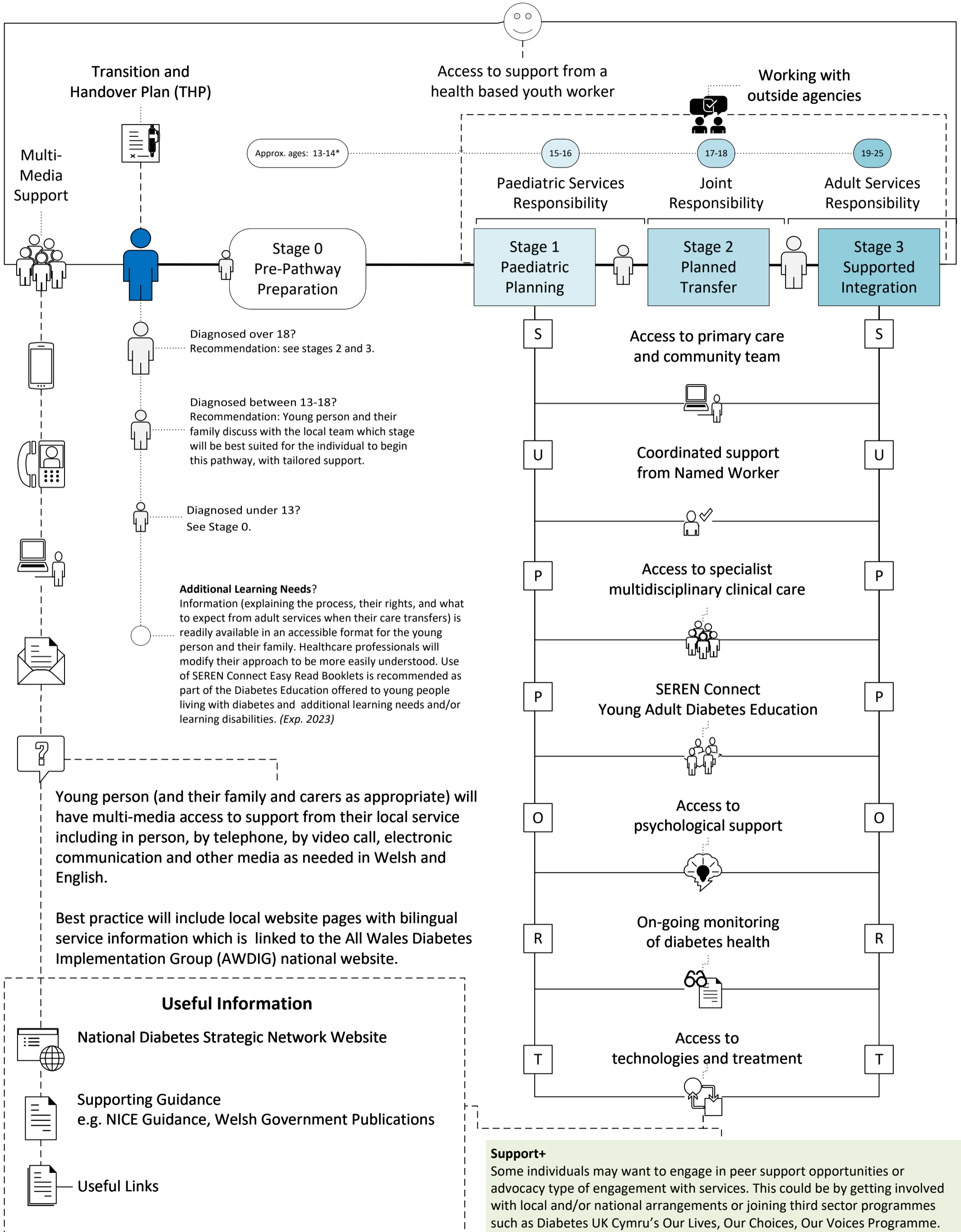


Transitional and Handover Care for Young Adults <25 years

Version 1: June 2023 Developed on behalf of the National Diabetes Strategic Network

