Report WP 3.1 Introduction of Developmentally Appropriate Healthcare

Normalising Developmentally Appropriate Healthcare for young people in hospitals: commitment, practice and inequity

Introduction

Adolescent health is a neglected yet pressing global issue[211] affecting the largest generation in human history.[212] Internationally, and in the UK, there is now increasing recognition of the importance of providing quality healthcare for the specific biopsychosocial needs of adolescents and young adults. One key challenge to addressing and researching this issue is the variable status of adolescent medicine across countries. Within the UK adolescent medicine is not a recognised medical speciality. Youth-friendly health care[104] has been promoted as a way to enable improvement of health services for young people. This concept has been used to underpin quality of care[105] and policy[94, 213] frameworks. However, as highlighted by the World Health Organisation (WHO), there is the need to move from the ad hoc provision of adolescent-friendly projects and services into adolescent-responsive health systems that can respond to the priority health and development needs of all young people.[106] Health care needs to respond to adolescents' and young adults' changing developmental needs. This provision needs to be consistent and universal, provided across all areas of the health care system. Such youth-responsive health systems need to focus on how health care professionals engage and communicate with young people in the consultation through to how services are planned, organised, delivered and commissioned. Developmentally appropriate healthcare (DAH) for young people[3, 4] is one concept that could underpin a youth-responsive health systems.

DAH has been described as a key principle underpinning the practice of adolescent medicine.[214] It is about making health care work for young people by recognising their changing developmental needs and the role of health care in addressing and supporting these through adolescence and young adulthood. It focuses on biopsychosocial development rather than chronological age. Each young person will make this journey to adulthood in a way that is unique to them and young people's development does not have a fixed time frame attached to it. Many of these developmental milestones will be met after reaching the legal age of adulthood.

DAH services with particular reference to adolescents and young adults have been reported nationally and internationally as a key mechanism to improve health outcomes for young people[212] and national guidance in the UK now specifically refers to the need for provision of DAH for young people.[14] Alongside this, the increasing knowledge surrounding adolescents' and young adults' development[215] offers unprecedented opportunities for service improvement. Existing approaches that draw on the concept of youth-friendly health care need to be reframed and extended. DAH offers an opportunity to transform traditional models of healthcare delivery, to create youth-responsive health systems. However, in spite of the existing evidence base and guidance, sub-optimal provision of health care for adolescents and young adults continues.[106, 212]

There has been a range of ways that the concept of DAH has been operationalized in the medical literature.[3] We have shown that clinicians and managers directly involved in the provision of health care for adolescents and young adults in three UK hospitals have different ways of making sense of the concept.[4] In this paper, we focus on the normalization[109] of DAH for young people within three UK hospitals. We explore the ways that people and services attempted to implement a more youth-responsive healthcare delivery.

Methods

Initially a scoping review[107] was conducted to explore the use and meanings attributed to the concept of DAH for young people. Articles were subjected to manifest and latent content analysis[108] in order to identify preliminary patterns and to explore the core ideas attached to concept.

A qualitative multi-site ethnographic study was then conducted across three hospitals in England: a district general hospital, a paediatric tertiary hospital and an adult tertiary hospital. Health professionals (HP) were recruited through six medical and surgical specialties chosen to represent the heterogeneous services found in UK National Health Service hospitals: Diabetes; Emergency Care; General Paediatrics; Outpatients; Rheumatology; and Trauma and Orthopaedics. In addition, some HP were recruited during the course of the study through other specialties (Endocrinology, Cardiology, Oncology and Respiratory), departments (Chaplaincy, Psychology, Radiology, and Youth Work) and settings (training sessions). Managers (MA) were recruited at each site when their roles were relevant to the provision of services for young people in paediatrics and/or adult care.

The Interview guide is at the end of this report.

Data collection took place over three phases, between June 2013 and January 2015. Recruitment was initially mediated through gatekeepers, then a mixture of snowball, criterion and theoretical sampling was used to recruit further staff. 192 participants were recruited. Approximately 1600 hours of non-participant observations were conducted, alongside 65 formal qualitative interviews (See Table 39). Observations where recorded in contemporaneous field notes. Formal interviews were audio-recorded, transcribed, edited to ensure respondents anonymity and then analysed alongside anonymised field notes.

