Seamless Diabetes Transition Programme

Trust Poster Pack

Children and Young People's North East and North Cumbria Diabetes Network

NHS North East and North Cumbria

Seamless Diabetes Transition

DigiBete

Improving the referral process within transition: Paediatrics to young adults: A QI project

County Durham and Darlington NHS
NHS Foundation Trust

Purpose: The referral process within paediatrics in CDDFT has been an ongoing issue with problems such as communication breakdowns, inconsistent referral process cross site, use of different IT systems for paediatrics and adults. This has resulted in delayed transition referrals and an unnecessary increase in workload for both paediatric and adult teams.

Background: County Durham and Darlington diabetes service covers a wide region as can be seen by the map on the right. The current caseload of transition patients within CDDFT is 137 patients .

Authors: Kelly Stobbart PDSN, Ashley Menhert young adult DSN
County Durham and Darlington NHS trust.

What have we done?

The transition from Paediatrics to young adult services are critical periods. Gaps in the referral process contribute to fragmented care, increased risk of unmet needs and then possible reduced engagement once in adult services. Our QI project aims to improve the timeliness and quality of referrals by collaborating to use the same systems.

Our team identified the inefficiencies in the current referral process. The main one being the use of various systems and Paediatric and adult teams not being able to see each others documentation.

Paediatric team to gain access to system one and have training

Template by Adult DSN shared to gain feedback

Next steps

Aim for all staff to be trained and have access to system one. Implement referral template

Gain feedback from both paediatric and adult team on the template to be used within system one for patient handover

Continue with transition meetings monthly. Meetings are recorded for those who cannot attend and this has been valuable to share ideas

Assess impact of QI project on timeliness and effectiveness for referrals to adults.

Conclusion

- Taking part in this seamless transition course has allowed our transition team to develop and work collaboratively in many ways as well as just within the realms of the QI project.
- The changes implemented for the purposes of the QI project may take time for the team to see an effect and any improvements
- The programme has made us as a team look at gaps in the service and how to improve on these, meaning better patient outcomes and experiences
- Challenges with the project have been the size of the caseload, the fact the service covers 3 hospital sites and engagement from the whole team

First Impressions Matter: A strategy for seamless introduction to the Adult Diabetes team

NHS North Cumbria Integrated Care NHS Foundation Trust

Why we chose this approach:

- Anxiety about the move to the adult service is a common theme picked up by the paediatric team as our young people approach the age of 18.
- Adult colleagues have picked up on gaps in the confidence of young people moving into their service
- Do we have the full picture of our young people and how do we know we are meeting their needs?

Current situation:

- Young people offered joint clinics with both teams in attendance. Clinics are run as a standard clinic with more MDT members. Not consistent over the two main sites.

Aim:

- To deliver a session where young people and their parents have a chance to meet the adult team outside of the clinic environment so that the relationship starts before first clinical engagement

How:

- We have had a successful primary school to secondary school event running for more than a decade, we can model our approach on this
- Are we going to meet the needs of our young people? To find out we engaged the patient experience team in the trust

A quality improvement project as part of the Seamless Diabetes Transition Programme 2025

Seamless Diabetes Transition

Result:

- Meetings held over Teams every Thursday at 2pm for about 15 minutes to plan and report back
- Transition event planned to take place each year after GCSE's for all our year 11 young people to start the transition process before they come to the joint clinics.
- First event planned for June 2026
- Draft outline of event started to map:
- Venue, personnel, resources, sessions
- Event planned to involve parent sessions on "letting go" and "supporting independence" facilitated by team Psychologist

Hurdles:

- Adult diabetes team have challenges in committing to process which has currently stalled at the stage of planning the event
- Past 4 meetings have not been attended by adult team

Future:

- Raise time commitment challenges to higher levels of management to get the process back on track
- Make a back-up plan so that if process of joint working continues to be a challenge, we can deliver the session with less input from adult team but with their presence on the day

A review of Type 2 Diabetes Structured Education AND Implementation of Contraception and Sexual Health Advice in Paediatric Type 1 Diabetes Clinics

The Newcastle upon Tyne Hospitals NHS Foundation Trust

THE great north CHILDREN'S HOSPITAL

The Challenges

It is known that there is a disparity between the education provided to young people diagnosed with type 1 diabetes, compared to those diagnosed with type 2 diabetes. Simultaneously, we acknowledge the lack of contraception and sexual health support for our T1 young adult population

The Objectives

To review the current education structure and obtain patient feedback to shape a new, formal education pathway for those newly diagnosed with Type 2 Diabetes.