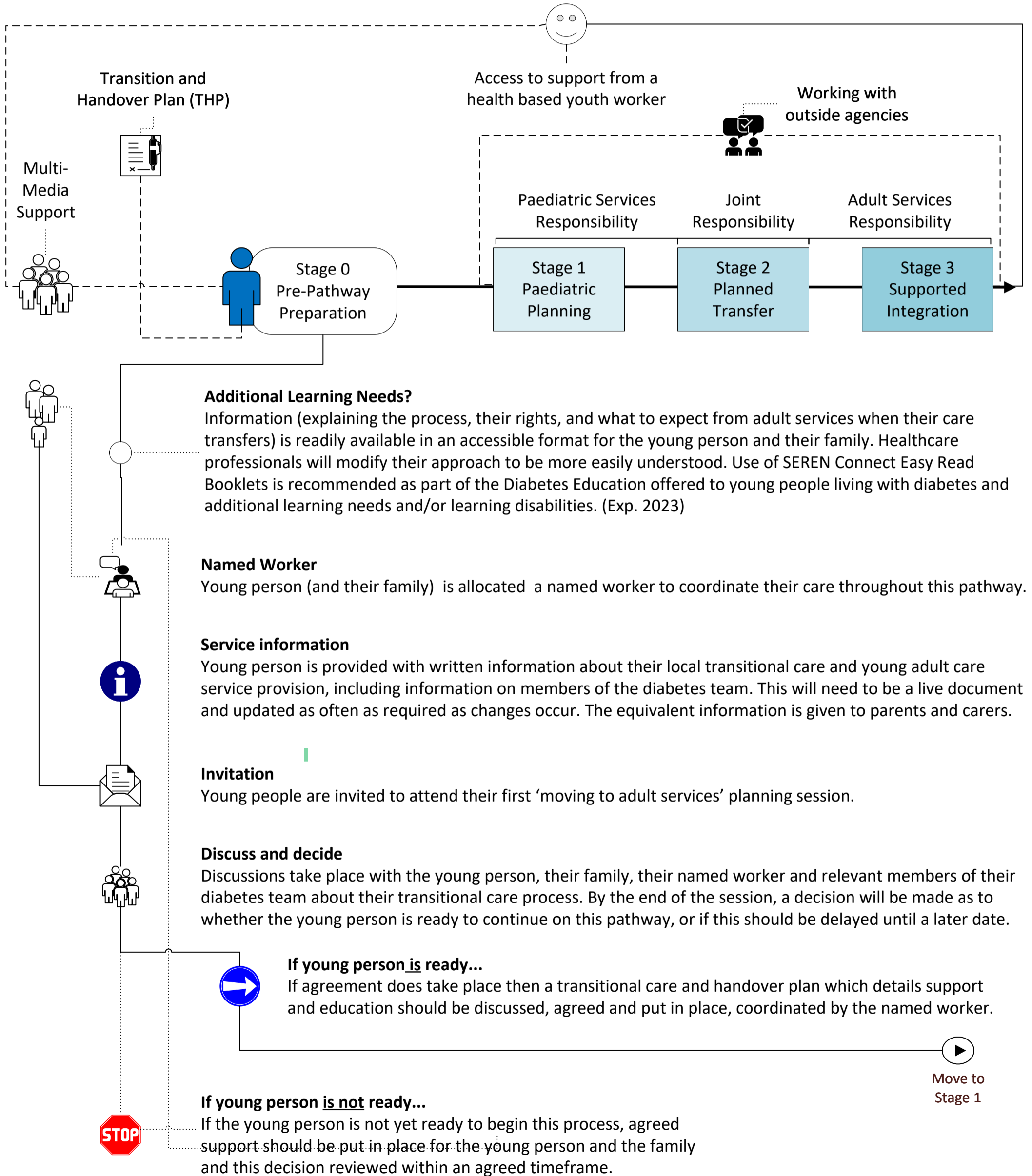


Transitional and Handover Care for Young Adults <25 years

Stage 0 Pre-Pathway Preparation

Stage 0

- Discussions about the importance of engaging with the transitional care process should start from diagnosis
- This stage of is led by paediatric service and paediatric clinicians hold clinical responsibility
- This stage aims to ensure young people are prepared to begin their transitional care process through to young adult services
- If young people are not yet ready for this pathway, moving to stage 1 can be delayed and this stage repeated
- Many young people will likely begin this pathway around the age of 13 and no later than school year 9

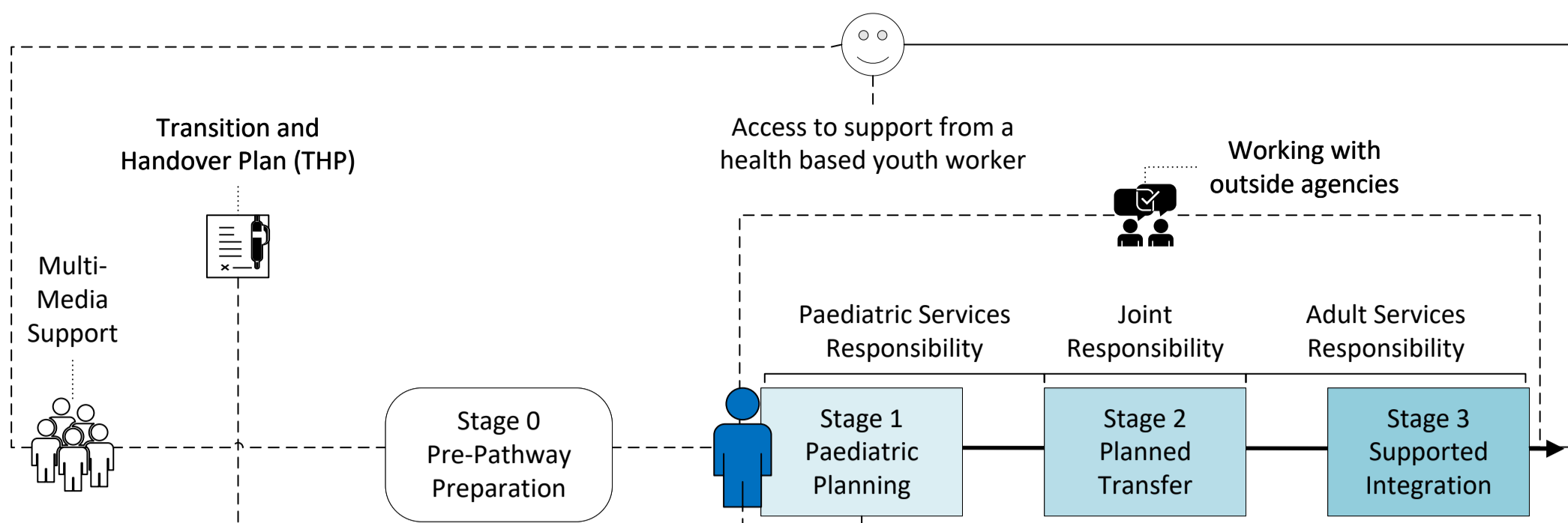


Transitional and Handover Care for Young Adults <25 years

Stage 1 Paediatric Planning

Stage 1

- Begins when the young person is ready rather than a set age (see stage 0)
- This stage of the transitional care process is led by paediatric services
- Clinical responsibility is held by paediatric clinicians working with early support from adult colleagues, detail agreed locally
- During this stage young people will be introduced to SEREN Connect Young Adult Diabetes Education
- This stage aims to prepare young people to manage their diabetes through adolescence



Additional Learning Needs?

Information (explaining the process, their rights, and what to expect from adult services when their care transfers) is readily available in an accessible format for the young person and their family. Healthcare professionals will modify their approach to be more easily understood. Use of SEREN Connect Easy Read Booklets is recommended as part of the Diabetes Education offered to young people living with diabetes and additional learning needs. (Exp. 2023)

Named Worker

Young person's care is coordinated by a named worker. Named worker helps the young person (and their family) develop an understanding of the relation between primary care, secondary care, emergency care and other healthcare services available in relation to managing their diabetes and associated wider health e.g. dental care, optical care.

Named worker helps coordinate the care that supports the young person to learn how they can self-manage their condition around other areas of their lives that affect young people and specific areas of importance to the young person, supported by resources as part of the SEREN Connect Young Adult Diabetes Education Programme.* Named worker is supported by a youth worker to coordinate other forms or support the young person may benefit from.

**If the young person is not ready to engage at this point, they are aware of what is available and possible in the future and the offer is made regularly.*

Registered with a GP

Young person is registered with a local GP practice.

Access to a full multidisciplinary team (MDT)

Young person has access to a full multidisciplinary team as defined by NICE Guidance [NG18].

This includes members with training in aspects of diabetes that cover:

- clinical care
- education
- dietetics
- lifestyle
- psychological health
- podiatry care

Young people will have access to a team who have developed a specific understanding of diabetes through adolescence and young adulthood who can access training events and/or courses to develop their knowledge in this area .

Diabetes Education

Diabetes education that aims to improve self management is discussed as a core part of the young adult's clinical care and treatment, and along psychological are given equal weight with medical care.

Aim: By the end of stage 1, young people should feel confident they can discuss the topics listed below in relation to their diabetes self management.

- Blood glucose monitoring
- Treating hypoglycaemia
- Treating hyperglycaemia
- Signs of ketoacidosis (DKA)
- Insulin requirements including dose adjusting
- Nutrition including carbohydrate counting
- Managing exercise
- Managing sick day rules
- Diabetes technology including downloading data
- Diabetes supplies including ordering/re-ordering prescriptions
- Additional equipment i.e. sharps bin, cooling bag etc.
- Self-care and emotional well-being
- Contraception
- Preconception care
- Annual review care checks (processes) and expectations

Refresher education

Young people's ongoing education needs are assessed annually. All young people are encouraged to take up specific refresher education which is provided to each young person as required. Each young person will have by now received their initial newly diagnosed education i.e. SEREN at Diagnosis, plus any additional modules that are applicable: SEREN Moving to Year 7, SEREN Active, SEREN Pumps. For some, this may have been some time ago or information may have been given to their parents. Consider offering a refresher education course using the most appropriate information. E.g. SEREN resources*

This will include the use of the SEREN Digital module when available. Please see Type 1 diabetes Paediatric Pathway for more detail.

