



**National Children & Young People's
Diabetes Network**

Transition and Young Adult T2 Diabetes care – NHSE TYA Pilots

- 1) King's Health Partners**
- 2) Barts Health**

Young adults with Type 2 diabetes service

Our learnings so far...

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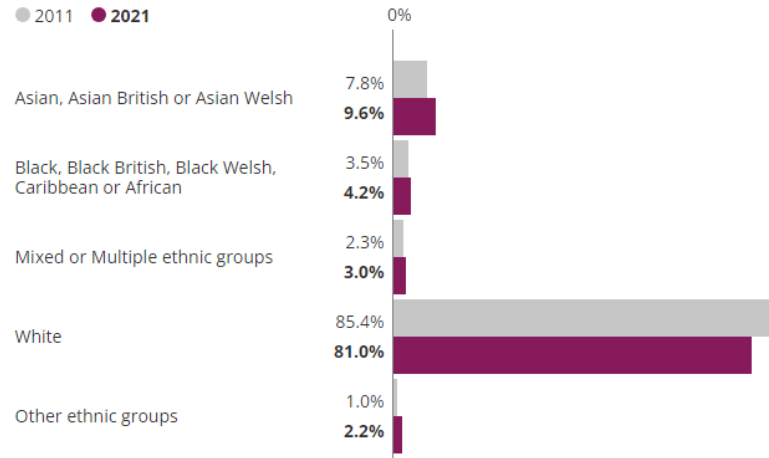


Overview

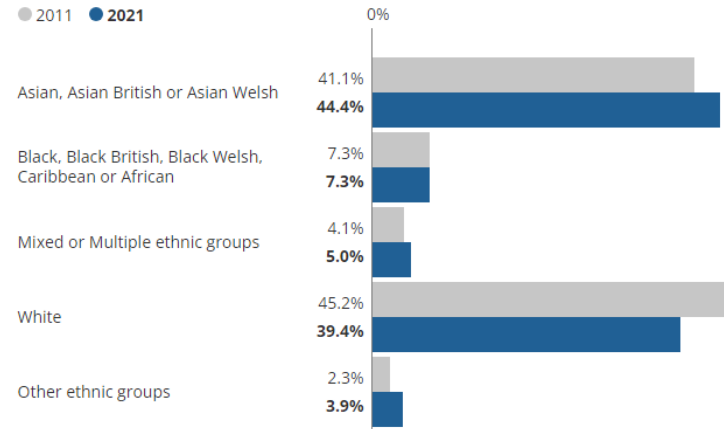
- Barts Health and our Young adults with diabetes (YAD) team
- Pilot initiatives to support young adults with T2D
- Our learning; successes and challenges
- Takeaway messages

Barts Health

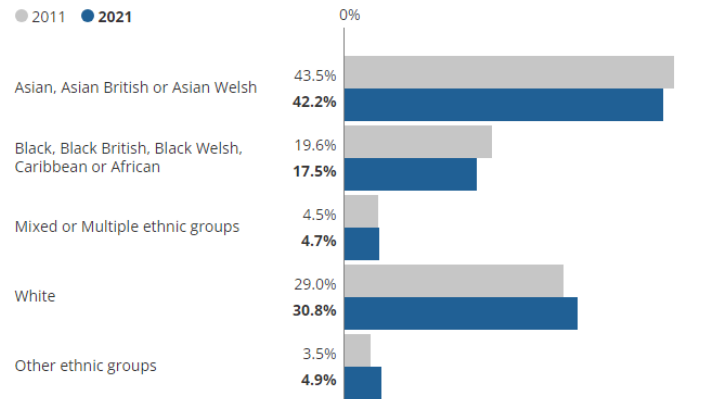
Percentage of usual residents by ethnic group, **England** ▾



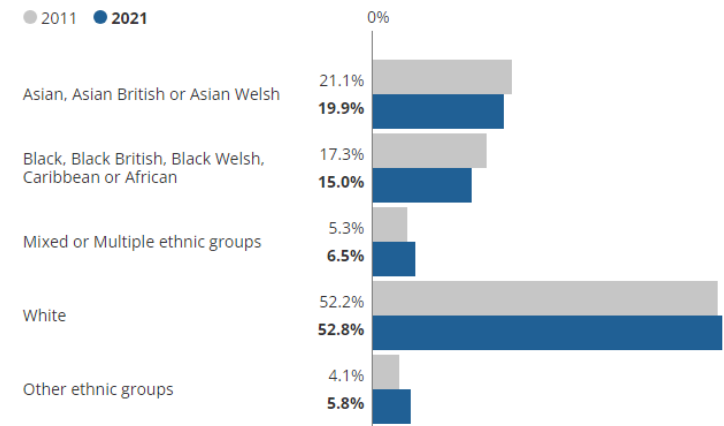
Percentage of usual residents by ethnic group, **Tower Hamlets** ▾