Develop contraception and sexual health advice and support for within the Type 1 Diabetes paediatric service.

The Aims

Type 2 Patients

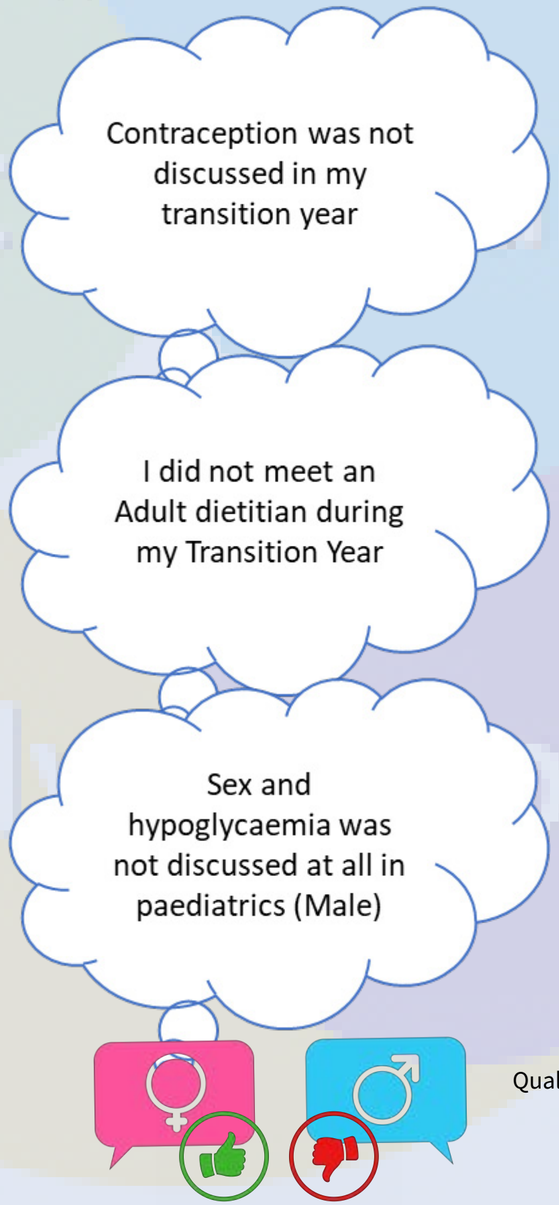
- Reduce HbA1c
- Reduce DNA rates

Type 1 Patients

- Raise awareness of the importance of sexual health and contraception

The Methods

- Patient survey to identify gaps in education
- Implement in paediatric, transition and adult clinics
- Review uptake and retention of patients
- Amend FYOC pathway to include new education
- Incorporate in discharge booklet



The Outcomes

We have begun to address the topic of contraception and sexual health with young people in our transition clinics (age 17-19) and are looking at bringing this topic into discussion for younger age groups so that it becomes a more open topic that can be re-addressed when needed

The Results

- Low uptake on feedback forms, especially from males
- Confirmed what we assumed, contraception and sexual health are gaps in education
- Started good conversations with young men around taboo of hypos and sex

Quality Improvement Projects as Part of the Seamless Diabetes Transition Programme

Seamless Diabetes Transition

NHS

Establishing a permanent diabetes transition clinic across two District General Hospitals

A Quality Improvement Project as part of the Seamless Diabetes Transition Programme 2025

NHS Northumbria Healthcare NHS Foundation Trust

PURPOSE

To provide a structured and patient-centred transition service from the paediatric diabetes to adult diabetes care at Wansbeck General Hospital with a view to replicating at North Tyneside General Hospital.

Ensure continuity of care and improve patient engagement during transition.