Table 39: Participants recruited for the study by site, type of staff and method of data collection

		District general hospital	Paediatric tertiary hospital	Adult tertiary hospital	Total
Participants observed	Health professionals	65	27	11	103
	Managers	57	0	15	72
	Total	122	27	26	175
Participants interviewed	Health professionals	13	18	10	41
	Managers	13	6	5	24
	Total	26	24	15	65
Overall participants	Health professionals	78	45	21	144
	Managers	70	6	20	96
	Total	148	51	41	240
Number of participants who were both interviewed and observed		39	5	4	48
Total number of participants		109	46	37	192

All analysis was conducted according to the standard procedures of rigorous qualitative analysis.[86] We used procedures from first-generation grounded theory - coding, constant comparison, memoing[87] - and from analytic induction, deviant case analysis.[88] Data collection and analysis occurred concurrently, so that issues raised in earlier phases of fieldwork were explored in subsequent ones. We undertook independent coding and cross checking, team data sessions and member validation with some of the participants in the fieldwork. The analysis was theoretically-informed by Normalization Process Theory.[109]

Findings

Diverse values and commitment

As we have outlined elsewhere,[4] there was a wide variety of definitions of DAH across clinical and managerial staff in all the sites. Some did not recognise it as a concept, for some it made little sense and for others it was difficult to conceptualise, it is 'a bit amorphous'. Many focused more on the need to create a more age appropriate environment, in terms of the physical space, the visual and material culture of waiting room and wards (e.g. age appropriate leaflets and computer games). Others, especially those who did some work with young people, often discussed 'the medical bit plus all the extras', outlining a wide array of features, including aspects like developmentally appropriate communication, norms around confidentiality and a more holistic focus. As one manager noted:

> the young people have told us that, um, we need, they're not bothered about where they are seen so, as in, what the building's look like or what the clinic room looks like. They want to make sure that they see somebody who's interested and who knows what their disease is like, but also has an awareness of all the other stuff that's going on when they're 16 to 18, as in their, the, sort of, the physiological bit of just being a normal teenager and what happens. (MA, General)

This manager's view is intimately informed by working closely with and listening to the experience of young people. At this site, there were a variety of ways in which young people were involved in the provision of services for other young people as well as research. Recruitment of young people was often done through various channels within the hospital, for instance via the posters and leaflets which adorn the walls. Centrally, involvement at this hospital was considered to be part of patient experience, and it was mentioned that young people were involved in doing things such as helping to design books about the patients' journey, as well as sitting in on governance meetings and helping with the training of staff. In this way, young people's experiences were a central resource in helping to shape their understanding of appropriate service provision.

Alongside the different understandings of the purpose of DAH, there were conflicting views on the value and worth of enacting it across the organisations. The numbers of young people accessing health services were often portrayed as quite small, so in organisational terms they can become 'just below the radar'. In contrast to older, and especially elderly, patients, they were also positioned to often be 'very rarely unwell'. For some, this raised questions about whether a focus on young people is legitimate.

the trouble that we still have is that it's seen as a paediatric problem. It's not recognised as an adult medical issue, uh, because it's a small number I think. … [for example] when you've got 10, at most, per year coming through with complex health problems. Why do they have to set up a separate service for them? Or why do they have to change the way that they work? Um … because they don't come into contact with them that, very often (HP, General)

In this way, the 'small number' argument, in both paediatric and adult contexts, led some to question whether they, or others, should be adjusting their practices or offering distinct, more tailored, services. Relatedly, there are always competing demands for resources, time and expertise.

It's small enough [numbers] that if you don't, if you don't buy into it, there's plenty to be getting on with the other 90%. And everybody's jobs are so frantic that you could easily do a very good job with that 90% who are 25, 26 plus. You wouldn't be short of things to do, do you see what I mean? So, you could actually ignore these young people completely. (MA, Adult)

Individuals can, at times, choose not to buy into such work. Questions of legitimacy and buy-in, or rather, enrolment, are central to individual, team and organisational change.