Percentage of usual residents by ethnic group, **Newham** ▾



Percentage of usual residents by ethnic group, **Waltham Forest** ▾



Barts Health

Newham

Child poverty rate

Child poverty rate (AHC)

44%

Worse compared to all London Boroughs (32%)

Income deprivation

Income deprivation (relative to London overall)

1.49

Worse compared to all London Boroughs (1)

Pay inequality

80:20 ratio of earnings

2.39

Average compared to all London Boroughs (2.5)

Poverty rate

Poverty rate

38%

Worse compared to all London Boroughs (25.93%)

Tower Hamlets

Child poverty rate

Child poverty rate (AHC)

48%

Worse compared to all London Boroughs (32%)

Income deprivation

Income deprivation (relative to London overall)

2.03

Worse compared to all London Boroughs (1)

Pay inequality

80:20 ratio of earnings

2.37

Average compared to all London Boroughs (2.5)

Poverty rate

Poverty rate

41%

Worse compared to all London Boroughs (25.93%)

Waltham Forest

Child poverty rate

Child poverty rate (AHC)

38%

Average compared to all London Boroughs (32%)

Income deprivation

Income deprivation (relative to London overall)

1.14

Average compared to all London Boroughs (1)

Pay inequality

80:20 ratio of earnings

2.41

Average compared to all London Boroughs (2.5)