OBJECTIVES

This will -

- Improve clinical outcomes within this age group.
- Enhance patient experience and provide psychosocial support.
- Ensure we comply with NICE NG43 guidelines of transitional care.
- Improve our 'Did Not Attend' rates within this age group.
- Reduce diabetes complications within this patient cohort.

North Tyneside General Hospital (NTGH) Paediatric Service

Wansbeck General Hospital (WGH) Adult Service

1. Standard Operating Procedure
2. Meet and Greet
3. Structured Education
4. Pilot Clinics
5. Evaluate, refine, scale up clinics

MEET & GREET EVENT PLAN

- Location: education centre, outpatients or child health centre
- When: Avoid exam dates and holiday dates
- Information Leaflet: contact details of adult service in and out of hours
- Intro?: a video recorded message, work in progress
- Patient No's: 8 patients turning 17 in late 2025
- Entertainment: Food and drinks provided

STRUCTURED EDUCATION

Rather than assuming content, gather patient feedback on topics to cover, use QR code questionnaire and involve patients in development of structured education

Roll out DigiBete Young Adult codes and encourage all to download the app.

This will save time as clinically-approved resources are already developed.

PROGRESS TO OCTOBER 2025

- Draft Standard Operating Procedure prepared for transition clinic which includes clinic template with a view to start in early 2026
- Meet and Greet programme has been prepared
- Structured Education Programme is under review
- Plan to continue with monthly project meetings
- Transition highlighted with managers in adult services

North Tyneside General Hospital
Rake Lane
Tyne & Wear
NE29 8NH

Seamless Diabetes Transition

NHS England

Wansbeck General Hospital
Woodhorn Lane
Ashington
NE63 9JJ

Young person's voice

We asked, they said...

Emotional Wellbeing

5

Complications

4

Uni, College, Work

2nd

3rd

Cooking & Healthy eating

Driving

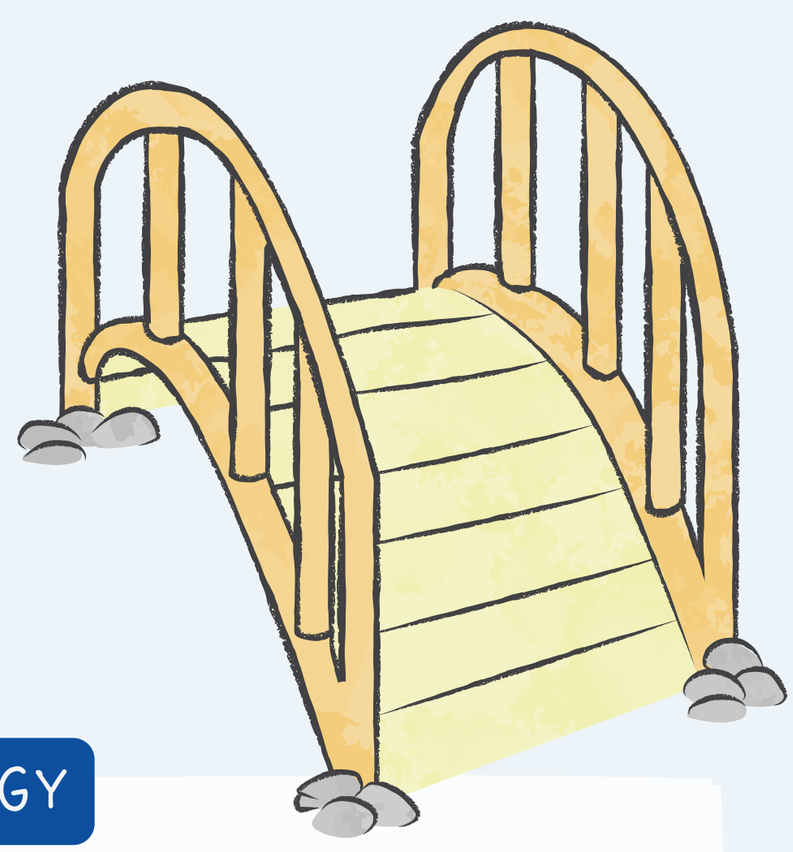
1st

63% said education in ...