In part, this lack of capacity and willingness seems to be compounded by the liminal status of young people within the organisational and professional culture of the UK healthcare system: 'adults don't really want them because they are too young and the paediatricians don't really want them because they are too old' (HP, General). Adolescent medicine is not a distinct profession, 'still considered as somewhat of an add-on'. Albeit with the exception of charity-supported oncology wards, adolescent only wards, or spaces within wards, were rare and often temporary affairs subject to dissolution given competing demands across all three sites. This is also reflected in management terms.

there isn't a designated clinical lead for adolescents or a designated board member for adolescence. … you know, who's flying the flag high up for adolescents? I don't know. (MA, Paediatric)

None of the sites had a senior clinical or management lead for young people. However, across all the sites we did observe a complex network of adolescent minded practitioners. We frequently either meet with, or heard about, people acting as adolescent or young people 'enthusiasts', or 'champions', within specific clinical or management teams in either a formal or informal capacity. In this way, specific services and practices were organised around the care of young people. However, relying on the enthusiasm and willingness of specific individuals can become problematic.

several people have left, who have been very senior members and very adolescent minded and have been replaced by either rotational posts or part-time posts, so that continuity within our team and the wealth of expertise has been impacted on significantly. (HP, Paediatric).

In this way, a focus on champions raises key questions for people about the sustainability of services for young people over time.

Across all three sites, we found a variety of definitions of DAH, alongside conflicting views on the value and worth of enacting youth orientated care across the organisations. For some, a focus on young people is questioned, given the contexts of small numbers and competing demands. Such a view is compounded by the liminal status of young people, given the lack of professional and managerial roles focusing solely on young people. Across all the sites, young people's champions, be they working in a formal or informal capacity, were key in getting people involved in the care of young people. However, people were aware of the practical problem of relying on key individuals. For them, it should be 'about consistency of approach, not a person', about developing local cultures of good practice within and across teams and clinical spaces, that can withstand changes in specific personnel.

Informal cultures of good practice

As one manager, with clinical experience outlined

'Transitions, probably, um, suggest a process where Developmentally Appropriate Healthcare suggests a philosophy' (MA, General).

Across all three sites, we observed local cultures – in teams, clinics, wards and meetings - where they attempted to enact botha set of processes and philosophy of care towards young people. Theywere driven by an awareness of how approaching young people in a different way can meanthat they 'might take the right messages away, might not end up neglecting their health needs, damaging themselves' (MA, General). For these professionals working with young people required a specific mind-set and skill-set.

At its simplest level this often involved the ability of the professional, or professional across an MDT, to communicate effectively, listening carefully to young people about their health needs and asking them questions, often tied to the dimension of the HEEADSSS assessment tool,[216] about their broader social situation in order to determine how the these fitted together. It was an approach that centred on going beyond strict medical issues or focusing solely on chronological age, to consider a range of psychosocial issues impacting the young person given their stage of development. As such, care is contextualised with a wide variety of information surrounding the patient's life, including educational, vocational, social, and friendship and family issues, exploring the normal 'risks' a young person faces. Such information is used by teams to generate an appropriate context for effective communication or to organise consultations in a particular way, including appropriate health education and support for self-management.

Providing an appropriate service for young people is often a deeply rooted value for these individuals and groups. The 'You're Welcome Quality Criteria'[94] were generally well known, including core issues such confidentiality and consent, joined-up working, transition and accessibility. So, for example, some schedule some of the clinics to start in the afternoon and extend them into the evening to enable young adults to arrange their appointments to suit their college or work schedule. Within the context of adult care, DNA was a prevalent issue in some of the clinics. Ways of dealing with this seemed to vary from clinic to clinic and across organisations, as policies regarding DNA may vary. However, we were told about what was referred to as, 'a softer approach to the DNAs'

> The Trust ruling of one strike and you're out, we don't adhere to, so we will give them multiple attempts to come into clinic … since as we don't actually put them as a DNA, because they just booked in [the consultants] calendar but we don't actually book it on the system so they don't officially come as a DNA … So I'll make informal appointments with the young people and then, when they arrive we book them into clinic, so that way they don't DNA (HP, Adult).

Working creatively with the existing norms, rules and resources was typical of individuals and groups that had bought into the idea that young people need to be recognized as group with specific needs and approaches.

