Transitional care for young people with diabetes: a national registry is urgently needed

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Abstract
Young people with diabetes require specialised and personalised care as they make the transition from children’s services to adult services. Getting the right care at this stage of their lives gives them the best chance of avoiding longer-term complications and remaining within the health service. Many policy documents and guidelines have been issued highlighting the importance of diabetes care during these years but little evidence exists as to what should constitute that care and how it should be provided. Few interventions have been evaluated and there are no national data comparing the effectiveness of transition services across the country. A national register of diabetes transition services and agreed measures of quality would enable paediatric and adult services to evaluate and improve the care they provide for this important group of young people. Copyright © 2014 John Wiley & Sons.

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Key words  
transition; diabetes care; young adults; continuity; models of care

Introduction
Transition is defined as ‘the process or a period of changing from one state or condition to another’. Many challenges face the young person with diabetes as they grow through their teenage years and move from the paediatric diabetes service to the adult diabetes service. This review article will consider these challenges and set out some of the national guidelines around the care of young people with diabetes who are going through the transition from paediatric to adult care. It will review the literature on best practice and look at the different models of care proposed to help young people through this period of their life.

Challenges to providing successful transition care
Numerous challenges face young people with diabetes as they go through adolescence and make the transition from a paediatric clinic to an adult clinic. Physically, there is an increase in insulin resistance as the young person goes through puberty often resulting in deterioration of their glycaemic control. Psychologically the young person may be reluctant to let go of a stable and affirming relationship with the health care professional (HCP) and transfer to an adult service with the possibilities of long-term complications. Carers may also fear being progressively excluded from the consultation process as the young person becomes increasingly independent.

The structure of the clinic system in hospitals can often lead to difficulties for the young person attending clinic. The paediatric and adult clinics are often physically far apart and may fall on different days. Young people can struggle to attend appointments during the day and many services provide early evening appointments or Saturday morning appointments. Considerable resources are put into contacting people who do not attend paediatric clinic appointments but there is often a change in culture in the adult clinic reflecting a sense that it is the person’s own responsibility to make, attend and cancel their appointments as they become increasingly independent. This can lead to higher ‘did not attend’ (DNA) rates and as the frequency of contact with the young person diminishes the risks of poor glycaemic control and development of complications increase.

National policy and guidelines
The importance of good transition care has been highlighted by numerous guidelines and policy statements published over the last 10 years. These have been developed for HCPs with the aim of helping young people manage their diabetes through this difficult time. The long-term aim of these guidelines is to reduce the risk of complications that can arise in
people with diabetes disengaging with the health service leading to poor diabetes control. Despite the publication of these guidelines, very little is known about the national state of transition care for people with diabetes in the UK.

A report from the Royal College of Paediatrics and Child Health published in 2009 outlined the number of young people with diabetes. This snapshot survey found that there were 4917 young people aged 16 and 17 years old diagnosed with diabetes, with almost 82% being cared for by paediatric services. The highest prevalence was seen in the North East and South East East regions (526 per 100 000 and 547 per 100 000 people 16–17 years old) and these areas also had the highest Standardised Mortality Ratios in the country. Only 122 people were diagnosed with type 2 diabetes (T2DM) in this age range.

The 5th UK Paediatric Diabetes survey (2010) examined the provision of adolescent diabetes services in the UK and identified changes in service delivery since 2002. Questionnaires were sent to the lead paediatric consultant from all paediatric and adolescent diabetes services and 129 services (63%) returned the questionnaires. Transitional care, as assessed by the NICE recommendations for diabetes care was variable, with only 76% of services having specific local protocols for transition and 21% of services organising transfer by letter alone. The National Diabetes Paediatric Peer Review Programme has been recently introduced and this should increase the number of centres with local policies, although may not influence the method or outcome of the transition.

NHS Diabetes, Diabetes UK and the Association of British Clinical Diabetologists (ABC D) have all commissioned and published guidance on the importance of good transition care and the principles underpinning this care. Unfortunately however, the recently published NICE Quality Standards for People with Diabetes (2011) only referred to adults and did not comment on the quality of care required during transition.