NHS Gateshead Health NHS Foundation Trust

‘BRIDGING THE GAP’: TRANSITION FROM PAEDIATRIC TO ADULT DIABETES CARE

Dr Vani Balasubrahmanyam, Terri-Ann Moran, Hue Flannigan, Catryna Kemp, Dr Yasmin Tanfield and Dr Hanan Alaib



BACKGROUND

Team’s purpose and plan

• To have a more effective transition service, adapted to the needs of each young person.

Why we want to do it / make change

• Improve communication between adult and paediatric team.
• Improve patient transition journey.
• Reduce admission rate for transition age range.
• Reduce DNA rates at initial adult appointment.

METHODOLOGY

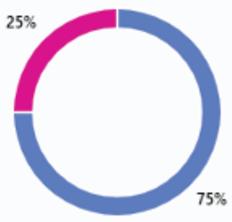
- Patient feedback: Collected from patients who transitioned in the last year. Questionnaire using Microsoft Forms utilising open and closed ended questions (quantitative and qualitative responses).
- Clinician feedback: Qualitative reflective discussions during and after clinic appointments.
- Audit: Data regarding attendance and diabetic ketoacidosis (DKA) admission rates one year pre transition and one year post transition for 15 patients. Gender: 6F; 9M.

RESULTS

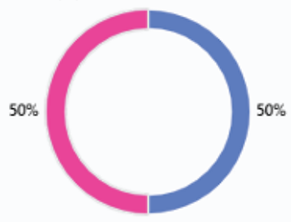
PATIENT FEEDBACK

Key: Blue: Yes; Pink: No

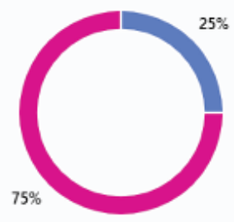
Did you feel prepared and ready to move to the young persons clinic?



Were your expectations of your first adult appointment met?



Do you know the nurse drop in contact numbers?



“Level of support in adult clinic is far less than paediatric clinic. Group session with dietician was not tailored to individual needs.”

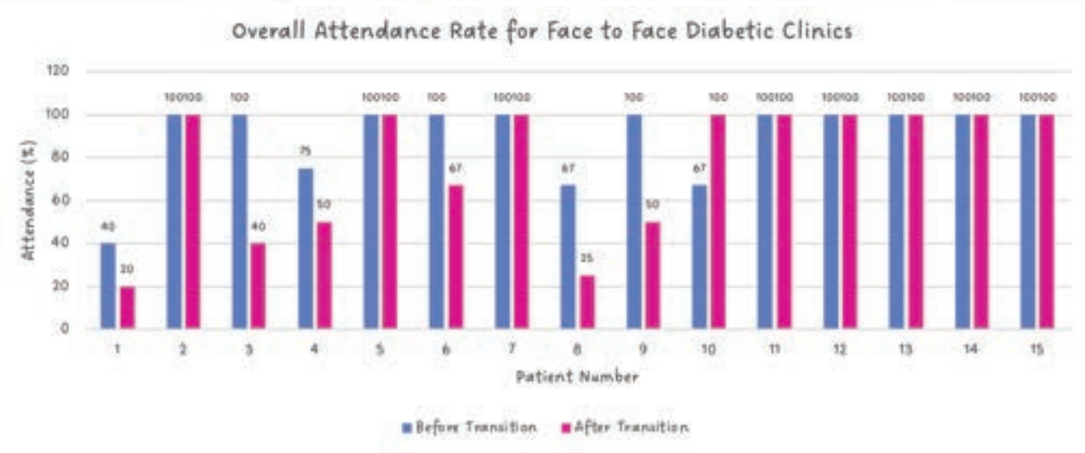
“we had a few appointments with children out patients then adults back with children now he with adults he seems happy…”

“There seems to be a problem with generating the next appointment after each visit”

