

Transition for Children & Young People with Diabetes Mellitus to Adult Diabetes Services at Frimley Park Hospital

Key Points

- Roles and responsibilities to provide the infrastructure for a good quality service
- Overarching Principles for smooth transition
- Transition Process
- Timings and age
- Transfer process into Adult Service at Frimley Park Hospital

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Key words: Diabetes, young people, young adults, diabetes transition

Abbreviations

NPDA	National Paediatric Diabetes Audit
PREMs	National Patient and Parent Reported Experience Measures

Transition Pathway

Age 12+ years:

Introduce the concept of transition to adult services at around age 12 years, depending on age of diagnosis, maturity and readiness of the young person and their parents/carers.

Start preparing the young person and their family for transition using the Novonordisk Educational Sheet.

**16-18 years:**

Refer to the joint transition clinic

"Transition Leaflet" given

A written summary of care is completed

**Transition clinic appointments:**

The young person will be seen by:

1. A paediatric diabetes consultant and an adult diabetes nurse, with the paediatric consultant leading the session with allocated dietitian/psychologist

Alternates with

2. An adult diabetes consultant and paediatric diabetes nurse with the adult consultant leading the session with allocated dietitian/psychologist

**Focus:**

Specific educational needs are explored and discussed.

Relevant education is covered and readiness for transfer is assessed.

An appointment in an adult diabetes clinic is arranged in a location to suit the young person, and contact details for the adult team are given.

If considered not ready, a further appointment in the transition clinic may be offered.

Recurrent non-attendance:

Consider fast track through transition period to adult clinic appointments

Teenage pregnancy:

Fast track pathway to teenage pregnancy unit and adult services

1. Transition Process

Transition is more than a physical transfer to adult services and should be well planned and co-ordinated. The young person with diabetes will need to have sufficient education and understanding to manage their diabetes on a day-to-day basis, independent of parents and staff, plus an acceptance of their own active involvement in their care in order to function effectively in the self-care model of adult services. Preparation is essential and must begin well before the anticipated transfer time. It should be the premise that transition will eventually occur, and the concept should be discussed regularly, so that it is seen as a normal part of growing up. An idea of likely timings and events should be worked out with the young person in early adolescence. The young person should be given increasing levels of information and responsibility throughout adolescence, dependant on their ability and developmental stage.

Everyone's need for information and education must be assessed. Educational interventions should include:

- Understanding of the condition and treatment.
- Recognizing deterioration of control and taking appropriate action.
- How to seek help from healthcare professionals.
- That some aspects of diabetes care will change at transition, e.g., short-term blood glucose targets.
- Information on young people's healthcare rights and effective ways of managing potentially difficult situations.

It is recommended that an individual health plan is offered to all young people that identifies their current and future needs to ensure that all educational needs are met during the transition process. This should be developed in conjunction with the young person and their family.

1.1 Principles

Both young persons and their parents need to be prepared for transition and eventual transfer.

Young persons should ideally be transferred to adult services when they have completed growth and puberty and have the necessary skills to function independently. When this is not possible due to cognitive impairment and/severe disability, appropriate advocacy and care should be ensured prior to transfer.

Transition planning must begin well before the anticipated transfer. Young persons should be helped to take responsibility for medications from as early an age as appropriate. Their parents should be encouraged to help them to do so.

1.2 Timings & Age

Timing of transition is multifactorial and therefore must be flexible and not just restricted to age criteria. Timing of transition and transfer may depend on:

- Chronological age
- Maturity
- Independence
- Readiness of the young person and the parents(s)
- Availability of adult specialist MDT (Multi Disciplinary Team)

Preparation of transition clinic transfer is started at 12 years with appropriate educational targets. Actual attendance to transition clinic commences at 16 to 18 years. At age 18 years, transfer to

adolescent clinic is made. This clinic happens on the 3rd Thursday of the month. The young person is to be given the opportunity to be seen independently of their parents should they wish.

Young person with complex medical problems, learning difficulties, etc., may require later transition.

1.3 Venue

All clinics are held at Frimley Park Hospital Children's Outpatients.

Two separate waiting areas are designed to ensure patients are waiting in the Teenage Waiting Lounge.

1.4 Transfer process to adult service

The Paediatric Diabetes Nurse Specialists start discussion regarding adult care, expectations and realities of the service available and address any concerns the young persons may have about these.

Consider sharing information leaflets on driving, employment, travel, contraception, alcohol, rights and roles, etc. Digibete is a valuable resource that is used.

The young person will be seen by the adult and paediatric consultants alternatively before being finally transferred to adult service. An annual review will be completed annually.

