Developing services for CYP with Type 2 Diabetes in Wales

CYP Wales Diabetes Network

Introduction

Dedicated Service for CYP with T2D

Development of structured education

Group Sessions

Development of the pathway

Tertiary Service

RCPCH NPDA and Us :Clinic Chats

"T1 get special things like a bear, a bag, stories but there isn't anything for T2. It would be good to get a T2 pack with a bag, video, an app, a booklet about food and suitable options."

"Doctor just told me I have to take medication, no leaflet or signposting I had to research myself."

"No real explanation, no additional information, had to find out on my own. Just told me about the medication."

WELCOME TO THE CHILDREN AND YOUNG PEOPLE TYPE 2 DIABETES SERVICE!

Our team cares for children and young people with type 2 diabetes. We are here to help and support you and your family through your diabetes journey! Whether you've been diagnosed recently or have had type 2 diabetes for a while, we hope that this leaflet provides you with useful information that you can refer to anytime.

WHAT IS TYPE 2 DIABETES?

When you were diagnosed, you may have received education on what type 2 diabetes is. This is a summary to help you remind you!

In type 2 diabetes, i
glucose or sugar in

Sugar cannot get int
in the blood go up.
you feel thirsty, tire
toilet m

RISK FACTORS FOR TYPE 2 DIABETES WHICH YOU CAN CHANGE OR REDUCE

Weight
Having a higher weight can contribute to type 2 diabetes.
Increasing lean (muscle) and

MEET THE TEAM OUR NURSES

MEET THE TEAM OUR DIETITIANS

Julie Lunn

WHAT CAN I EXPECT AT MY CLINIC APPOINTMENTS?

1. You will be greeted by our friendly clinic team!
2. Your height, weight, blood pressure and HbA1c will be measured.
3. You will see your consultant and nurse and chat about how things are going.
4. You may also see your dietitian and psychologist.
5. There will be time to answer any questions you may have.
6. At your annual review you will also be offered a questionnaire and a blood test

WHEN?
Usually on a Tuesday between 15:30-17:30, but may be at another time

WHERE?
Noah's ark Children's Hospital Outpatients

WHAT DO I NEED?
Bring your blood glucose meter and make sure your data is linked to our team

NSULTANTS

Ambika
hetty

Dr Rebekah Pryce

Structured Education

Currently Developing a Seren Type 2 education package!

Involving the whole family!

Idea: Spring 2012 –

Consensus to develop an "All Wales" structured education programme

that was adaptable to different environments and transferable between hospitals

-a multidisciplinary working group formed

Philosophy: To empower the CYP and family to manage diabetes in their journey from diagnosis right through and into adult services

S tructured E ducation R eassuring E mpowering N urturing

NICE (NG17) Type 1 diabetes in adults and children

Structured education programme *that is planned, graded and comprehensive*
"Available to all people with diabetes at the time ***of initial diagnosis*** *and then as required on an* ***ongoing basis, based on a formal, regular assessment of need****"*

- Structured curriculum
- Resource-effective
- Trained educators
- Quality assured
- Regular audit

NICE accredited
www.nice.org.uk/accreditation

- ✓ Curriculum
- ✓ Interactive age banded resources
- ✓ Health professional training
- ✓ Quality assurance
- ✓ QISMET accredited
- ✓ Evidence based
- ✓ Bilingual

SEREN

First standardised diabetes structured education programme for children in Wales- 2016

Structured Education For CYP with T2D Sections

- All about me and my family
- What is diabetes?
- Food and diabetes (carbohydrate awareness)
- Activity, sleep and screen time
- Well being and change
- Medication and Type 2 Diabetes
- Glucose monitoring (hypoglycaemia and illness)
- Expectations and goal setting

Activity 5.1

What does a diabetes 'diet' look like?
Tick the boxes that you think each statement corresponds with.

	Person with Type 2 diabetes	Person without Type 2 diabetes
Aim for a healthy balanced diet		
Eat enough food for sports and activity		
Eat 5 or more portions of fruit and vegetables every day.		
Choose wholegrain options where possible		
Aim to have 2-3 portions of milk (or dairy alternatives) each day		
Enjoy Ultra-processed foods, which are high in sugar / fat / salt occasionally and in sensible		
Take prescribed medication with meals or as directed by your doctor.		