AUDIT

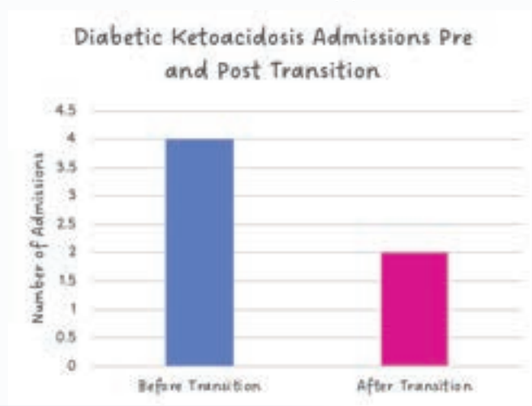
Table 1. Patient Demographics

Characteristics	Mean (SD)	Range
Age (years)	17.7 (0.62)	17-19
Age at diagnosis	9.8 (3.8)	3-16
Age at transition	16.5 (0.5)	16-17
Time to first adult appointment (months)	3.4 (1.2)	1.5-6



Diabetic Clinic Attendance

• Before transition: Average attendance was 91.4%
• After transition: Dropped to 86.5%



ADULT CLINICIAN FEEDBACK

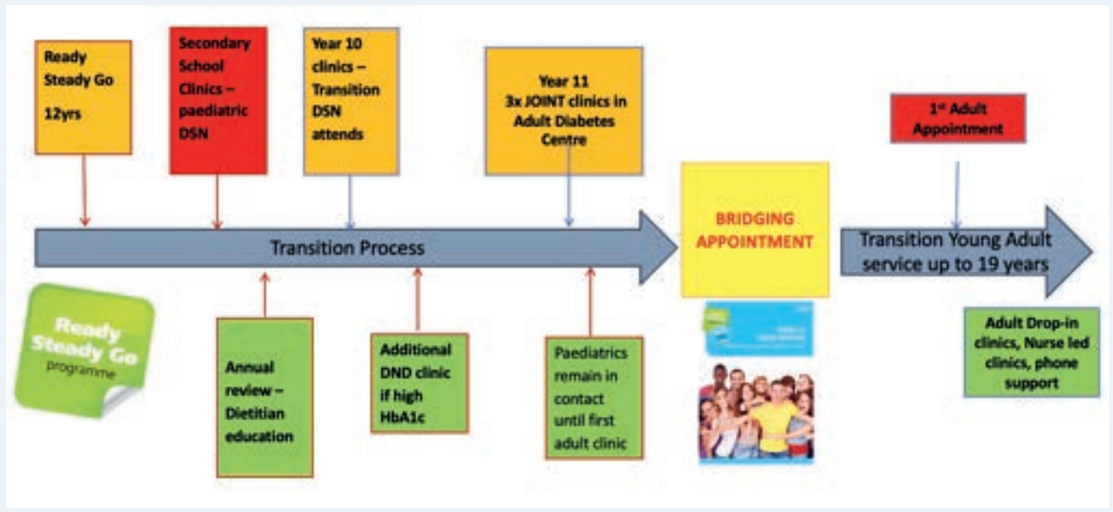
First appointment not efficient:

•Time taken to link technology to adult systems.
•Accessing and gathering relevant key information (annual review data).
•Clarifying additional needs and support.

NEXT STEPS

Deliver Bridging Clinic

- Preparing and supporting the young person towards their first adult appointment.
- Ensure practical aspects (e.g., technology, appointments) are completed.
- Ensure continuity of care with minimal delays in the first adult clinic visit.



KEY: Red: Not working well; Amber: Smaller issues identified; Green: Working well; Yellow: our new bridging clinic that ‘bridges the gap’

REFLECTIONS

The whole seamless transition Q1 project has improved:

- Communication and relationship between paediatric and adult team members.
- Processes e.g. transition letters, appointment bookings, transition nurse consistent attendance in year 10 clinics.
- The full team immensely benefited from the training on effective transition.
- Reinvigorated the team!

Seamless Diabetes Transition

SOUTH TEES CHILDREN & YOUNG PEOPLE’S UNIT

Bridging the Gap: facilitating early introductions in pursuit of a seamless transition.

University Hospitals Tees

Author: Kerry Camara Paediatric Diabetes Specialist Nurse/Transition

North Tees and Hartlepool NHS Trust

Introduction

Transition from paediatric to adult diabetes services is a high-risk period of disengagement, often associated with poor health outcomes. Young people (YP) have anxieties and worries about moving into a new service where staff members are unfamiliar.