SEREN Connect

Young people are introduced to SEREN Connect Young Adult Diabetes Education Programme through the use of the SEREN Connect booklets. This will be documented in the Transition and Handover Plan (THP). SEREN Connect topics form regular parts of discussion and communication with young people throughout their journey. Copies of the booklets can be offered to parents, carers and family/friends as appropriate. This is to encourage support and understanding received outside of the clinical setting from those closest to the young person.

[Click here for more information on SEREN Connect Young Adult Diabetes Education](#)

Monitoring diabetes health / annual review

Young person is offered on-going routine care as recommended by NICE guidelines throughout their diabetes journey to monitor their health.

- Time in range
- HbA1c
- Blood pressure
- Body Mass Index (BMI)
- Eye health (this is done by Diabetic Eye Screening Wales)
- Foot health
- HbA1c
- Thyroid disease (*routine monitoring often stops once care is transferred to adult services*)
- Coeliac disease management (if relevant)
- Kidney health - Albumin Creatinine Ratio (ACR)
- Smoking status - including family
- Preconception advice
- Immunisations Flu and Covid vaccines
- Encouraged to engage with routine care provided for their wider health e.g. by an Optician, Dentist

This care, including the recommended care processes offered as part of a young person's annual review helps detect any diabetes related complications early. When complications are suspected or detected, the most appropriate and effective form of treatment is offered to the young person with access to emotional and psychological support available to support the young person during this stage of their lives if they feel this would be of benefit.

Access to technology

Young people have access to downloadable technology including continuous glucose monitoring and/or insulin pump therapy and on-going education to support them to develop their confidence and get the most out of their devices as per the national technology guidance recommended by the National Diabetes Strategic Network.

Annual Tech-Check

A 'Tech-Check' should take place on that annual basis to check that technology is suitable, in date and under warranty. Young people are kept up to date as to when a technology upgrade is due and a choice of technology is encouraged.

As part of this check, a discussion is held with the young person to determine whether they feel confident in using the technology independently, including being able to reorder their supplies, access support from their pump company, and download and understand their data download on a regular basis. If no further support is needed, continue the pathway. If refresher education would be beneficial, arrange follow-up support. Offer the young person the option to bring somebody along to the session for support, as this could be helpful after they leave the clinical setting.

Access to psychological support

Young people have psychological care integrated and embedded into the diabetes team and makes up a core part of their diabetes care. As they become available, young people have access to psychological care as per the paediatric psychology pathways.

Access to peer-support

Young people are informed of the benefits that can come from receiving and providing peer support. This can include gaining knowledge, connection, experience, emotional, social and/or practical help from others living with diabetes who have a shared experience.. Young people (and their family) are provided with and have a space where they can find information and links to trusted local and online support groups. Work with third sector organisations to promote age-appropriate events and activities. This information is kept up to date and promoted regularly.

Agreed transfer of care

When the young person and the diabetes team are in agreement, the young person will move to stage 2. This is a gradual and planned process over approximately two years. The young person is supported by the current diabetes team, with opportunity to meet and begin to get to know members of the adult team who will be responsible for their care up to 25 years. They will adjust to their service set-up, and learn about managing their diabetes as a young adult.

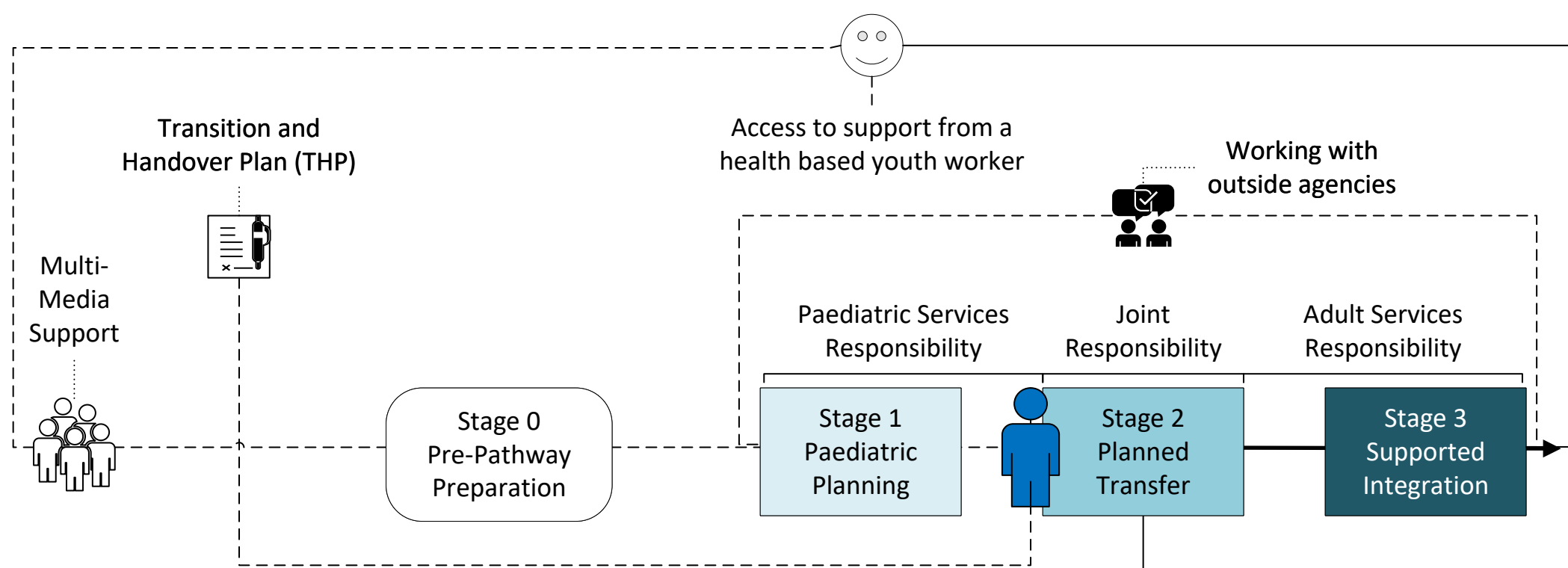
Move to Stage 2

Transitional and Handover Care for Young Adults <25 years

Stage 2 Planned Transfer

Stage 2

- Begins when the young person feels ready to begin meeting the adult team and complete their SEREN Connect young adult education programme.
- This stage of the transitional care process is shared between paediatric and adult services i.e. led by paediatric services, supported by adult services.
- Clinical responsibility is held by paediatric clinicians working with support from adult colleagues which will need to be agreed locally.
- During this stage young people will be invited to attend the SEREN Connect programme as detailed below (or equivalent).
- This stage aims to introduce the young person and their family to their young adult team who will be providing their care up to 25 years.
- In addition this stage ensures young people are able to be provided with education they need to manage diabetes as young adults.



Additional Learning Needs?