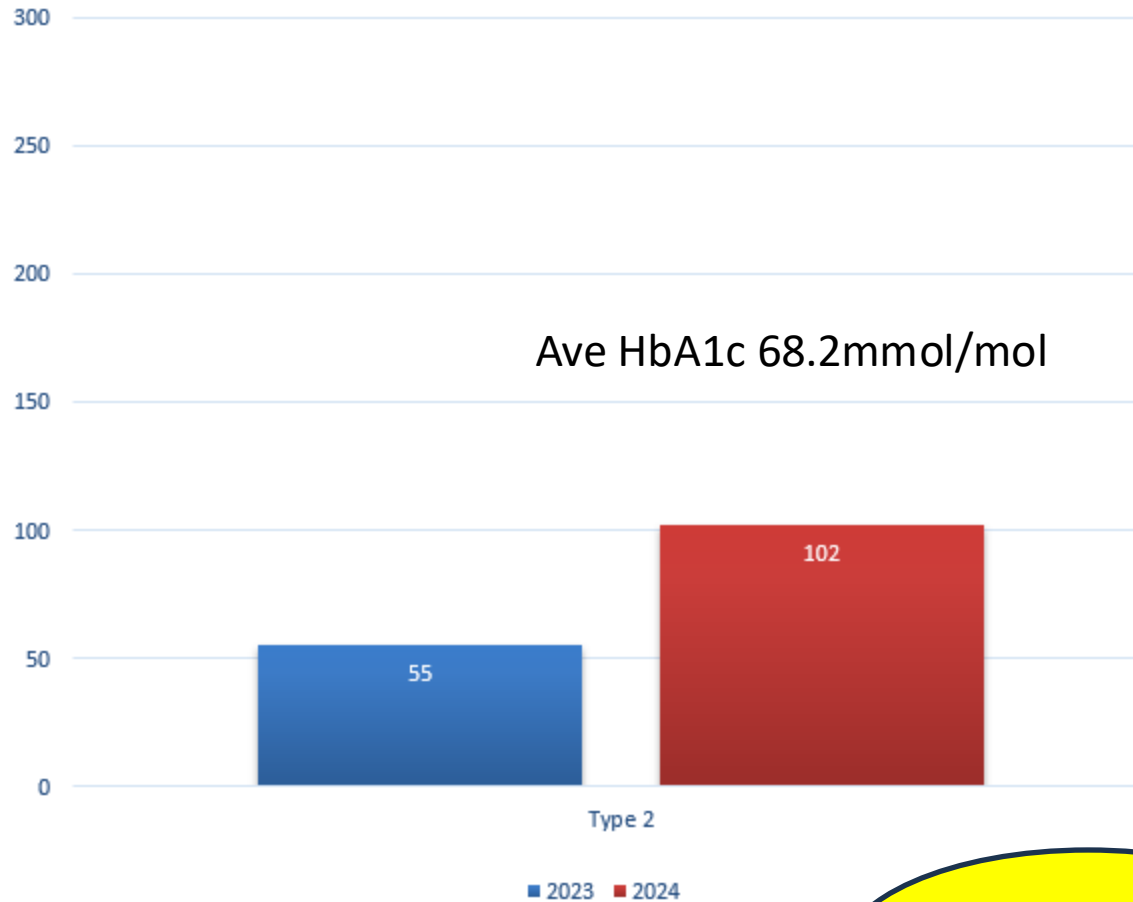
Poverty rate

Poverty rate

23%

Average compared to all London Boroughs (25.93%)

Barts Health



148 in Tower Hamlets
150 in Newham

40% of deemed high risk

- HbA1c >100
- Non attenders
- Frequent DKA admissions
- 1 or more diabetes complication
- Mental health inc eating disorders
- Learning Disabilities
- Homeless

NHSE Pilot

- Equity across Barts health services
- Improve outcomes and reduce health inequalities in YA with diabetes

Mobile, Cross-Site Young Adult Diabetes Team

1 WTE Band 7 diabetes specialist nurse

1 WTE Band 7 dietitian

0.8 WTE Band 8a Psychologist

1 WTE Band 4 Administrator

2 WTE Youth workers

0.8 WTE Social prescriber



Interventions

1. Robust Transition process from paediatric to adult care
2. **Working with community services to deliver healthcare outside of the hospital**
3. **High risk pathway to improve engagement and reduce DNAs**
4. **Maximising impact of each clinical appointment**
5. Promoting self-management
6. Improving access to diabetes technology
7. Providing psychological support



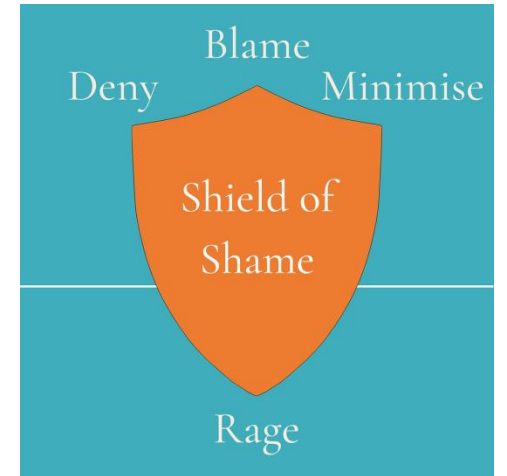
Focus Groups

“But it’s an older peoples’ disease”

“It is my fault I have this condition”

“I don’t want to leave the house”

“I don’t want to tell my friends”



Joint Consultant and Dietitian clinic

- Dedicated young adult type 2 clinic
- Getting to know our patients, monitoring their progress
- More personalised plan, to start to address both medical and dietary factors in one appointment
- Holistic care
- ½ day virtual 'Food and Diabetes workshop'

Peer Support Session

- Following focus groups- established a monthly virtual peer support group
- Regular AccuRx text message invites and 1:1 clinic
- Session format
 - Initially open ended, no set agenda: challenging to engage and generate discussion
 - Introduced a ‘skeleton’ structure: icebreaker/quiz leading onto general discussion, scheduled topic, sharing resources and services, and then closing with general discussion.

Low attendance
max 4 participants
Cameras usually switched off
Those who did attend had positive feedback.



	Theme	F
4	Experience of living with type 2 diabetes Focus group Focus -virtual	
4	Diabetes and Wellbeing	
4	Diabetes and Stigma	
4	Eating for health	
4	Emotional eating	
4	Keeping active	
4	Keeping active	
4	Keeping well during the festivities	
4		

Walk and Talk Sessions

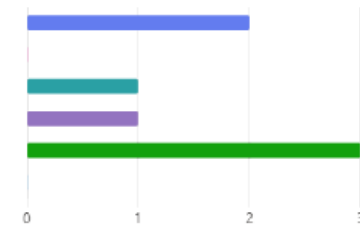
- Monthly walking group
- Led by dietitian and psychologist
- Promote peer support and increasing activity levels
- Exploring our local green spaces
- Complimentary tea/coffee at a local café at the end of the walk.