People with Type 2 diabetes do not need to follow a special diet. Making sensible choices around food and nutrition is important for everyone, whether they have diabetes or not. However, some people may be advised on a more personalised approach to healthy eating and managing Type 2 Diabetes.

ctivity?

think about physical activity they think about exercise such as mill, sweating in a gym class or sports played in P.E lessons.

en and young people exercise can include being more playful, such ound in the local park, going to girl guides or scouts, walking and dog or friends, walking to and from school or college, riding a bike with mates, acticing netball or rounder's', dance, martial arts, gymnastics, drama, ny more!

ed activity, building activity into your day can be really useful!

as choosing to take the stairs over a lift, walking to the shops (rather than a bus), doing chores or housework at home, getting off the bus a stop earlier king the rest, doing a rise and shine stretch using a YouTube video, one/laptop time be sedentary; can you stand or do squats during the adverts, route or do wall push-ups at home whilst the kettle is boiling.

Can you think of opportunities to build activity into your day?

.....

.....

.....

⇒ Top Tip

- Walking after meals is particularly effective at reducing blood glucose levels.
- Look for opportunities to keep active across your day!
- Limit screen time to no more than 2 hours per day.

The Pathway

- **Aim** : Early intervention including structured education to improve understanding of Type 2 diabetes and empower patients and families to manage the condition.
- Improve outcomes- early identification and management of complications.
- Ensure transition to appropriate services takes place.