What we observed across all the organisations was 'lots of great pockets of work' as some specialties, teams, people or spaces seemed to offer very strong young person orientated care. However, not all people or services felt it relevant to make 'special arrangements', but choose instead to treat them like 'an ordinary patient'. Alongside this, the uneven distribution of resources within and across specialties can create inequities of care.

> There are … areas in the hospital who, because they have more funding or they're funded in a different way, they might have a youth worker because it's part of their team and just for their team. They might have a psychologist who is just part of their team, social worker. … it very much depends on what speciality you're unfortunate to fall into, depending on what illness you've got as to what service you then get. … So, if you were a liver patient, you've got access to more services that if you were a medical patient. That's not appropriate. … We should be offering the same service to everybody that comes through the doors. (HP, Paediatric)

However, resources are not the only source of inequities. In part the inequities in skills and experience across the organisations seem to be self-sustaining within organisations. Centrally, those with an interest, the 'enthusiasts', are embedded in an informal network of care.

> we've now got a group of interested people across the Trust. So if a young person comes to me and they've got a, a joint problem, but they've also got a bowel problem, I know which bowel consultant and which bowel nurse will be the most appropriate to send them to, which chest doctor, which chest nurse will be the appropriate. Um, so we've got a good group of people across the Trust that we can actually send these youngsters to who've got more awareness of the issues that they could have (HP, General)

In this way, an informal knowledge economy of young person friendly practitioners and practices exists within the organisations. These are networks of trust. These referrals help to create, sustain and reinforce the network over time. This practice also exists across organisations, as practitioners, especially in terms of the transfer of young people to adult services, will seek to refer the young person to specific organisations, clinical teams or individuals over others – as this early field note illustrates:

> they refer to known doctors from this or that hospital as being more 'appropriate' or 'adolescent friendly' for the patient being discussed, it's as if they are able to assess the suitability of a professional based on some not evident informal knowledge that I am not aware of at this point. (Paediatric)

Adolescent-minded practitioners refer to other adolescent-minded practitioners – in this way, they work to actively avoid referring young people to those less adolescent minded practitioners. As such these people then gain less practical experience with managing these patients, and so less chance to reappraise there values and commitment to working with young people in new ways, as well as to develop the right mix of skills.

We also see an informal network in terms of spaces, as well as, people. At each site, at least one specific ward was known to offer more young person friendly care. They are seen as repositories of key knowledge and skills, able to manage the potentially unruly, undisciplined, teenage other.

> We were getting so much inquiries regarding adolescents from the other wards, even just for the basics. So, they would ring us and say, 'We can't get them out of bed in the morning'. You know, 'they just want to stay in bed all the time and they don't want to interact with anything'. So we would say, 'Well then you have to be stern, you know, you have to tell them, 'This is the plan,' you have to do a contract with them and agree with them that if they get over this time, then they can do this at this time' (HP, Paediatrics).

Such wards were not only required to offer basic advice to teams on other wards, but were also called onto to manage more complex issues. For example, when a young patient was self-cutting, the ward staff panicked and sought to move the patient to the more youth-friendly, or rather youth-experienced, ward.

> instead of sort of accepting that everybody has these patients throughout the hospital because this is just another component of young people's care, they are not just a regular like thing, they've got other parts to them as well and about holistic approach. There was quite a bit of panic and, 'This patient needs to get off our ward immediately,' (HP, Paediatrics)

The immediate reaction was to move the teenager. It is not only that 'just different wards have a different tolerance', but rather that different wards and teams, develop, over time, different young-person orientated understandings and different sense of what is legitimate work, as well as young-person friendly skills, competencies and routines.

> in some situations, we've had patients on our general wards where the parent has wanted to stay. And we, my nurses, would find that very strange. But actually, in oncology, that would not be strange at all. Because … [they] would be used to that, even a patient could be 22, 23 and still may want their mum. But they're not exposed to that in the main wards because they only see bits of the journey as well. (HP, Adult)

Centrally, exposure to working with young people was a central resource to enable them to become seen as just another young patient, over a set of unknown and unexpected concerns. Exposure offers a chance to adjust expectations and develop new skills.