Observational outcomes:

- Exchanging information on how to rearrange retinal screening appointments
- Sparked interest in hiking and photography
- Sharing information on courses

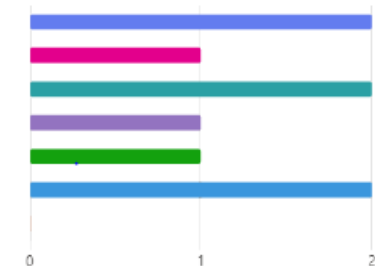
7. What motivated you to join this walk and talk session? (Select all that apply)

Meet new people	2
Stress relief	0
Explore local area	1
Have fun	1
Do something active/ Increase activity levels	3
Other	0



10. What did you enjoy the most about the session?

Meeting new people	2
Reducing my stress levels	1
Exploring local local area	2
Having fun	1
Conversations with the group (connecting)	1
Doing something active/ Increase activity levels	2
Other	0



YAD Events



JOIN US FOR THE
**YOUNG ADULTS
DIABETES**
SUMMER EVENT

Where: Mile end hospital gardens
E1 4DG

When: Thursday 22nd August

Time: 2-6pm

Come and take part in a day full of fun
and games!
Bring a friend or two

Food and drinks available

Prizes to be won



WALK AND TALK GROUP
For young adults (18-25) living with T2 Diabetes

Do you want to keep active? Would you like to meet new people?

**Join us for a walk and a chat on
Tuesday 16th of July at 5.30pm**

To book or more information call/message
07729 046748

All abilities welcome and
you can bring a friend!

Meeting point → **across the road from Mile End
station.**



Joining a 'Mailing' List & Peer WhatsApp group

Message

Dear [Patient Name], Join us TODAY at 5.30 across Mile End Station for our Walk and Talk Session! Don't miss this opportunity to be active and meet new people 🌟 everyone will be invited to a tea/coffee/soft drink after the walk at a local café 🎉 You can also bring along a friend/friends or family member if you want. Hope to see you there! Claudia & Soniya

Batch type

Message

Message

Dear [Patient Name], ONE WEEK for our next Walk and Talk session! Join us for a walk and a chat on the 16th of July at 5.30pm. An opportunity to be active and meet new people - You will be given a £10 Love2shop Gift Voucher just for joining 🌟 and we will invite everyone to a tea/coffee/soft drink after the walk at a local café 🎉 You can also bring along a friend/friends or family member if you want Hope to see you there! Claudia & Soniya

Batch type

Message

Message

Dear [Patient Name], Are you living with diabetes and looking for connection and empowerment? Join us at the YAD Summer Social Event - an afternoon of music, food, games, fantastic prizes and great company. Only TWO DAYS 🎉 Thursday 22nd August! Time: 2-6pm Location: Mile End Hospital Gardens (map attached) RSVP by tomorrow to secure your spot: <https://www.eventbrite.com/e/965168062657?aff=oddtcreator> Bring friends or family, or come solo – we can't wait to see you there 🌟

Batch type

Message

Message

Dear [Patient Name], Come along to our young adults games evening! 🎮 What we have lined up for you: multiple board games, quizzes, access to a projector to watch videos, wii. Snacks will be given ;) 🍷🍷🍷 Judgement free zone and a safe space for you 😊🙌 Where: Spotlight, E14 6GN When: Every first Thursday of the month from 5:30-7pm Our first games evening will occur on Thursday 5th December We are looking forward to seeing you there 😊



message

Message

Dear [Patient Name], Join us TODAY at 6pm for our peer support group session 🎉 The topic will be 'Staying Active' and Kane (youth worker) will be joining us to share some useful information. Time: 6-7pm Location: online (MS Teams) https://teams.microsoft.com/l/meetup-join/19:meeting_ZTA2NDAYzQtNjlhYi00MGNjLWFkOcontext=%7B%22Tid%22:%2237c354b2-85b0-47f5-b222-07b48d774ee3%22,%220id%22:%22257f61f7-581b-475b-9c81-07741734d179%22%7D Tap on the link or paste it in a browser to join. Hope to see you there! Soniya & Claudia

