thoughts and feelings. Some young people may prefer to have these conversations without their parents/carers present</p>
	<p>What changes can you make to your policy to reduce any negative impacts or better accommodate the needs of this group? Consider signposting to community organisations for ongoing support.</p>
Homeless people	<p>What positive or negative impacts will your policy have, considering the needs of this group? Homeless- any young person who is living through homelessness may require additional support and advice to understand the health and social care systems</p>
	<p>What changes can you make to your policy to reduce any negative impacts or better accommodate the needs of this group? If a young person is living through homelessness negotiate how the young person will receive any outpatient appointment notifications and clinic letters. Consider arranging the next appointment whilst the young person is attending their current appointment and provide the previous clinic appointment letter if appropriate to do so.</p>
People involved in the criminal justice system	<p>What positive or negative impacts will your policy have, considering the needs of this group? Young people may be involved in the criminal justice system.</p>
	<p>What changes can you make to your policy to reduce any negative impacts or better accommodate the needs of this group? Consider virtual appointments if appropriate</p>
People of low	<p>What positive or negative impacts will your policy have, considering the needs of</p>

income	<p>this group?</p> <p>Low income - considering joint appointments between specialty teams could reduce the number of times families need to travel for appointments which could reduce travel costs</p>
	<p>What changes can you make to your policy to reduce any negative impacts or better accommodate the needs of this group?</p> <p>Virtual appointments are an option but consideration needs to be given for access to virtual equipment and access to phones and computers. Combining appointments may also help to reduce travel costs.</p>
Ex-service personnel	<p>What positive or negative impacts will your policy have, considering the needs of this group?</p> <p>This policy is not directly related to ex-service personnel</p>
	<p>What changes can you make to your policy to reduce any negative impacts or better accommodate the needs of this group?</p>
Any other groups (i.e vulnerable people, different language needs, refugees & asylum seekers)	<p>What positive or negative impacts will your policy have, considering the needs of this group?</p> <p>Availability of documents within other languages has been discussed with the health advocacy service. Young carers</p>
	<p>What changes can you make to your policy to reduce any negative impacts or better accommodate the needs of this group?</p> <p>Currently this is not something that has been requested by young people and/or their families/carers but is something that could be provided by the health advocacy service on request.</p>

4. Conclusions

a. Did you find any negative impacts or unmet need during your research that you weren't able to address through making changes to your policy?

No

b. Did your equality analysis raise any concerns or areas of escalation for the inclusion team?

No

c. Did you identify or agree any other actions to promote inclusion in addition to making changes to the policy itself?

No

For questions completing this template or for further input/advice, contact the inclusion team for help: diversityinclusion.bartshealth@nhs.net .

Organisational Impact Assessment

Name of policy					
Date of impact assessment		Completed by:		Position	

Area for consideration	Description of issue	Trust contact	Policy author description of how issue has been taken into account in the policy/guideline
Financial impact on Trust	Does the policy impose an additional direct or indirect financial cost on the Trust and how will this be managed?	TBC	
Impact on PFI Service Providers	How will the policy impact on the volume/cost of services provided by the Trust's PFI partner and how has this been addressed?	TBC	
Impact on other partner organisations	How will the policy impact on other partners?	TBC	