Information (explaining the process, their rights, and what to expect from adult services when their care transfers) is readily available in an accessible format for the young person and their family. Healthcare professionals will modify their approach to be more easily understood. Use of SEREN Connect Easy Read Booklets is recommended as part of the Diabetes Education offered to young people living with diabetes and additional learning needs. (Exp. 2023)

Registered with a GP

Ensure young person is registered with a local GP practice, and know how to make contact with their GP and local pharmacies. It's vital the young person understands what support is available and offered with relation to their diabetes e.g. prescriptions, mental health support.

Hybrid Young Adult Team

Young person is supported by a hybrid young adult team with protected time to support young adults aged 14-25 years. The team should be made up of staff working in paediatric and adult services supported by a health-based youth worker that young people can access on a voluntary basis.

Developing Rapport

Before young people transfer their care to the adult services, they will need to have met the adult team through a gradual and planned process as detailed in this pathway. Staff working in adult services will need dedicated and protected time to support this vulnerable group. Young people will need to have received education that prepares them for young adulthood through the SEREN Connect programme as detailed in the below pathway. Alternative delivery times (e.g. combining sessions or sessions delivered over a shorter overall timeframe) can be explored where this gains better engagement from participants.

On-Going Care (as detailed in Stage 1)

During this stage, young people will have access to the following as required:

- Access to support from the full multidisciplinary team
- Opportunity to meet new members of the adult team
- Appropriate refresher education
- Monitoring of diabetes health/annual review
- Access to technology
- Annual tech-check
- Access to psychological support
- Access to peer support

Clinic location

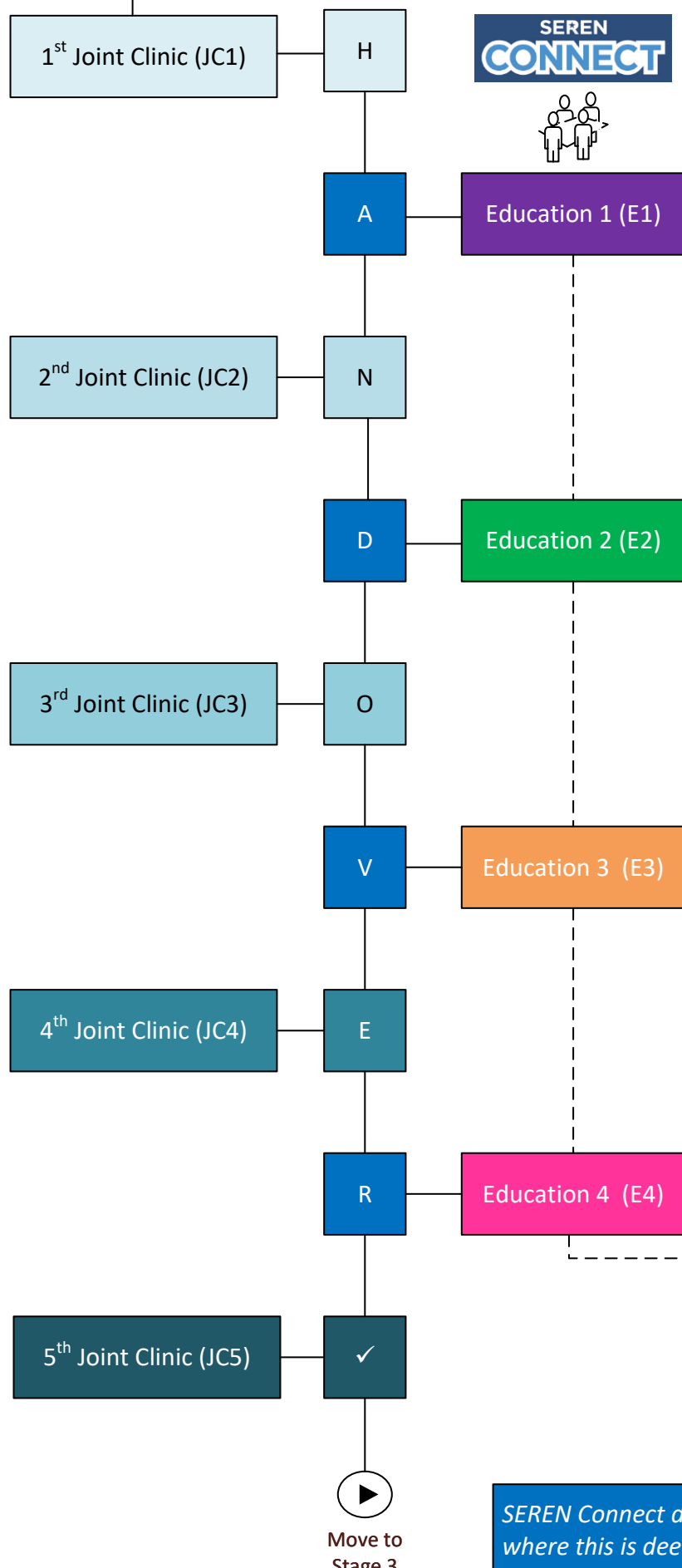
JC1 and JC2 take place in a paediatric setting, with support from adult services. The location of JC3 will depend on local arrangements. By JC4, clinic takes place in the adult setting, with support from paediatric services until the end of JC5.

Timeframe

Young people and their parents/carers need a gradual and well planned model of care to ensure they are supported, included and able to move across to the young adult service safely. It is recommended that this model is used over a two year period. Some young people will need additional 1:1 support from the diabetes team in between these clinic appointments.

Open Contact

Young people are encouraged to contact the team anytime they need to in-between routine appointments if they are struggling or need more support. They understand how to do this, who to contact and have a multi-media approach in doing this to suit their communication preferences.



SEREN Connect Programme



















Edrych am y fersiwn Cymraeg?
Cliciwch yma i lawrlwytho!