Sharing relevant resources

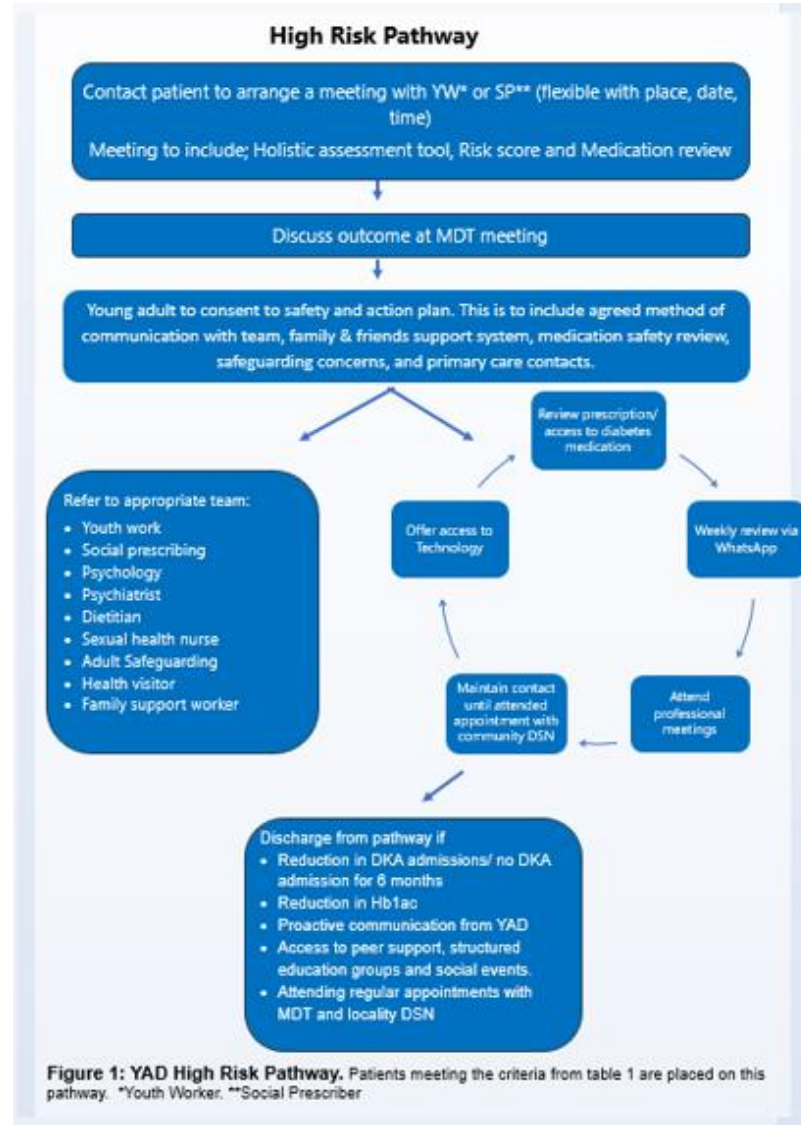
- Community established programmes- e.g. XPERT Bengali
- Weight management (12-week programme- NHS app or in person at Queen Mary University)
- Diabetes UK - <https://www.diabetes.org.uk/diabetes-the-basics/types-of-diabetes/type-2/young-adults>
- T2 DigiBete- <https://www.youngtype>
- Kooth - emotional wellbeing and counselling support for CYP 11 to 25 <https://www.kooth.com/>
- Sexual Health and Wellbeing- <https://www.brook.org.uk/>
- Student Minds - student mental health charity <https://www.studentminds.org.uk/about.html>