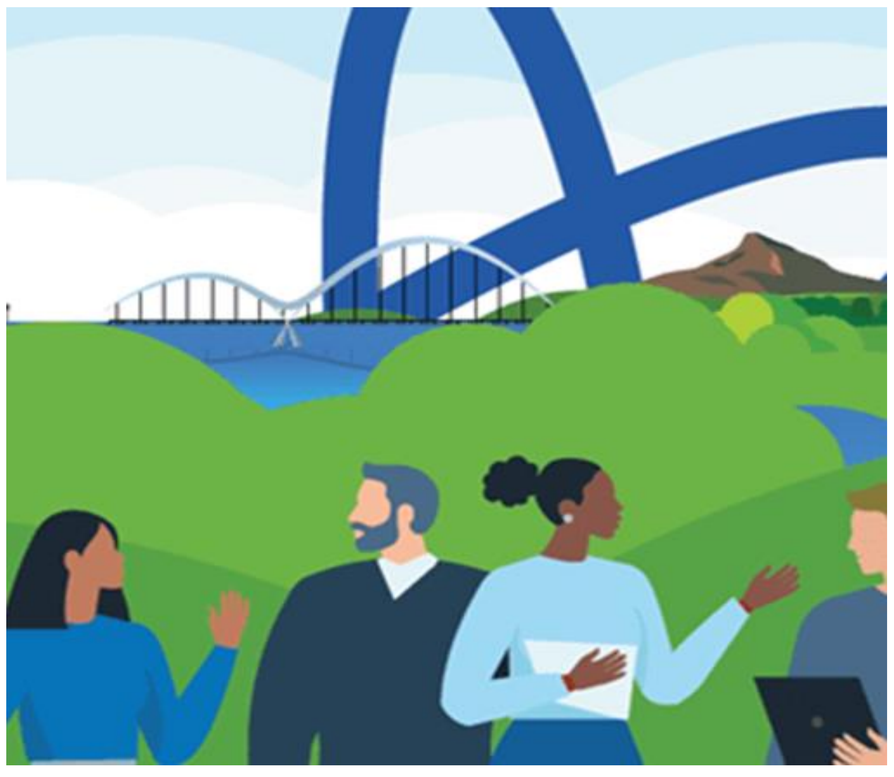
In our team we have a Diabetes Transition service with joint paediatric and adult consultant transition clinics. Locally we have limited opportunity for our Adult Diabetes Specialist Nurses (DSN's) to meet with our YP prior to their first clinic attendance in the young adult clinic (YAC), our DSN's equally felt they lacked knowledge of the YP and their care needs.

Aims

Aims of our service improvement project was to introduce a "bridging appointment" to facilitate an early introduction to their new nurse and keyworker.

Hopes

We hope the intervention reduces transition related anxiety for both parties, strengthens therapeutic relationships, increases engagement and reduces the numbers lost to follow-up.



The Intervention

The bridging appointment was offered to all young people with diabetes prior to transfer to occur following their final appointment in paediatrics and before their first clinic appointment in adults.

- Attended by the young person, their paediatric DSN and their designated adult DSN.
- Took place in the Adult Diabetes Service Area in a relaxed environment
- Included introductions, explanation of the adult service structure, including what to expect in terms of appointments, responsibilities, and communication channels.
- A person-centred approach is used to explore socio-economic factors, any safe-guarding concerns that may be affecting the young person's emotional health and wellbeing.
- Diabetes management and technology linked up to adult services.
- Provided an opportunity for the young person to raise questions and concerns, and for the adult DSN to begin establishing a therapeutic relationship.

RESULTS

Pre intervention data sample

16 patients in total transferred to adult diabetes team 2023/24

13 patients attended their last clinic in paediatrics

- 7 attended first clinic appointment in Young Adult Clinic
- 4 were Non-attenders
- 1 transferred care
- 4 appointments were cancelled by hospital (3 of 4 attended the next offered appointment, 1 had a further appointment cancelled by hospital)

5 patients attended their 4th adult clinic apt (1 year post transfer)

4 patients attended full complement of appointments in the first year post transfer

Diabetes related admission in the first year

5 patients (1 of which had 3 DKA admissions 7 in total) – all 5 patients had inconsistent attendance at appointments

Post intervention

3 patients in total since April 2025

All patients eligible have been offered a bridging appointment

Attendance rate has been 100%

Timing has occurred as planned approximately 6 weeks from their last clinic in paediatrics and 6 weeks prior to their first in adult service

All patients involved have since attended their first appointment in the Adult service

Patients have reported less anxiety regarding their transition post bridging appointment

Adult DSN's have reported feeling more informed about the YP and their needs going forward

What Now??