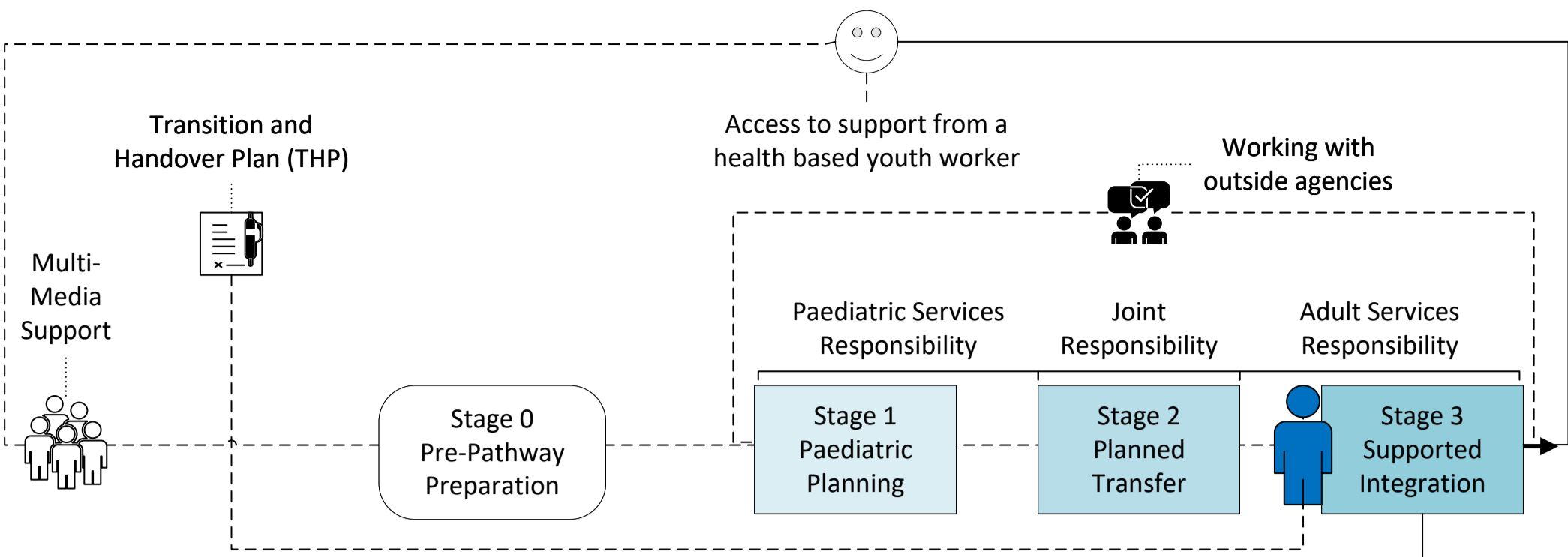
SEREN Connect delivery timeframe can be flexible where this is deemed beneficial or generates better engagement from participants.

Transitional and Handover Care for Young Adults <25 years

Stage 3 Supporting Integration

Stage 3

- Begins when the young adult is ready rather than a set age, young person will remain on this pathway until they reach 25 years old
- This stage of the transitional care process is led by a young adult team under adult services
- Clinical responsibility is held by adult services clinicians with occasional support from paediatric colleagues for some individuals (agreed locally)
- During this stage young adults will continue to use SEREN Connect Young Adult Diabetes Education
- This stage aims to support young adults to manage their diabetes through young adulthood until their mid twenties



Additional Learning Needs?

Information (explaining the process, their rights, and what to expect from adult services when their care transfers) is readily available in an accessible format for the young person and their family. Healthcare professionals will modify their approach to be more easily understood. Use of SEREN Connect Easy Read Booklets is recommended as part of the Diabetes Education offered to young people living with diabetes and additional learning needs. (Exp. 2023)

Named Worker

Young adult's care is coordinated by a named worker from adult services. Named worker helps the young adult (and their family) develop an understanding of the relation between primary care, secondary care, emergency care and other healthcare services available in relation to managing their diabetes and associated wider health e.g. dental care, optical care.

Named worker helps coordinate the care that supports the young adult to learn how they can self-manage their condition around other areas of their lives that affect young adults and specific areas of importance to the young adult, supported by resources as part of the SEREN Connect Young Adult Diabetes Education Programme. Named worker is supported by a youth worker to coordinate other forms or support the young adult may benefit from.

Registered with a GP

Ensure young adult is registered with a local GP practice, and knows how to make contact with their GP and local pharmacies. It's vital the young adult understands what support is available and offered with relation to their diabetes e.g. prescriptions, care processes (especially if this differs to paediatrics) mental health support.

Access to a full MDT

young adults entering adult services and those newly diagnosed as young adults have access to a dedicated young-adult team, consisting of a full multi-disciplinary team that matches NICE guidance [NG18].

This team includes members with training in

- clinical care
- education
- dietetics
- lifestyle
- psychological health
- podiatry care

Young adults will have access to a team who have developed a specific understanding of diabetes through adolescence and young adulthood who can access training events and/or courses to develop their knowledge in this area, and will continue to see the same team until they are 25 years, unless they choose to move their care out of area i.e. for university.

University Students or young adults Moving Out of Area

The named worker supports young adults moving to university by supporting in their choice of moving their diabetes care to their new area or keeping their care close to home. young adults who chose to continue their care close to home will be able to schedule their appointments in line with the academic calendar around times when they will be returning home wherever possible. All young adults are recommended to register with a local GP if moving away.

University Students Moving Into the Local Area

Young adults moving into the area who choose to transfer their care to centres near their place of study should be offered SEREN Connect Young Adult Diabetes Education (see below) as soon as possible and remain on stage 3 of this pathway until they move out of area or reach 25 years. Their named worker should work with the young adult and the university to assist in care plans for each student.

Diabetes Education

Diabetes education that aims to improve self management is discussed as a core part of the young adult's clinical care and treatment, and along psychological are given equal weight with medical care.

Aim: By the end of stage 3, young adults should feel confident they can discuss the topics listed below in relation to their diabetes self management.

- Blood glucose monitoring
- Treating hypoglycaemia
- Treating hyperglycaemia
- Signs of ketoacidosis (DKA)
- Insulin requirements including doses adjusting
- Nutrition including carbohydrate counting
- Managing exercise
- Managing sick day rules
- Diabetes technology including downloading data
- Diabetes supplies including ordering/re-ordering prescriptions
- Additional equipment i.e. sharps bin, cooling bag etc.
- Self-care and emotional well-being
- Contraception
- Preconception care
- Annual review care checks (processes) and expectations

Refresher education

Young adults' ongoing education needs are assessed annually. All young adults are encouraged to take up specific refresher education which is provided to each young adult as required. Each young adults will have by now received their initial newly diagnosed education i.e. SEREN at Diagnosis SEREN at Diagnosis, plus any additional modules that are applicable: SEREN Moving to Year 7, SEREN Active, SEREN Pumps.. For some, this may have been some time ago or information may have been given to their parents. Consider offering a refresher education course using the most appropriate information.

SEREN Connect

Young adults are introduced to SEREN Connect Young Adult Diabetes Education Programme through the use of the SEREN Connect booklets. This will be documented in the Transition and Handover Plan (THP). SEREN Connect topics form regular parts of discussion and communication with young adults throughout their journey. Copies of the booklets can be offered to parents, carers and family/friends as appropriate. This is to encourage support and understanding received outside of the clinical setting from those closest to the young adult. If young adults have not yet been offered the full SEREN Connect programme, including group sessions or if they were unable to attend previously, adult services will offer an adapted course again over a shorter time-span.

[Click here for more information on SEREN Connect Young Adult Diabetes Education](#)

Monitoring diabetes health / annual review

Young adult is offered on-going routine care as recommended by NICE guidelines throughout their diabetes journey to monitor their health.