Promoting and facilitating increased activity

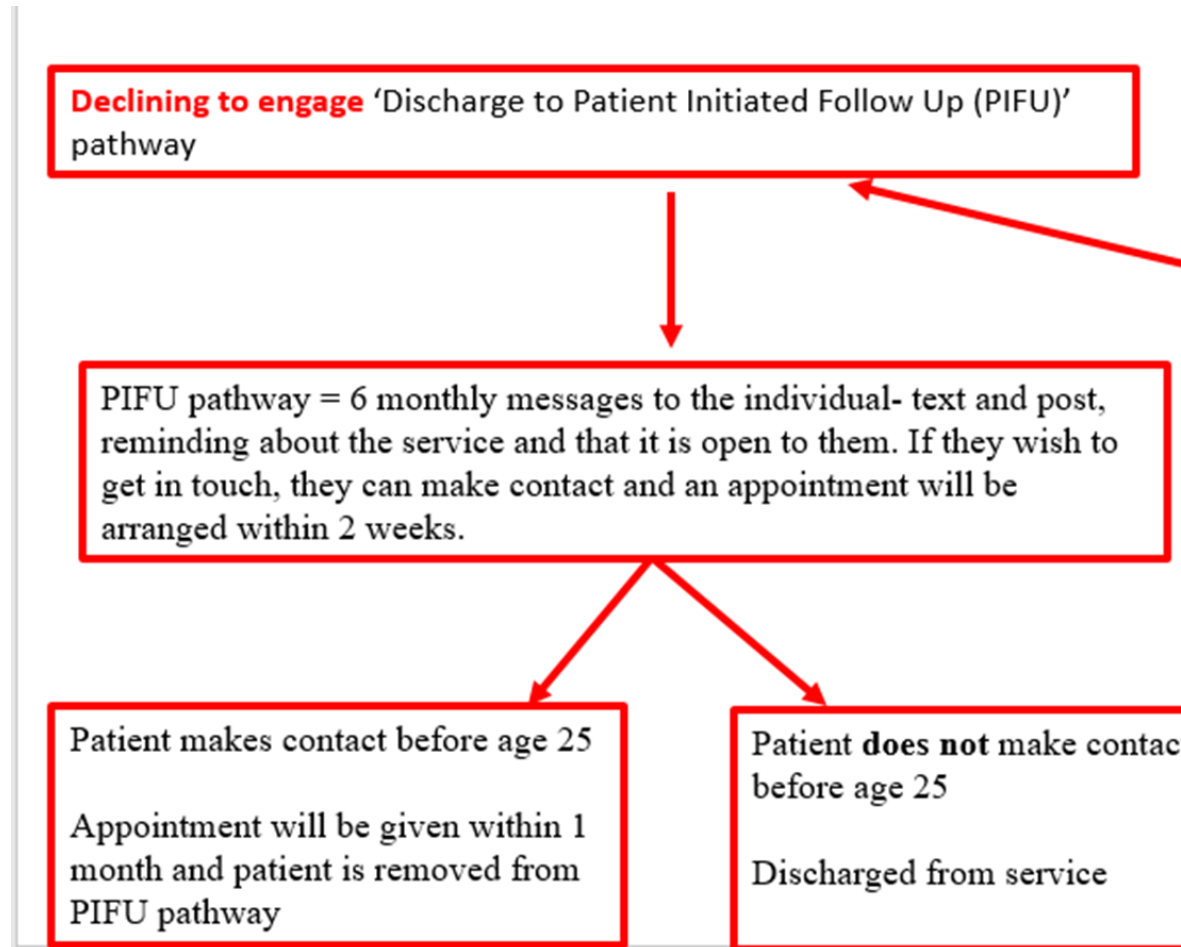
- Sessions at Spotlight (Youth Centre): exercising and boxing groups
- Healthwise- Physical activity on referral. Referral from GP <https://www.better.org.uk/what-we-offer/activities/healthwise>
- Couch to 5k - <https://www.nhs.uk/live-well/exercise/get-running-with-couch-to-5k/>
- Dr B's Exercise club <https://www.eventbrite.co.uk/e/dr-bs-exercise-club-tickets-770739441417>
- Cycle Sisters - charity that enables Muslim women to take up recreational cycling. <https://www.cyclesisters.org.uk/>
- GP referral to Social Prescribers who can link them up with activities in their local area
- Parkruns- <https://www.parkrun.org.uk/>
- YouTube videos- e.g. Joe Wicks



High Risk Pathway



YAD non attendance policy



Case Example- 'R'

- Woman in early 20s. Studying at law online university and working part-time in family business
- Diagnosed T2D 3 years ago - diabetic ketoacidosis- admitted to hospital and started on insulin and metformin
- Referred to Diabetes Service - weight loss diet and activity. HbA1c: 49 mmol/mol was taken off insulin. Slight weight reduction to 102 kg
- End of 2022: no longer taking medication due to side-effects. Dad diagnosed with schizophrenia - abusive. Brother also psychotic episodes for the past 10 years. Parents and two siblings living in a 2 bedroom flat. Mum experiencing physical health problems- arthritis and heart diff and depression.
- 2023- high glucose levels (100 mmol/mol). Cholesterol had raised and also raised liver function, referred to weight management clinic; started on sertraline; no taking diabetes medication regularly. Prescribed: Dapagliflozin and Mounjaro