Table 1 provides a summary of national policy documents and guidelines on transition from children’s services to adult services.

Examples of best practice in UK and beyond

In order to find examples of best practice in transition care, a review of the literature was carried out. Fifty-two articles were identified, 20 of which were reviews, two were surveys, five addressed other long-term conditions and 22 were new studies from the UK and around the world. Several of the UK and international studies with differing models of care are described below.

Within the UK, different models of transition care have been compared within the Thames Valley region. A total of 164 young people with type 1 diabetes (T1DM) over the age of 18, who had been diagnosed under 16 years old, were interviewed about their experience of transfer from the paediatric to the adult service. Clinic attendance, HbA1c and inpatient admissions were also recorded for the 229 patients in this age group. The clinic attendance two years after transfer varied between the four different districts from 29–71% with higher rates seen in districts where young people were given the opportunity of meeting the adult diabetes consultant beforehand. The questionnaire responses from the young people confirmed the importance of meeting the adult diabetes consultant prior to transfer of care.

In a special issue of Child: Care, Health and Development in November 2011 devoted to transition, Price et al. from Northumbria reported the results of semi-structured interviews with 11 young people who had been through a ‘transition’ pathway. Six main areas of concern were identified including the process, the organisation of the transfer and the services, information and education, the consultation itself and the need for inclusivity. Two overarching themes were identified: (1) making the transition process developmentally appropriate, and (2) tailoring it to the individual’s needs.

Although the actual pathway was important, the quality of the consultation experience was a major factor in determining the future engagement of the young people with health care services.

Witczak et al. from Merthyr Tydfil submitted a poster presentation at the annual professional conference of Diabetes UK in 2014 describing the outcomes of changing their transition process from a single handover to a phased transition process. They highlighted the importance of planning a phased multidisciplinary approach to transition. As a result the glycaemic control of the more recent patients improved rather than deteriorated (HbA1c falling from 93 to 79mmol/mol as opposed to rising from 80 to 88mmol/mol), there were lower non-attendance rates, and there was a reduction in hospital admissions (16 vs 42% within 12 months of transition).

Outside the UK there have been several intervention and observational studies looking at the reasons for poor transition in young people with diabetes and how it could be improved. In Canada the Maestro project provided administrative support and systems navigation service for 323 adults aged 18–30 years old. Through easy access to clinicians and diabetes education, there was a fall in drop out of attendance with adult medical care from 40% to 11%. However, no improvement in short-term medical outcomes was observed.

A transition support programme in Australia involving a transition coordinator/diabetes educator providing a reminder system for appointments and out-of-hours telephone support service was introduced in 2001 for 190 young adults between 15 and 25 years old. Significant reductions in HbA1c and admissions for diabetic ketoacidosis were achieved over five years as the young people felt increasingly well supported and knew who to contact if there were problems with their diabetes.

Helgeson et al. from Pittsburgh prospectively followed 118 young people with T1DM in the senior year of their high school education. They documented the transition process, the timing of the transition and who the young people saw at the time of their transition and one year later. Those patients remaining under paediatric care at the beginning of the study had a significantly lower HbA1c than those who had already been transferred to the adult service. The paediatric group also had the best measure of self-care behaviour which deteriorated significantly with the transition group. Although glycaemic control
In the permanent residence of the Children’s Hospital of Pittsburgh is to that the general philosophy at the groups, this was seen most markedly in the patients seen by the adult physi-

dian. Worryingly, nine out of the 118 patients saw no physician for the year after their enrolment into the study. Patients with T1D M, were followed of 185 patients, who were recently transferred to adult care compared to those still under paediatric care. The difference in the organisation of the USA was confirmed in another study with the median age of transition being 20.1 years old. The odds of poor glycaemic control were 2.5 times higher for patients who had transferred to adult care compared to those still under paediatric care. The difference in the organisation of health systems and payment for medical services in the USA compared to the NHS may have an impact on the

deteriorated over the year in all groups, this was seen most markedly in the patients seen by the adult physicians. Worryingly, nine out of the 118 patients saw no physician for the year after their enrolment into the study. Interestingly, the authors comment that the general philosophy at the Children’s Hospital of Pittsburg is to offer continued appointments until the permanent residence of the patients has been established (usually after college or when they have a job).