Across all three sites, local networks of people, teams and spaces, work to enact services tailored to the specific needs of young people. They work to integrate biological, psychological, social and vocational issues across MDT and offer specific services and spaces for young people. Developmental assessment is used to inform aspects of service delivery and they seek to offer appropriate and timely health education and support for self-management. However, in all the sites, such DAH is unevenly distributed. Some people or services feel no 'special arrangements' are required. Some services are perceived as being overly- or under-invested. In this way, inequities of care for young people exist within each organisation. Informal networks of trust existed within each site, where certain people, teams or spaces were understood as having the right skill-mix, or mind-set, or access to resources, to work effectively with young people. As a young person moves through an organisation, the preference is to direct them to those people and spaces that are known to have an interest in young people. Albeit for good clinical reasons, this can mean that some of the inequities in skills and practical experience across the organisations can be self-sustaining. A lack of meaningful exposure to the care of young people, can also mean a lack of a chance to reappraise values and reconfigure practices.

(In)formal cultures of training

Within each of the organisations there were different ways in which the young people enthusiasts or champions met and supported each other collectively. They took the form of both formal and informal groups. Essentially, these groups were a collective effort to promote initiatives to raise awareness across the organisations, create change, offer support and, importantly, learn from each other outwith their team, area or specialty.

> 'I have nothing in writing in my job plan that says I specialise in young people. … The training that I've had is training that I have thought that I need. Nobody said, 'If you want to be a young adult person, you need to go on this'. It's just something that I became aware of through organisations or talking to people. So, it's all quite ad-hoc rather than really, really planned. And it's just really by hearsay and talking to people and networking throughout [this organisation] over many years.' (HP, Paediatrics)

Without any formalised professional routes available to people, the local, regional and national special interests groups became a central resource in supporting young people focused training across the organisations. Training in how to communicate effectively and around the needs of young people was seen to be an important component of effectively delivering DAH as well as an important driver to raise awareness and create change across the organisations.

In two of the sites, the only initiatives involving training around young people that we were aware of originated from their respective special interest groups in the form of yearly organised study days. At one of these sites, there was a policy initiative explicitly around transition, yet no specific training had been organised. It is worth noting that, focusing on young people in relation to transition means a focus on young people with long-term conditions, over a broader focus on the experience of all young people that enter the organisation. At the other, development of a formal policy was said to be 'not a priority for the trust'.

> Priorities are the front door, A&E, CDU, waiting times and, it's those things that they are being judged on.
> Interviewer: Why do you think this is not a priority at all?
> Just because they've got bigger fish to fry … I mean if you sat them down individually and talk about it they would be very, they are, very supportive. But it's not a priority for the [organization] because of all the other things by which they are measured. And young people's care isn't on that list. (MA, Adult)

In the current context of the factors that drive organisational change at this site, creating further engagement and buy-in from senior management was not seen as a practical solution to enable change. As such, issues about the care of young people remained focused in the informal, organisation-wide group, of young people's champions. As we discovered during our fieldwork, not everyone interested in the care of young people in that organisation was aware of the existence and work of that group.

Even within the group, they were often surprised by the number and range of young person-orientated initiatives that were occurring within the organisation.

However, at one site we did observe specific training around the topic of DAH being planned and delivered. A DAH strategy emerged as the result of the work of a number of key people who sat on a transition strategy group. The group comprised of managers, clinicians and allied healthcare professionals who meet every couple of months and who all had a particular interest in the healthcare of young people and transition. There was strong cross over between managerial and clinical levels and they worked to actively foster communication and create connections across services in order to highlight the issue. In this way, the ideas emerged from the local special interest group, but centrally the dissemination was targeted well beyond the special interest group. Part of this involved looking where change was currently occurring within the organisation and 'where the energy within the Trust at the moment is', alongside the broader national, governmental, agendas on young people's health, in order to harness that momentum and get people involved.

Training at this site was very much linked to the development of a DAH strategy and consisted of 'delivering key messages' from various government policy initiatives, especially the 'You're Welcome Criteria'.[94] It was positioned both in management meetings and in training sessions as 'just … good holistic healthcare'.

The focus of the strategy, and concomitant training, was on organisational level factors (e.g. staff appraisal includes training goals around young people; provision of age-banded clinics) clinic and consultation level factors (e.g. signpost sexual health, drug and alcohol services; copying letters to young people) and training and awareness factors (e.g. adolescent development; confidentiality).