2. Consultation and Development of Guideline

The Paediatric Diabetes team consulted with many individuals, representing a wide variety of both staff and patient groups.

Team members included in the guideline are:

Chief of Paediatrics
Consultant Physician Endocrinologist
Consultant Paediatricians with Interest in Diabetes & Endocrinology
Paediatric Diabetes Specialist Nurses
Adult Diabetes Specialist Nurses
Young persons and their parents who use the service

A PREM patient satisfaction survey was a national survey annually undertaken to give service users the opportunity to comment on the current level of service and comment on any future improvements that we might undertake.

2.2 Approval and Ratification

A pathway has been completed for this guideline and submitted with the final draft for approval and ratification.

This guideline was reviewed and approved by FHFT Clinical Governance Committee/Group on 18/01/2023

3. Review and Revision Arrangements

3.1 Review

This guideline will be reviewed every 3 years unless clinically necessary to do so earlier.

A Transition Guideline Review Meeting will be held at least annually to allow for amendment and updating of the guideline, to discuss audit data and service improvement matters.

3.2 Revision

There are no revisions; the pathway remains the same as before.

4. Dissemination and Implementation

4.1 Dissemination

This transition guideline will be distributed to the Paediatric Diabetes Team and Adult team. This will be presented at the Paediatric Clinical Governance Board.

A Plan for Dissemination of Procedural Documents has been completed and submitted with the final draft for approval and ratification.

4.2 Implementation

All clinical staff who are responsible for carrying out this guideline will have received relevant training as part of their specialist qualifications.

Copies of the information leaflet are available in all relevant locations in outpatients.

5. Monitoring

The matrix below identifies all the monitoring of this guideline which will be carried out, how this will be done (e.g. audit), frequency, who is the lead person responsible for ensuring that the monitoring is carried out, where reports from monitoring are reported, who (individual / group / committee) is responsible for ensuring that any gaps or deficiencies are recorded on an action plan which is followed up and who is responsible for ensuring that implementation of any changes which follow the action plan completion are implemented and, where appropriate, information disseminated within the Trust to enable learning from the experience.

Any deficiencies identified during monitoring will be recorded and reported to the Transitional Diabetes Lead. The nominated persons and, ultimately, the Clinical Risk Committee, will be responsible for ensuring that an action plan has been developed, is followed through, all required actions taken to remedy the deficiency/s identified and, where appropriate, information disseminated within the Trust to enable learning from the experience.

What will be monitored and/or Standard to be Achieved	How/ Method	Frequency	Lead	Reported to	Deficiencies/gaps recommendations and action plans followed up by	Implementation of any required change responsibility of
Quality of Service Provision	NPDA Audit	Annual	Consultant Paediatricians responsible for Diabetes	Trust Audit team and Medical Director	Quality & Risk Committee	Transition Paediatric Diabetes Team
Patient Satisfaction	PREM	Annual	Consultant Paediatricians responsible for Diabetes and Paediatric Diabetes Specialist Nurses	Paediatric Diabetes Steering Group	Quality & Clinical Risk Committee	Transition Paediatric Diabetes Team
Education/Training of MDT	Attendance Records	Annual	Consultant Paediatricians responsible for Diabetes and Adult /Paediatric Diabetes Specialist Nurses	Paediatric Diabetes Steering Group	Quality & Clinical Risk Committee	Transition Paediatric Diabetes Team

6. References

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National Service Framework for Children Standard for Hospital Services.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/199953/Getting_the_right_start_-_National_Service_Framework_for_Children_Standard_for_Hospital_Services.pdf) (Accessed 26/01/2023)
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Version Control

Version:	2.0
Guidelines Lead(s):	Dr Elizabeth George, Lead Diabetes Paediatrician Dr Rasha Mukhtar, Lead Adult Diabetes Physician
Contributor(s):	Carolyn Hill, Lead PDSN Caroline Martin, Trust Transition Lead
Lead Director / Chief of Service:	Dr Rekha Sanghavi, CoS for Paediatrics and Neonates
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This guideline has been registered with the trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt contact a senior colleague or expert. Caution is advised when using guidelines after the review date. This guideline is for use in Frimley Health Trust hospitals only. Any use outside this location will not be supported by the Trust and will be at the risk of the individual using it.

Version Control Sheet

Version	Date	Guideline Lead(s)	Status	Comment
1	2015	A Malik	Final	
2	2023	E George/R Mukhtar	Final	

Related Documents

Document Type	Document Name
Operational Policy	FPH Paediatric Operational Policy
Annual Report	FPH Paediatric Annual Report