- Time in range
- HbA1c
- Blood pressure
- Body Mass Index (BMI)
- Eye Health (this is done by Diabetic Eye Screening Wales)
- Foot health
- HbA1c
- Thyroid disease (*routine monitoring often stops once care is transferred to adult services*)
- Coeliac disease management (if relevant)
- Kidney Health - Albumin Creatinine Ratio (ACR)
- Smoking status - including family
- Preconception advice
- Immunisations Flu and Covid vaccines
- Encouraged to engage with routine care provided for their wider health e.g. by an Optician, Dentist

This care, including the recommended care processes offered as part of a young adult's annual review helps detect any diabetes related complications early. When complications are suspected or detected, the most appropriate and effective form of treatment is offered to the young adult with access to emotional and psychological support available to support the young adult during this stage of their lives if they feel this would be of benefit.

Access to technology

Young adults have access to downloadable technology including continuous glucose monitoring and/or insulin pump therapy and on-going education to support them to develop their confidence and get the most out of their devices as per the national technology guidance recommended by the National Diabetes Strategic Network.

Annual Tech-Check

A 'Tech-Check' should take place on that annual basis to check that technology is suitable, in date and under warranty. young adults are kept up to date as to when a technology upgrade is due and a choice of technology is encouraged.

As part of this check, a discussion is held with the young adult to determine whether they feel confident in using the technology independently, including being able to reorder their supplies, regular support from their pump company, and download and understand their data download on a regular basis. If no further support is needed, continue on pathway. If refresher education or additional support would be beneficial, arrange follow-up support. Offer the young adult the option to bring somebody along to the session for support, as this could be helpful after they leave the clinical setting.

Access to psychological support

Young adults have psychological care integrated and embedded into the diabetes team and makes up a core part of their diabetes care. As they become available, young adults have access to psychological care as per the paediatric psychology pathways.

Access to peer-support

Young adults are informed of the benefits that can come from receiving and providing peer support. This can include gaining knowledge, shared experience, emotional, social and/or practical help from others living with diabetes who have a shared experience.. young adults (and their family) are provided with and have a space where they can find information and links to trusted local and online support groups. Work with third sector organisations to promote age-appropriate events and activities. This information is kept up to date and promoted regularly.

Agreed transfer of care

When the young adult reaches 23, there will be a locally agreed gradual and planned process for the young person to transfer their care to the regular adult service by the time they are 25. During this time, the individuals will have opportunity to meet the team who will be responsible for their care post 25 years. They will adjust to their service set-up, and learn about managing their diabetes as an adult. They will know who to contact in between routine appointment for support and be supported in how to navigate their care if they feel it's been too long since they have had contact from the team. They are encouraged to take up opportunities for advocacy and peer support if they wish and are sign-post to relevant support as required.

End of Pathway
— Follow Type 1 Pathway

Transitional and Handover Care for Young Adults <25 years

Transition and Handover Plan (THP)

To comply with Welsh Government's Transition and Handover Guidance (2022) health boards must ensure:

Information should be readily available and in an accessible format for the child or young person and their family prompting their engagement, explaining the process, their rights and what they can expect when their care is transferred from paediatric to adults' services. In each case a plan for the transition and handover of the child or young person's care between services to another must be written and shared.

Each young person will have a Transition and Handover Plan (THP) or equivalent. This will ensure that the young person has an understanding of their care, treatment and education and relevant professionals have access to essential information about the young person.

In line with the Welsh Language (Wales) Measure 2011, Welsh language services should be built into planning and delivery and Welsh language services should be offered to Welsh speakers without them having to request it, this includes all information, education and documentation.

Young people will be encouraged to contribute in developing their own healthcare information for their THP to help smooth the process of transition and handover of care.

Each young person will be given information about their condition and THP in a form they can understand.

It will include:

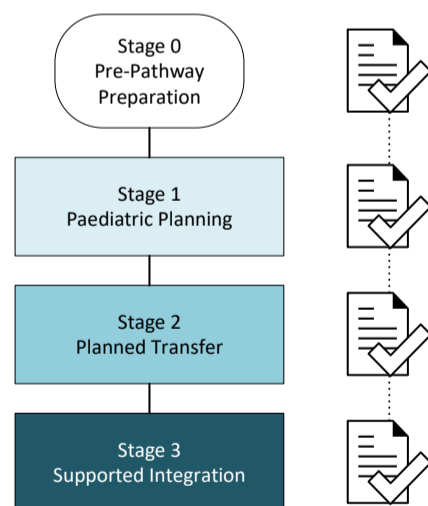
- Personal information
- History
- Care needs
- Treatment and education requirements
- What is important to the young person
- Setting expectations of the transition journey
- Timeline

The THP will need to link or be integrated with other plans.

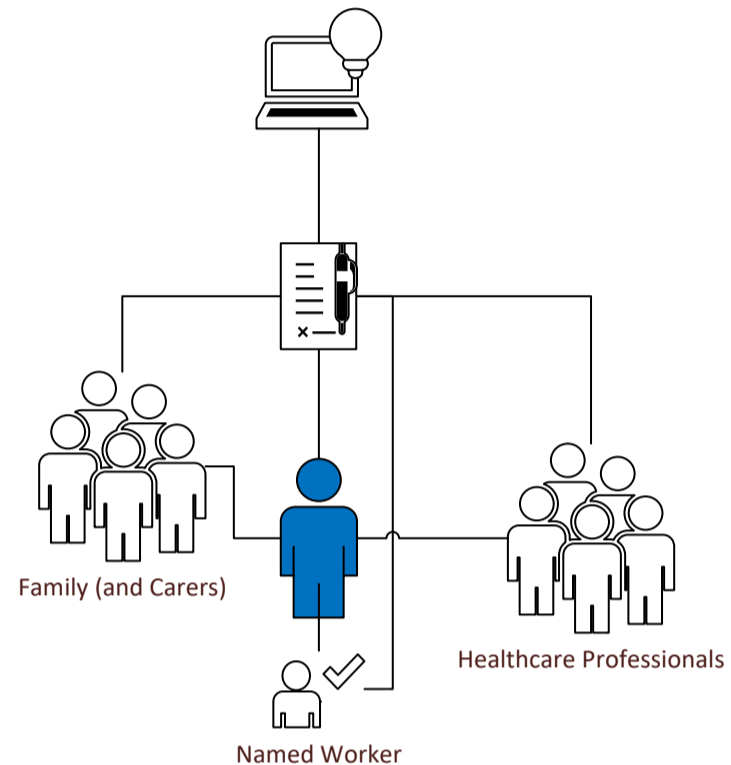
Examples:

- Individual Development Plan (IDP) required by the ALN act
- Continuing Care Plan or Care and Support Plan
- Mental Health Plan
- End of Life Plan etc.

The THP will need to be reviewed and updated at appropriate intervals.



The THP will need to be supported by common IT systems in order for information to be shared via secure online platforms, with appropriate consents to ensure that the information is accessible to all. This is essential data for continuing monitoring and quality assurance. With the increasing move to integrated IT systems information should be easily shared across agencies.



The THP will be co-produced in consultation with the child or young person, family, carers and health professionals with support of the Named Worker, using resources such as the SEREN Connect programme and 'Ready Steady Go'.

The THP can be individualised and should be a continuous and evolving process that should be adapted to meet the needs of the young person as they move through the transitional care stages. Healthcare professionals involve the young person throughout and will be responsive to their wishes feelings and needs at every stage.