This programme of training had senior management support, albeit initially from within child health, alongside access to resources. Using money to 'back fill' was seen as a key component in the success of the roll-out of training, as without this, departments would not only be unwilling but also unable to release staff for training. For example, some training sessions, were focused on raising awareness of basic issues.

> Last year we did, um, we did ten days, so ten individual day sessions for training in adolescent, basic adolescent health. Basically to increase awareness across the [organisation] so as to make sure it wasn't just the, the chronic illness patients that were being looked at … but it was the patients coming through A&E, coming through X-ray. And so we had members of staff from all over the [organisation] came on these training days. So it could've been a radiographer taking an X-ray, um, it could've been a nurse in theatre, it could've been a, a nurse in, um, A&E, just to get them aware of what a young person's needs are and why they're different to being an adult [HP, General].

In this way, central norms and practices of good, everyday care for young people were distributed well beyond the local existing networks of people, teams and spaces of young people's champions. The initiative emerged from, and depended on, their enthusiasm and expertise. The network of trust of young person friendly practitioners was then supported by key actors within wider management. This led to an on-going programme that sought to make the young people's healthcare visible across the organization, to begin to get to people to reappraise values and commitment.

Discussion

Our findings reveal the everyday working practices of something like a discipline of adolescent medicine-in-action without a formal professional or organisational status as a 'Discipline'. Across each organisation a complex distributed network of young people minded practitioners understood the potential value and worth of practices and services for young people, such as DAH. These were people committed to working with and for young people, to enacting adolescent medicine, to enacting DAH, within consultations, clinics and wards. Within and across organisations, an informal knowledge economy of young people friendly practitioners, practices and spaces exists. People have a preference for referring to other young people friendly practitioners or spaces, to others within the networks of trust. Such referrals help to create, sustain and reinforce the network over time. Such networks also support and provide, through formal and informal means, the training and development around young people's health.

In this way the concept of DAH is being normalised as networks of people within each hospital make sense, buy-into, enact and reflect on and adapt it. Clearly, the enactment of DAH is fluid - both present and not, both excellent and not - within and across professional, organisational, ward and team boundaries. It is largely sustained and (re)enacted by a distributed network of informal ties, knowledge and practices. However, the very definition of DAH, its organisational and policy relevance and its resource and spatial allocation, are contested issues within and across hospital settings. To move beyond normalisation of DAH for a few, to normalisation for an organisation, we need to move beyond the informal cultures of training and good practice. At one site, providing a trust-wide strategy and training on organisational, team, clinic and consultation level factors as well as training and awareness factors offered such an opportunity. It relied on buy-in and formal support from senior managers in both adults' and children's services to initiate and sustain it over time. The WHO recommendations to achieve adolescent-responsive health systems,[106] highlight the centrality of service delivery and workforce capacity issues to achieve successful integration and consistency of health services for all young people within and across organisations and levels of care.

There is also a need for strong and clear guidelines, strategies and policies on the practical implementation of DAH. At the end of the fieldwork, guidance appeared in the UK around the need to implement DAH in relation to transitional healthcare.[14] However, such a focus on transition and transfer has important limitations. Currently, the guidelines are concerned with young people with long term conditions whose care is planned at the clinic and team levels within a specific speciality. However, not all young people attending hospital services will have a long term condition. Some will follow acute, emergency or surgical pathways. Young people with long term conditions will often experience care in various settings within an organisation, whether that be as an in-patient, out-patient, day-case or in other departments such as radiology, pharmacy or investigation suites. As we saw, normalisation of DAH for a few, introduces inequities. The potential normalisation of DAH around transition and transfer may reduce some inequities, but may sustain inequities in the access and provision of DAH care across an organisation.

