Transition of young people with Diabetes Mellitus from Paediatric to Adult Services - Full Paediatric Clinical Guideline

Reference no.: CH CLIN D10/April 2022/v006

1. Introduction

This guideline explains the process by which young people with diabetes mellitus transition from paediatric to adult services.

2. Aim and Purpose

The aim is to provide smooth transition of care for young people with diabetes, ensuring that the young person is fully involved and informed of the process whereby they transfer from the paediatric clinic to the transition clinic to the young adult clinic.

Young people will be seen by the combined paediatric and adult diabetes team in the transition clinic prior to transfer to the young adult clinic.

The young person should always be at the heart of the transition process which must be flexible to their needs. The parents will be going through a transition of their own and the service should be sensitive to their needs and provide them support.

3. Definitions/ key words

Transition: a smooth process designed to ensure the coordination and continuity of health care (in this situation for diabetes) as young people move from the children's to adult services.

4. Main body of Guideline

Clinic sessions in Derby:

Approximate age group	Venue	Session
0-13 years	Children's outpatients	Wednesday afternoon
13-16 years	Children's outpatients	2nd, 4th and 5th Thursday afternoons
>16 years	Children's outpatients	1st and 3rd Thursday afternoon
>18 years	Young adult clinic, diabetes specialist nurse and dietitian clinics, Florence Nightingale Community Hospitals	

Clinic sessions in Burton:

Approximate age group	Venue	Session
0-16 years	Children's outpatients	Monday afternoon and Thursday morning
16-19 years	Adult Diabetes centre	Friday morning, monthly
>18 years	Young adult clinic, Adult diabetes centre	1st and 3rd Thursday afternoon

Principles of transition

- Young people should be offered sufficient education to enable them to manage their diabetes independently to the best of their abilities.
- Progress towards transition will start from annual reviews at the age of 13 years, with structured education to include a range of topics appropriate to age.
- The young person should be offered the choice of when they transfer from the transition clinic to the young adult clinic and this should ideally be at a time of relative stability.
- Transition should focus on what is positive and possible for the young person, rather than on a pre-determined set of transition options.
- We recognise that transition is particularly challenging for young people with additional needs and the transition plan will be adapted to best meet those needs.

Transition clinic

- An appointment will be made in the transition clinic at approximately 16 years of age depending on the young person's wishes, physical development and emotional maturity.
- Each young person will be offered a minimum of 4 clinic appointments per year.
- We encourage the young person to bring family or a friend to clinic, but aim to see them on their own for part of the consultation to encourage independence.
- Once established in the transition clinic, the young person will be offered written, verbal or filmed information regarding the young adult clinic prior to transfer.
- It is expected that all young people will have seen the adult diabetes specialist nurse (DSN) and/or adult physician prior to transfer to the young adult clinic.
- Consultations should be led by the young patient's concerns, but medical issues should also be covered for educational purposes. The health professional should support the young person to make decisions and build their confidence to direct their own care over time.
- Diabetes education will be offered either individually or in groups to cater for differing preferences. Each young person will have an individualised care plan consisting of a school/ college care plan plus 'action plan' concluding each clinic letter.
- Consider use of the 'Ready Steady Go' documentation for documenting transition for the individual young person.
- When a young person does not attend a clinic appointment, a further appointment will always be sent (and the patient contacted by telephone) and the team will follow the 'was not brought' policy for children and young people with diabetes mellitus (CH CLIN D13). If a second appointment is not attended, the paediatric diabetes specialist nurse (PDSN) will contact the young person to discuss any barriers to attending clinic.

- The young person will decide when they feel transfer to the young adult clinic is appropriate, but this will usually be around the age of 18 years. If the young person plans to move away for further education, they may prefer their diabetes care to be managed elsewhere and appropriate arrangement will be made from the transition clinic.
- The young person may be offered a 'virtual tour' of the young adult service before the first clinic appointment in order to orientate themselves if the clinic will be in a new environment.

Clinic assessment

Processes for measurement, near patient HbA1c checks and additional annual review monitoring will be conducted according to guideline CH CLIND04.