If diabetes teams are already using handover documentation, the introduction of a THP should not be a duplication of work, rather a good opportunity to ensure existing documentation it is fit for current purposes.

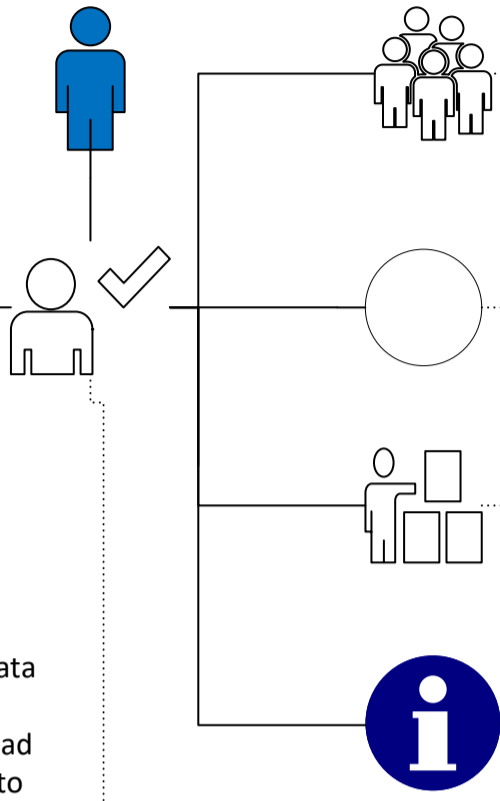
Recommendation: Consider standardising an all-Wales collaboration document between the National Diabetes Strategic Network and the Children and Young People's Wales Diabetes Network for THP use. (Phase 2 Pathway)

Transitional and Handover Care for Young Adults <25 years

Named Worker Information

To comply with Welsh Government's Transition and Handover Guidance (2022) health boards must ensure:

There is a Transition and Handover Named Worker ('Named Worker') identified and appointed to support each young person living with diabetes who is moving to adult services. They will be a healthcare professional from the young person's existing diabetes team who takes a key role in the coordinating and promoting continuity and integration of the young person's healthcare.



They will be involved in the healthcare of the young person from the earliest stage of the transitional care process as possible. They will be a core member of the multidisciplinary team, attending meetings as necessary.

Arrange appointments for the young person, act as their representative, direct them to other services and sources of support, and support the young person's family and carers if appropriate.

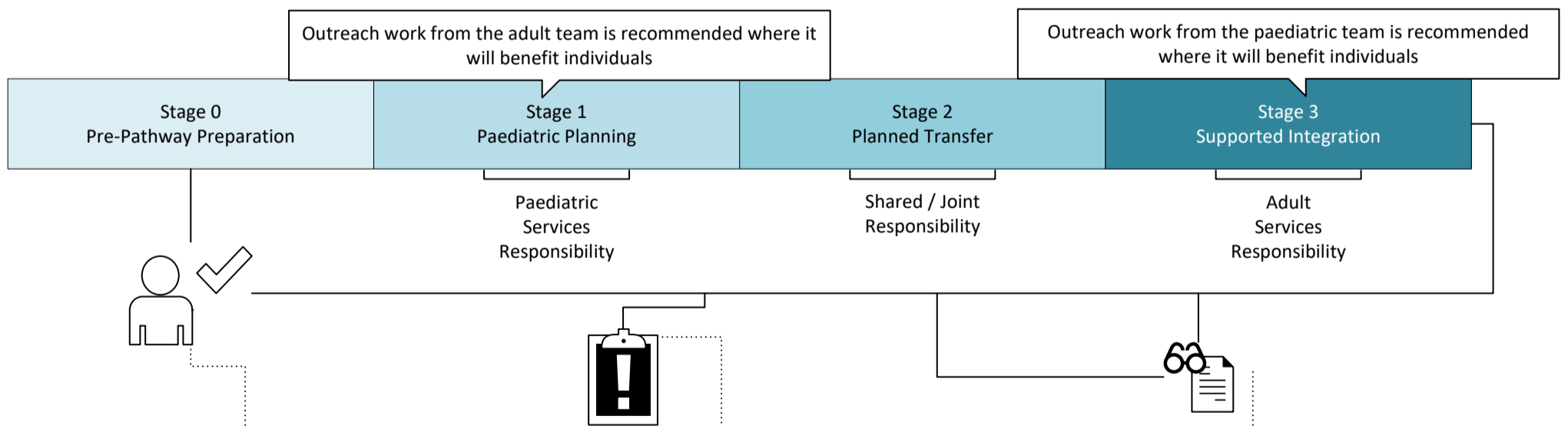
They will promote and advocate the wishes and views of the young person to ensure appropriate access for them and their family or carers to all necessary healthcare services and wider services as appropriate.

They will ensure relevant information such as healthcare needs or any safeguarding concerns are shared with other agencies, in line with information governance arrangements, to promote integrated multiagency service provision for the young person's safety and wellbeing.

They will provide data that will allow the identified Senior Lead to report regularly to the health board.

In addition, the Named Worker role is likely to encompass the following:

- Manage the transitional care process and handover (transfer) of healthcare between care settings.
- Support the coordination of healthcare plans and services during the period of transition and handover of clinical accountability for care.
- Include cross-border co-ordination if care is placed across the Wales-England border.
- Coordinate a summary of all healthcare needs, especially where there are complex health needs.
- Collate existing assessments from key health professionals in the young person's multi-disciplinary team
- Link between the young person and the various health professionals involved in their care across all care settings.
- Ensure the young person knows who to contact when help or advice is needed and they understand the best method of communication to use.
- Manage expectations around how adults' services might be differently configured and delivered.
- Ensure healthcare plans have been agreed with the young person (and where relevant, family and carers).
- Be a source of easily accessible information around healthcare advocacy as part of wider support
- Support the young person, family and carer to access appropriate independent healthcare advocacy support.
- Be available to coordinate support the young person and their family and carers (for a minimum of 6 months) after the transfer of care.
- Support the child and young person to feed back on their experiences to improve future services



A Named Worker is involved throughout all stages of the transition and handover process. Supporting the young person before and after transfer for a minimum of six months or until a time agreed with the young person and their family and carers. This will help address gaps identified in the young person's healthcare management, offering continuity and familiar support when concurrent life transitions interfere with the young person's diabetes management.