This later age of transition in the USA was confirmed in another study published by Lotstein et al. A total of 185 patients, who were recently diagnosed with T1DM, were followed up until they were over 18 years old to determine the correlates of poor glycaemic control during the transition from paediatric to adult care. Only 57% of patients had moved to adult led care with the median age of transition being 20.1 years old. The odds of poor glycaemic control were 2.5 times higher for patients who had transferred to adult care compared to those still under paediatric care. The difference in the organisation of health systems and payment for medical services in the USA compared to the NHS may have an impact on the

<table>
<thead>
<tr>
<th>Name of document</th>
<th>Organisation</th>
<th>Year</th>
<th>Comment on transition</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Service Framework for Diabetes: Standards</td>
<td>Department of Health</td>
<td>2001</td>
<td>Standard 6. All young people with diabetes will experience a smooth transition of care from paediatric diabetes services to adult diabetes services…</td>
</tr>
<tr>
<td>National Service Framework for Diabetes: Delivery Strategy</td>
<td>Department of Health</td>
<td>2002</td>
<td>The role of the named contact is particularly important at those times when diabetes care is most difficult – for example … during adolescence and the transition to adult services. Access to psychological support. Periods of transition – for example … when moving from paediatric to adult services … are times when self-management, routine care and surveillance are potentially more difficult</td>
</tr>
<tr>
<td>National Service Framework for Children, Young People and Maternity Services</td>
<td>Department of Health</td>
<td>2004</td>
<td>Standard 4. Growing up into adulthood: Young people supported to make the transition to adulthood and to achieve their maximum potential in terms of education, health, development and well-being</td>
</tr>
<tr>
<td>Diagnosis and Management of Type 1 Diabetes in Children, Young People and Adults</td>
<td>NICE</td>
<td>2004</td>
<td>Young people with type 1 diabetes should be allowed sufficient time to familiarise themselves with the practicalities of the transition from paediatric to adult services…</td>
</tr>
<tr>
<td>Making Every Young Person with Diabetes Matter</td>
<td>Department of Health</td>
<td>2007</td>
<td>Services should ensure the transition from children’s to adults’ services is negotiated and explicitly planned around the assessed needs of each individual young person</td>
</tr>
<tr>
<td>‘You’re welcome’: Quality criteria for young people friendly health services – 2011 edition</td>
<td>Department of Health</td>
<td>2007 / 2011</td>
<td>Theme 8. Health issues and transition for young people: The service has a clear procedure to prepare young people for the transition from health services designed for children and young people to adult health services</td>
</tr>
<tr>
<td>Transition: Moving on Well</td>
<td>Department of Health</td>
<td>2008</td>
<td>13 key principles for health transition planning for young people with complex health needs or a disability</td>
</tr>
<tr>
<td>Commissioning Services for Children and Young People with Diabetes</td>
<td>NHS Diabetes</td>
<td>2010</td>
<td>High-quality diabetes services for children and young people should ensure arrangements for the smooth transition between children and adult services that take into account the developmental needs and personal choices of the individual</td>
</tr>
<tr>
<td>State of the Nation</td>
<td>Diabetes UK</td>
<td>2012</td>
<td>Effective transition services must be in place to support young people when it is time for them to transfer into adult diabetes services</td>
</tr>
<tr>
<td>Diabetes transition: Assessment of current best practice and development of a future work programme to improve transition processes for young people with diabetes</td>
<td>NHS Diabetes &amp; Association of British Clinical Diabetologists (ABCD)</td>
<td>2012</td>
<td>The move from paediatric to adult services needs to be via a smooth process that helps young people feel empowered to self-manage their diabetes for the rest of their lives</td>
</tr>
<tr>
<td>Paediatric Diabetes Best Practice Tariff</td>
<td>Department of Health</td>
<td>2012 to 2013</td>
<td>Each provider unit must have a clear policy for transition to adult services</td>
</tr>
<tr>
<td>Adolescent transition care: guidance for nursing staff</td>
<td>Royal College of Nursing</td>
<td>2013</td>
<td>This guide provides an overview of the issues to consider when planning transition services and a practical framework for working with young people at each of the major phases of adolescence</td>
</tr>
<tr>
<td>Quality Standards for Transition</td>
<td>NHS Diabetes</td>
<td>2013</td>
<td>To provide a short checklist of diabetes specific information needed by a service to ensure they are offering a good quality transition process</td>
</tr>
</tbody>
</table>