Personnel in clinic

- Patient (+ relative or friend)
- Consultant Paediatrician with an interest in diabetes
- Consultant Diabetologist
- Paediatric diabetes nurse specialist
- Adult diabetes nurse specialist
- Paediatric dietitian
- Access to Youth Worker
- Clinical Psychologist

In order to retain attendance at clinic

- Date and time of next appointment are usually sent in the post after clinic
- Text reminder of the appointment sent

Services provided by Paediatric Diabetes Specialist Nurse

- Continuity of point of contact for patients, acting as 'named worker' during transition.
- Advice regarding insulin regimes and doses
- Offer group / individual education in conjunction with Paediatric Dietitian and Adult DSN

Services provided by Adult Diabetes Specialist Nurse

- To work with the Paediatric DSN to build up relationships with the young adults to enable smooth transition to the young adult clinic. This could be done one-to-one or in groups working alongside the paediatric team.
- To explain to patients changes in expectations on transfer to the young adult clinic (biochemical, BP targets, frequency of appointments, more autonomy and responsibility)

Services provided by Dietitian

- Promote a healthy lifestyle to maintain a healthy bodyweight and image
- Individual dietary advice to maximise glucose levels in target range
- Ensure each young person with type 1 diabetes is trained in Level 3 carbohydrate counting (where appropriate) and aid the transition to the DAFNE programme
- Patient follow up offered at each clinic appointment and when clinically indicated between these appointments
- Be involved in projects related to food that promote independence and healthy lifestyle.
- Individual handover to adult diabetes dietitian as required.

Role of Youth Worker

- To encourage involvement of young people in a variety of activities to enable a smooth transition to adult services as assessed by improved attendance at clinic.
- To facilitate a forum where young people can become actively involved in the planning, development and delivery of the service.
- To signpost young people to services designed to provide advice, information and support.
- The youth team are able to provide 1:1 support and guidance to young people at home or in the community if they feel they require any additional support

Clinical Psychology and Child and Adolescent Mental Health

A Clinical Psychologist will usually be present in transition clinics to facilitate annual review psychological screening and offer consultation to patients as required. Patients above 16 years of age may have specific needs which are better met by the Child and Adolescent Mental Health Service (CAMHS) and referrals to this service can be arranged if needed.

Patients can also be referred to Clinical Psychology provided their transition to the adult service is not imminent. If a patient is currently accessing support from Clinical Psychology and they are approaching 18yrs, appropriate transition arrangements will be made so that psychological support can continue. This would currently involve signposting or referral to relevant community services, such as adult Improving Access to Psychological Therapy (IAPT) team, but it is anticipated that Clinical Psychology provision will also be available in the adult diabetes service in the future. Any outstanding needs will be raised with the adult diabetes service as part of transition to the young adult clinic.

Audit

There will be on-going review of glycaemic control and long-term complications as part of the

National Paediatric Diabetes Audit.

Patient satisfaction survey

Audit patients transferred to young adult clinic regarding attendance and outcome.

5. References (including any links to NICE Guidance etc.)

Diabetes (Type 1 and Type 2) in children and young people: diagnosis and management. National Institute for Clinical Excellence. Clinical Guideline August 2015, updated 2022. https://www.nice.org.uk/guidance/ng18

Diabetes in children and young people. National Institute for Clinical Excellence. Quality standard 125. July 2016, updated March 2022. https://www.nice.org.uk/guidance/qs125

Transition from children's to adults' services for young people using health or social care services. National Institute for Clinical Excellence. February 2016. https://www.nice.org.uk/guidance/ng43

Transition from children's to adults' services. Quality standard 140. National Institute for Clinical Excellence. December 2016. https://www.nice.org.uk/guidance/qs140

'Transition, getting it right for young people'. Department of Health. March 2006.

Making every young person with diabetes matter. Department of Health. April 2007.
NHS England Diabetes Transition Specification. January 2016
https://www.england.nhs.uk/wp-content/uploads/2016/01/diabetes-transition-service-specification.pdf
https://www.digibete.org/goals-diabetes-resources/

Trust Policy for the transition of young people with long term conditions to adult services
opac-retrieve-file.pl (koha-ptfs.co.uk)

6. Documentation Controls

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Training and Dissemination: Discussed at MDT meetings				
Development of Guideline: Tracy Tinklin **Job Title:** Consultant Paediatrician				
Consultation with: Dr Emma Robinson, Dr Mohamed Bakhit, Dr Richard Lloyd-Nash, paediatric and adult diabetes specialist nurses, paediatric and adult dietitians, Youth Worker, Clinical Psychologists.				
Linked Documents: State the name(s) of any other relevant documents				
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