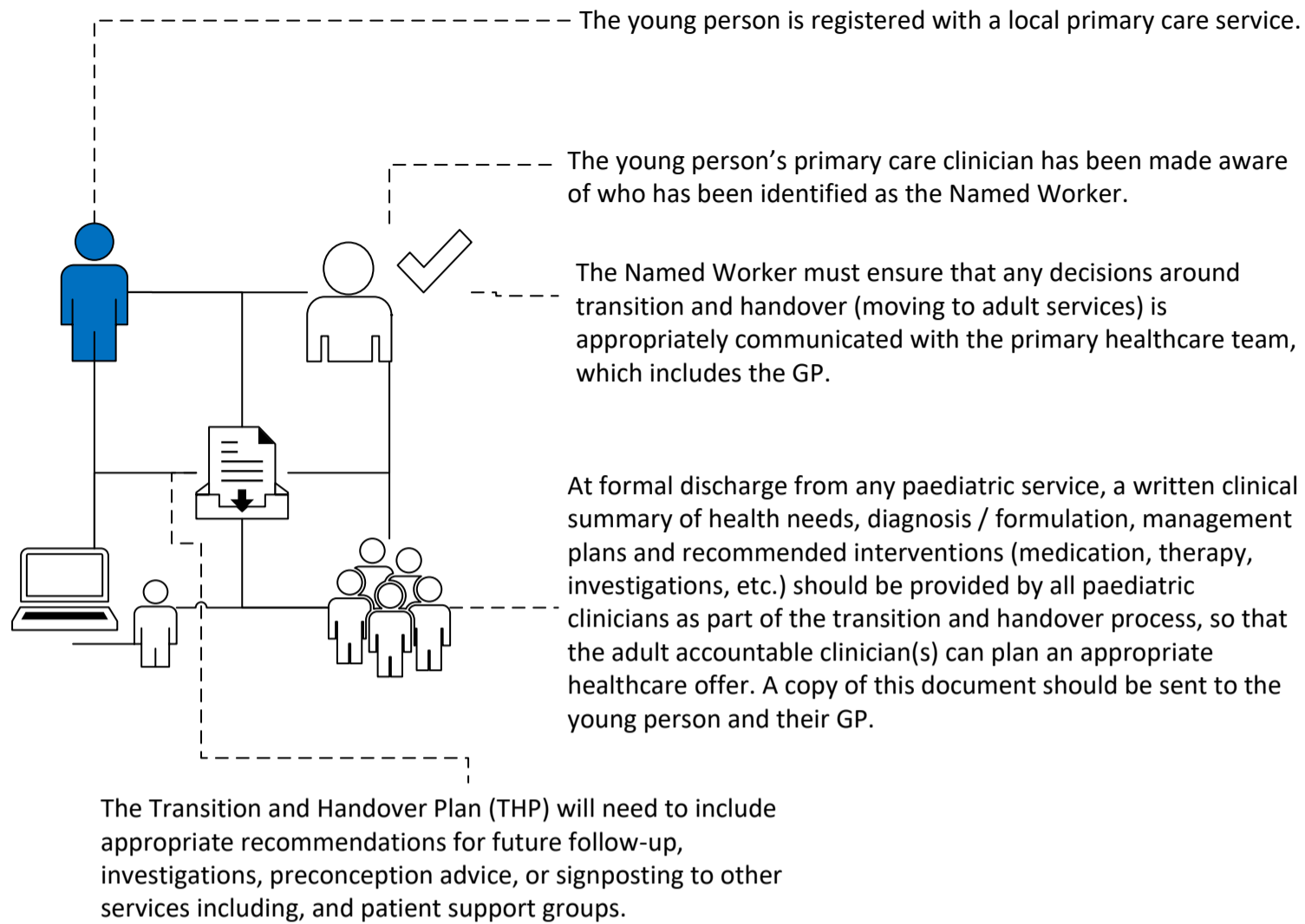
Local arrangements should be put in place to provide cover during any absence of the single Named Worker and any changes should be agreed by the child and young person.

The allocation of the Named Worker should be reviewed by the existing MDT at key points in the transition process. The transition process can be lengthy and it would be expected that the Named Worker may change over time. Changes to the Named Worker must be discussed with the young person and their family and carers if appropriate.

The existing multidisciplinary team (MDT) who will be aware of the young person's health and care needs, history and requirements as they are often best placed to provide robust and up to date information to the receiving MDT to plan the most appropriate care going forward.

Transitional and Handover Care for Young Adults <25 years Primary Care Info

To comply with Welsh Government's Transition and Handover Guidance (2022) health boards must ensure:



Transitional and Handover Care for Young Adults <25 years Supporting Documents

Supporting Documents For Reference

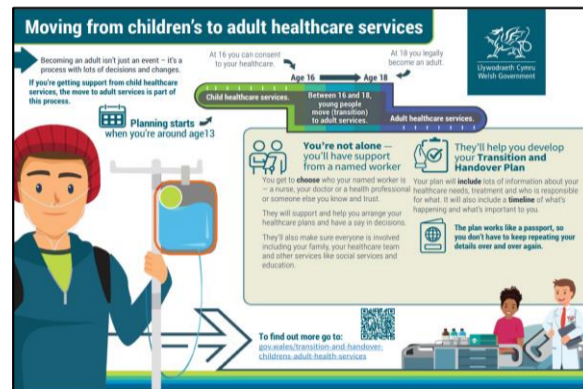
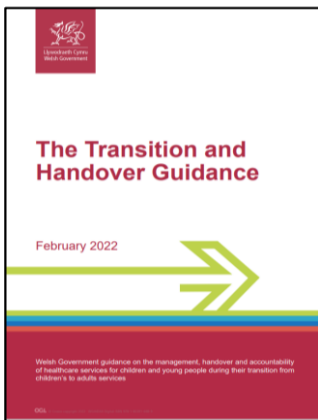
If any links stop working, or you know of other documents that would be useful to list here, please send document information and online link to AWDIG@wales.nhs.uk with the title *FAO Transitional Care* and the National Diabetes Strategic Network can consider adding it to this document.

NICE Guidance

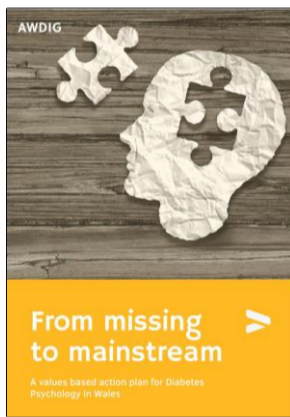


Click document covers to view full document

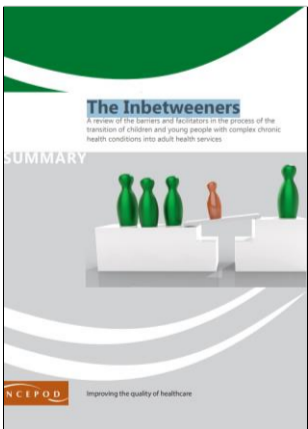
Welsh Government Guidance



National Diabetes Specific Guidance



NCEPOD Transitional Care Report – The Inbetweeners



Transitional and Handover Care for Young Adults <25 years

Useful links and resources suitable for sharing

DigiBete: <https://www.digibete.org/>

Bertie Online Education: <https://www.bertieonline.org.uk/>

JDRF: <https://jdrf.org.uk/>

Diabetes UK: Our Lives, Our Choices, Our Voices Youth Programme https://www.diabetes.org.uk/how_we_help/community/youth-programme

Beyond Type 1: <https://beyondtype1.org/>

*Need some inspiration? We recommend Beyond Type 1's Bike Beyond Documentary, **watch the trailer here.***

*For the full length Beyond Type 1's Bike Beyond movie, **click here.***

This document is a live document, which may be amended or changed as required.

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