YAD Support:

- Seen at the YAD MDT clinic by YAD consultant, dietitian, psychologist and specialist nurse. Main concern: weight gain (107 kg) and feeling very low in mood and anxious about leaving the house. Following this:

1:1 Input YAD dietitian: recognised low mood leading to binge eating . Given dietary advice and healthy recommendations: going for a 30 min walk, phoning friend , sleep hygiene strategies

1:1 Input from YAD psychologist: PHQ-9: 17 (moderately severe low mood); GAD-7: 15 (severe anxiety); Binge Eating Scale (BES)- scored 25 (indicate moderate Binge eating behaviour). High levels of self-criticism, broken sleep, lethargic and avoiding going out and self-care

8 psychologist sessions CBT (behavioural activation) and CFT approaches. Sessions in the park. Psychoeducation re: emotional eating – recognising relational, emotional and biological triggers

1:1 Input from YAD social prescriber: Supported with PIP application, looking for employment and liaising with GP re: prescribing antidepressants.; Regular check-ins

Initial Outcomes:

- Passed exams at university and taking a gap year to look after her health
- Reduced self-criticism and binge eating
- Improved mood and activity levels – passed driving license, attending all medical appointments , attended boxing session, going for regular walks
- Further support from Talking Therapies for social anxiety – diabetes psychologist to continue to provide indirect support
- Gradual progress- Still high HbA1c 90 mmol/mol (down from 119 mmol/mol in April) ; weight down from 107 kg to 101 kg – continue to provide MDT input;

Case Example- 'J'

Man in early 20s

Type 2 diabetes, aged 14

NovoRapid- 28 units with meals (**not taking any other medication**)

Moderate-severe depression and social anxiety

Hb1ac 112 mmol/mol Nov'24 (131 mmol/mol July'24, 115 mmol/mol April'24)

BMI 53kg/m²

Multiple previous DNA's with the team

YAD Support:

- Feb 2024 Telephone call with Consultant. J shared avoids medical appointments , health deteriorating, feeling low, no motivation and emotional binge eating. Medication reviewed.
- Placed on the 'high risk 'pathway. As part of this he was referred to the Social prescriber to engage with the service, High risk DSN and dietitian.
- March DSN- messages sent to contact team for support
- April '24 DNA dietitian message sent to contact team for support open appointment.
- May 2024 SP had a brief conversation with J to introduce herself. Telephone appointment agreed, however J failed to answer the call. Messages sent requesting J return call.
- June2024 Consultant concerned J has not been seen or engaging with service. Requested home visit be made for a welfare check to be undertaken by SP and YSW

- June 2024 Home visit by Social Prescriber and Youth Support Worker
- J shared he was not managing his diabetes well, experiencing financial difficulties, not receiving his Universal Credit payments on a regular basis due to missing his Job Centre appointments.
- Currently living with his 25-year-old brother. The council are in the process of evicting them as they have not paid the rent or council tax for more than a year.

Currently J is

- Engaging with the Social prescriber and youth support worker to speak with housing, job centre, agencies providing debt and housing advice .
- Supported by the psychiatrist, attending regular face to face appointments
- Regular High risk DSN
- Offered dietetic support
- Commenced Mounajro

What we learnt... empowering the YAs

1. Engagement

- Using problem free questions
- Consider their own reasons to engage/ manage their diabetes
- Groups and Community activities – *using incentives: free food, games, vouchers, prizes*
- Flexibility- appointments outside the clinic setting (walk, café, etc)
- Offer to write letters to employers and schools/universities

What we learnt... empowering the YAs

2. Collaboration

- Involving YAs in decision making and service development – *focus groups*
- Responding to feedback
- Consider supporters – family, friends
- Be sensitive to cultural norms and expectations
- Working with YAD MDT and wider team

What we learnt... empowering the YAs

3. Communication

- Appointment reminders. *Contacting them through preferred methods – e.g. WhatsApp, text messaging*
- Joint appointments to reduce frequency of appointments
- Compassionate and understanding letter for those who DNA
- Ensure understanding – adapting information to individual needs: LD, ADHD, dyslexia, language barriers, literacy



THANK YOU!



Any questions?

