NHS
Greater Manchester and Eastern Cheshire
Strategic Clinical Networks

Greater Manchester Diabetes Transition Strategy Draft Objectives

12 September 2023

Introduction

The NHS in Greater Manchester is working on a plan to improve care for children and young people when the transfer from children to adult diabetes services.

We are sharing our ideas with you to get your feedback on the proposed plan, specifically around the main objectives. We want to make sure that it covers all the important things it needs to.

The six objectives below highlight the main areas the strategy document will concentrate on and how these will be delivered.

1. Ensure every young person with diabetes who can participate in decision-making be involved in discussions and make informed decisions about their diabetes care.
2. There will be a designated Diabetes Transition Team with appropriate infrastructure and key professionals identified to support the transfer of every young person from children to adult diabetes services.
3. All staff involved in diabetes transition and transfer of care will have training and support to enable them to care for young people and manage transition of care effectively.
4. Every young person transferring across to the adult diabetes team will have a diabetes transition programme and documented transition plan to ensure relevant professionals have access to essential information about the young person's transition journey and needs.
5. Every young person with diabetes who are at higher risk of disengagement and complications to be identified during transition and following transfer to adult care.
6. The organisation will work closely with primary care colleagues; Integrated Care System, voluntary sector organisations, schools and colleges, local networks, other health and social care providers, Integrated Care Board and Greater Manchester Local Care Organisations, offender's team to ensure the Diabetes Transition process is inclusive and efficient.

These objectives are draft and may change depending on the feedback received.

Draft objective one

Ensure every young person with diabetes who can participate in decision-making be involved in discussions and make informed decisions about their diabetes care.

How we will achieve it:

1. Involve the young person and their family in their transition and transfer plan early in their clinical journey, utilising locally developed or adapted programme documents and treat them as equal partners in the process.

2. Involve the young person in decisions related to their current and future use of diabetes technologies (e.g., continuous glucose monitoring, insulin pump) and other therapies.

3. Utilise youth forums which has representation from young people for peer support, and digital programmes to support diabetes self-management in young people (e.g., DigiBete, Diabetes My Way).

4. Acquire feedback from the young person whether the transition process has helped them achieve their agreed outcomes and feedback these outcomes to the young person, their parents/carers and other clinical teams (e.g., primary care).

5. Review the transition planning with the young person on a regular basis (at least annually).

6. Perform survey among young people attending the service and their parent/carers for feedback on their experiences with the diabetes transition service.

Draft objective two

There will be designated a Diabetes Transition Team with appropriate infrastructure and key professionals identified to support the transfer of every young person from children to adult diabetes services.

How we will achieve it:

1. Each local organisation to identify individual(s) with responsibility to lead the diabetes transition team.

2. Each local organisation to review job planning and roles required for paediatric and adult diabetes teams to deliver diabetes transition as recommended by national guideline and Diabetes Transition Service Specification.

3. Each local organisation to support diabetes transition by providing infrastructure such as designated area and clinic space appropriate for young people.

4. Each local organisation to allocate key worker(s) for each young person to provide support and coordinate the delivery of diabetes transition. The key worker could be a diabetes consultant, diabetes specialist nurse, or other health care practitioner with whom the young person has a meaningful relationship. The key worker(s) will initially be someone based in paediatric services but will hand over their responsibilities and ensure relevant information such as any safeguarding concerns are shared to the professional in the adult diabetes service when appropriate.

5. Each local organisation to support diabetes transition by regularly participating in local/national audits of their care processes, outcomes, and other quality improvement programmes.

Draft objective three

All staff involved in diabetes transition and transfer of care will have training and support to enable them to care for young people and manage transition of care effectively.

How we will achieve it:

1. Ensure all staff involved have access to training relevant to caring for this population, which may include but not limited to signposting team members to a competency framework specific to diabetes transition issues.

2. Ensure all staff involved in transition have access to training (face to face and e-learning), dependant on need, which covers:

    - Effective communication with young people.
    - Young people's development.
    - The legal context and framework related to supporting young people through transition, including their rights to confidentiality, consent and safeguarding.
    - Special educational needs and physical disabilities.
    - Learning disability.
    - Autism.
    - Youth friendly health services.
    - How to involve young people, carers and families in their care, development of services and work in partnership.
    - Identifying a diabetes transition champion within the team.

Draft objective four

Every young person transferring across to the adult diabetes team will have a diabetes transition programme and documented transition plan to ensure relevant professionals have access to essential information about the young person's transition journey and needs.

How we will achieve it:

1. In consultation with the young person and their parents/carers where appropriate, to complete a diabetes transition programme and documentation (e.g., Ready Steady Go) to address outcomes including those related to specific diabetes self-management goals.

2. Review the documentation on an on-going basis to ensure it meets the needs of the young person and their diabetes care.

3. Sharing of the documentation and output with healthcare professional involved in the young person's transition planning.

4. Recognise that there is a possibility of the young person becoming disengaged with the diabetes team during this process and that there is a need to ensure shared records of care are maintained with both secondary and primary care. This may be through a comprehensive letter and plan to primary care, to enable primary care re-refer to adult services when the young adult is ready.

Draft objective five

Every young person with diabetes who are at higher risk of disengagement and complications to be identified during transition and following transfer to adult care.

How we will achieve it:

1. Engage with young people as individuals to discuss personal strategies that will enable them to reduce their risk of disengagement, complications, and unplanned hospital admissions.

2. Allocate additional support if the young person requires further input to mitigate their risk, either through clinical consultations or involvement of a Youth Worker.

3. Identify the support available to the young person, family or carer by signposting to resources which may include but not limited to e-learning/online digital programmes (e.g., DigiBete, Diabetes My Way), Psychology or Youth Worker service.

4. Establish a clinic database to identify/stratify at-risk individuals that can be integrated into local clinical pathways and policy (e.g., High HbA1c clinic, Diabetes MDT with Psychologist involvement).

5. Undertake regular audits of clinic attendance and waiting list of Transition Clinic (and Young Adult clinic if appropriate) to identify organisational challenges where changes and support are needed.

Draft objective six

The organisation will work closely with primary care colleagues; ICS, voluntary sector organisations, schools and colleges, local networks, other health and social care providers, ICB and Greater Manchester Local Care Organisations, offender's team to ensure the Diabetes Transition process is inclusive and efficient.

How we will achieve it:

1. The Diabetes Transition Strategy will be shared with all partners.

2. Systems and practices will be jointly reviewed to identify where changes and support are needed.

3. Engage and involve all practitioners providing support to the young person and their family or carer, including the GP.

Abbreviations:

ICS – Integrated Care System (The Health and Care Act 2022 is making it easier for organisations to work better with each other and the public to improve people's health, plan and deliver effective services while being as efficient as possible. Integrated Care Systems have been set up across the country to support integrated and more collaboration.)

ICB – Integrated Care Board (NHS Greater Manchester is the Integrated Care Board for Greater Manchester, and is responsible for making decisions about health services across Greater Manchester and in the ten boroughs and cities)

MDT – Multidisciplinary Team

GP – General Practitioner (doctor