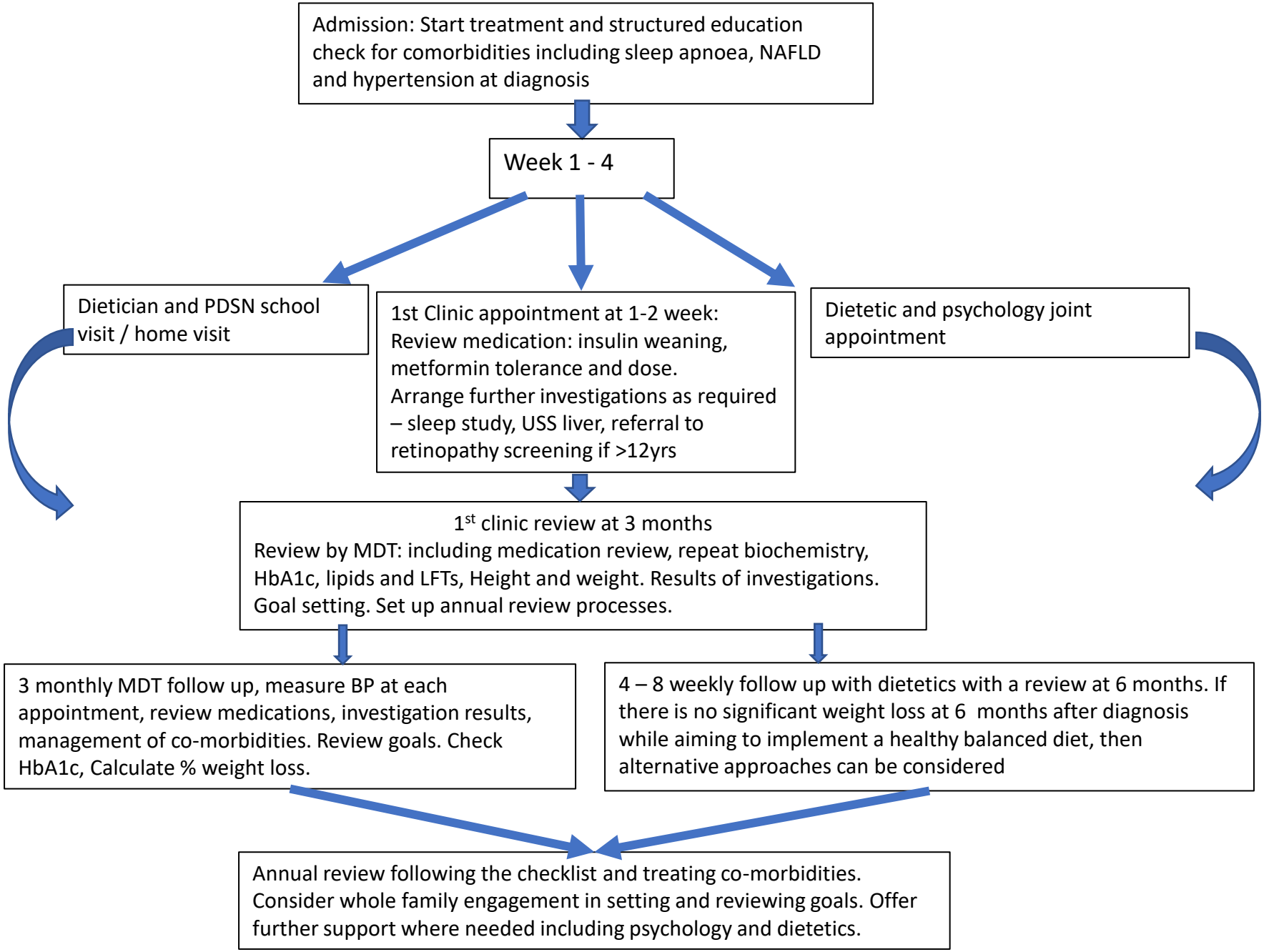
Key points from pathway

Clinical recommendations as per ACDC

- Diagnosis - admission
- Structured education
- Target HbA1c <48mmol/mol
- Dietary support to improve healthy lifestyle to facilitate weight reduction
- Exercise recommendations as per government recommendations 60 minutes of moderate – vigorous physical activity daily
- Mental health – access to psychological support

The Service

- Cohort patients into single clinic if feasible – named consultant for Type 2 diabetes
- Multi-disciplinary service within secondary –care diabetes service including access to dietitian and psychologist - with close liaison with primary care, adult diabetologists and multi-agency organisations
- Children managed within a weight management service may be managed in parallel with medical management of Type 2 diabetes undertaken by the diabetes team
- Standardise clinic sheets – or checklist for Type 2 patients to include – BP monitoring, urine, lipids, ALT, sleep apnoea


Admission: Start treatment and structured education check for comorbidities including sleep apnoea, NAFLD and hypertension at diagnosis
Week 1 - 4
Dietician and PDSN school visit / home visit
1st Clinic appointment at 1-2 week: Review medication: insulin weaning, metformin tolerance and dose. Arrange further investigations as required – sleep study, USS liver, referral to retinopathy screening if >12yrs
Dietetic and psychology joint appointment
1st clinic review at 3 months
Review by MDT: including medication review, repeat biochemistry, HbA1c, lipids and LFTs, Height and weight. Results of investigations. Goal setting. Set up annual review processes.
3 monthly MDT follow up, measure BP at each appointment, review medications, investigation results, management of co-morbidities. Review goals. Check HbA1c, Calculate % weight loss.
4 – 8 weekly follow up with dietetics with a review at 6 months. If there is no significant weight loss at 6 months after diagnosis while aiming to implement a healthy balanced diet, then alternative approaches can be considered
Annual review following the checklist and treating co-morbidities. Consider whole family engagement in setting and reviewing goals. Offer further support where needed including psychology and dietetics.

Monitoring at diagnosis

Bloods at Diagnosis: **HbA1c (point of care), U&E's, LFT (including AST and GGT), Antibody Bloods (GAD, IA2, ZnT8).**	
Blood Pressure	
Urine Albumin Creatine Ratio	
Referral to retinopathy (if over age 12yrs)	
Referral for sleep study - Refer for sleep study for those with BMI SDS +2 plus (at diagnosis)/or symptoms suggestive of OSA)	
Liver USS Referral	
Height and weight	
PDSN	
Psychology	
Dietitian	
Youth Worker	

1 – 3 months Review

Height and weight	
Blood Pressure	
Bloods: lipids, LFT's, ATL, AST, GGT (After first 3-month appointment LFT's then annual)	
HbA1c (POCT)	
% weight loss to be calculated	
Review of Sleep study if done	

Annual review checklist and PDSN, Dietician, diagnosis checklist.


Type 2 Diabetes
Family session 16th May


ily session 16th May

Next Steps

- Feedback from families and young people
- Draft pathway going through network approval
- Ongoing development of structured Education
- Tertiary clinic / service

Questions?

Thank you !!!