Limitations

The selection of ethnographic methodology is a major strength of the study as it facilitated the immersion of the researchers into the organizational culture of each hospital, enabling them to observe and examine the process and practices in context. A limitation was that only three sites in two UK regions were studied. However, a significant number of staff participated and a wide range of settings were encompassed including outpatient, inpatient and emergency care. Furthermore, although the hospitals involved had a history of championing research and innovative service provision for young people, this did not include a defined adolescent medicine service and participating areas and/or specialties were at different stages of familiarisation with providing DAH, thus providing the study with breadth and depth of experience. We think, therefore, that we captured a broad range of relevant views but it is likely that not all were covered. Similar work in a comparator group of hospitals who did not have the same history would be of interest. Other limitations, such as the UK scope of the study and the hospital-based (non-community) sampling of professionals, should be addressed in future research.

Conclusion

Currently there are a wide variety of definitions of DAH within the literature and across clinical and managerial staff. There are conflicting views on the value and worth of DAH. Youth-friendly practitioners and managers, be they working in a formal or informal capacity, are initially key to raising the profile DAH. To move beyond pockets of good practice to services responsive to young people buy-in and formal support from senior managers in both adults' and children's services is central. Providing a trust-wide strategy and training on organisational, team, clinic and consultation level factors is key.

WP 3.1 Interview schedule: clinician manager
Interviews
Implementation of Developmentally Appropriate Healthcare in an Organisation (IDAHO)

Note: The interview schedule is developmental. The questions will be developed from the findings of the observations. The questions will need to be tailored to the specific answers of each interviewee. The interview schedule given here is therefore a general topic guide for the one-to-one qualitative interviews.

Plan of interview
Setting
Staff member will choose setting – mainly hospital room

Introduction
Explain purpose of the study and this interview and that it is the first of two or three.
Explain interview recorded but details will be confidential.
Explore any questions or concerns?

About you
Can you just explain what your role is?
How long have you been working in this role?
What where you doing prior to this?

Definitions
The WHO defines 'young people' as those aged 10 to 24 years old, 'youth' as those aged 15-24 and adolescents as those aged 10 to 19
What types of distinctions do you make?

How would you define 'developmentally appropriate services'?
And specifically in relation to young people?
What do you think are the key aspects of developmentally appropriate services for young people?

How would you define Transition?
What do you feel are the key aspects for a successful transition?

Trusts wide issues
Do you feel that the Trust as a whole is particularly young people friendly?
Are young people are priority for the trust?

Are you aware of any Trust wide strategies promoting developmentally health care for young people?
Where did you first hear about them?

Have you heard of the 'Trust Transition Strategy'?
Has this been discussed in your governance meetings?

Your service
Roughly what percentage of your service provision (in patient /clinic) do young people make up?
Those aged 10–19?
Those aged 16-24?

Do you feel that the in your service is particularly young people friendly?
Are young people are priority for your service?
Is there a 'young person's champion' in the speciality?
Are they formally recognised (i.e. in job description/within Trust?)
Or are they only internally recognised?

Does your service offer specific services for young people?
What are they?
Which of these focus on transition?
How developmentally appropriate do you think they are?
Are you considering developing them?
In what ways?
What's been successful/unsuccessful?
What do you feel are the key barriers?
What are the key drivers?
Are staff supportive?

What steps have been taken to introduce/further develop services in line with the Trust Transition Strategy?
What's been successful/unsuccessful?
What do you feel are the key barriers?
What are the key drivers?

Do you think the roll out of developmentally appropriate services should be a priority for your service?
What priority should be given to those focused on transition?

Are you aware of the Department of Health 'You're Welcome' accreditation and are you considering using this?

Feedback
Have you had concerns / complaints / compliments about your services for young people?
From young people themselves?
What issues did they raise?
How where they managed?
Did any change happen as a result of this?

Are young people involved in the design and evaluation of your services?
What issues did they raise?
What impact have they had on your service provision?

Training and support
Have your staff had any specific training/CPD about working with young people (as distinct from the care of children)?
How useful did you find it?
Is training ongoing?
What, if any, further training do you feel they need?

Have your staff undertaken the Trust in house awareness raising programme on the needs of adolescents?
How useful did they find it?
Do you know if they apply it in their day-to-day practice?

Finally, we need to understand whether the kinds of questions we are asking actually relate to the issues that you think are important?
Are we asking the right questions?
Did these questions allow you to talk about what was important for you?
Is there anything else you would like to tell me?

Thank you for taking part
Remind them that you will be contacting them about the arrangements for a follow-up interview at some point in the future.