Embed the Bridging appointment into regular practice and offer to all YP pre transfer

---

Monitor the uptake and explore alternative delivery methods i.e. virtual or telephone contact
Continue to gather feedback from YP on their experiences,
Consider collecting confidence and anxiety levels pre and post "Bridging appointment"

And suggestions for improvement!
Monitor post transfer data to review engagement at 3, 6, 12 months, HbA1cs and diabetes related hospital admissions.

OTHER TRANSITION Q.I. WORK WE ARE PROUD OF!

TRANSITION TO ADULT SERVICES – My Record

Name	Date of Birth	NHS Number

Age	Pathway element	Date completed	Digitally recorded
11	Leaflet provided "Transition: moving to adult care" and Ready Steady Go introduced		
	Observed video about Ready Steady Go! www.readysteadygo.net, family advised of website as a useful resource		
	Introduction to Shared Decision Making and the Ask 3 Q's model		
11 – 13	Ready element of the pathway		
13 – 16	Steady element of the pathway*		
15+	Transition N clinic to disc • Appointr birthday • Introduc appointr • Admissi • Access t turns 19		
	Offered adc Nurse		
	PDSN and T including ps		
16+	YP should h around thei		
	PDSN and Transition Nurse met for an official handover of patient including psychosocial details and any safeguarding concerns		
16+	YP should have their first clinic appointment in Transition on or around their 16th Birthday		
16 – 18	Go element of pathway*		
18	Readiness to Transfer Assessment Completed		
19+	First appointment in young adult clinic arranged to occur on or around their 19th birthday		
	YP should be offered an informal meet up "Bridging appointment" with the Transition Nurse and Adult DSN		
	YP technology synced to adult services reporting platforms and software		
	YP should be aware of how and who to contact for support moving forward		
	Transition Nurse and Young Adult Nurse met for an official handover of patient to include psychosocial and safeguarding concerns and discuss hospital passport if applicable		
	Transition Nurse attended YP's first clinic in the young adult service		
	"Hello to Adults" leaflet and questionnaire supplied		

Ready Steady Go programme

Transition Readiness Checklist

Tick the answer that matches closest to how you feel about your own ability.

My Knowledge

I am able to…	I haven't thought about it	I plan to start	No, I still need lots of practice	Somewhat, but I need a little practice	Yes, I can do this
Describe diabetes in my own words					
Explain what Haemoglobin A1c (HbA1c) measures					
Recall my most recent HbA1c					
State my target HbA1c					
Understand how my HbA1c impacts on my health now					
Describe three problems that might come from high HbA1c					
List examples of tests done during your diabetes care which may identify or prevent complications of diabetes					
Tell someone how alcohol affects blood glucose					
Explain long term impact of smoking on heart health in people with diabetes					
Explain the impact of diabetes on sexual health/function					
Explain the impact of glucose control needed before considering pregnancy *(female patients)*					

Caring Better Together

NHS
South Tyneside and Sunderland
NHS Foundation Trust

DigiBete

Seamless Transition Project South Tyneside and Sunderland NHS Foundation Trust

Introduction

Digibete was already utilised within paediatric diabetes and proved to be an effective resource, we felt this could be adapted for use in the young adult service

Aim

To provide seamless continuity of accessible information using the Digibete clinic app across both hospital sites during transition from paediatric to adult service

Plan

- Fortnightly meetings
- Meet with Digibete rep
- Populate with relevant content
- Rollout Digibete in young adult clinic
- Review uptake/feedback

Challenges

- Working across sites/ different ways of working
- Time constraints
- Staff unavailability
- Patient engagement/clinic attendance
- Access to technology

Outcomes

- Currently unable to review feedback
- Marked Improvement to team communication
- Cost effective means to reach patients