Table 1. National policy documents and guidelines on transition from children’s services to adult services
age of transition but, clearly, providing continuity of care seems to mitigate against the deterioration of glycaemic control in this age group.

Most recently, the quality of transition care provided by a range of clinicians in Ireland was examined by Begley, who sent a postal questionnaire to 132 physicians and nurse specialists looking after people with T1DM and cystic fibrosis.30 Although the transition process varied according to the service, location and resources, disappointingly, the main factor determining when to transition was the age of the patient and not the patient’s choice.

**Systematic review of the models of transition care in the UK**

In 2009, NHS Diabetes commissioned Leeds Metropolitan University to undertake a systematic review of transition care for young people with diabetes.31 Three main questions were addressed:

- What models or components of models are effective in ensuring a successful transition process for young people with LTCs?
- What are the main barriers and facilitating factors in implementing a successful transition programme?
- What are the key issues for young people with LTCs and professionals involved in the transition process?

Twenty-nine studies including 16 systematic reviews were examined to understand the key components of successful transition models. No one model was found to be the most effective but a number of components were identified which were common in all good models. These included:

- The process was centred around the young person.
- It was a planned and structured process, with a written ‘roadmap’ and designated transition clinics attended by paediatric and adult HCPs.
- The provision of self-management education to provide them with the skills needed to manage their own condition.
- The need for a nominated transition coordinator to oversee the transition process, liaise with health, education and social sectors and maintain a link with the young person.
- A multidisciplinary approach integrating primary care and social services.
- Good collaboration and communication between the paediatric team, the adult team and the young person and their family. This could be helped by the introduction of a personal portfolio containing all the information required by the adult team about the young person’s medical and social history.
- Ongoing training of HCPs in effective interpersonal and communication skills.
- Adequate resources to deliver and maintain the transition programme.

Kime and Carlin also undertook a three-year study for NHS Diabetes to develop a model of care that would reflect the aspirations of ‘Making every young person with diabetes matter’ resulting in improvement in the care for children and young people with T1DM in England.27,32 They undertook process mapping in the nine sites across Yorkshire and Humber and used ‘talking groups’ (focus groups) and individual interviews to gain an understanding of current transition care and what was lacking.

The importance of a period of transition was highlighted and they suggested a minimum of a year in a transition clinic. However, during this time it was considered to be essential that the young people and parents were aware that they were in a transition process and understood what to expect during this time. Some services were involving young people in planning their transition and drawing up specific pre-transition plans. One of the main concerns was the difference in record keeping between the paediatric and adult services (paper vs electronic). This was recognised as a significant barrier to providing continuity of care for patients as the accumulated knowledge about the person over the previous 18 years could be lost on transfer to an electronic record system.

**Achieving smooth transition: what is the evidence?**

A study to describe and evaluate the different models of transition care for people with diabetes was carried out by Allen et al.33,34 They surveyed 35 different diabetes transition services in England and categorised them into six main models of care. Case studies with young people and their carers were undertaken to help evaluate five of these models and understand the mechanisms central to smooth transition. They found that local services often developed as a result of national guidelines, local champions, the need to reduce DNA rates and in response to the needs of the young people. For each service, there was a range of ages at which young people entered the transition process with a varying number of clinics between the general paediatric and adult clinics. Their research outlined a number of different types of continuity in moving from the paediatric to the adult service including:

- Relational and longitudinal continuity – these types of continuity facilitate other key aspects of care and provide security and safety during times of change.
- Cultural continuity – minimising the differences between the paediatric and adult care culture.
- Management continuity – the continuity of diabetes management through a common purpose and plan, shared between the team members.
- Information continuity – ideally, developed by both the paediatric and adult teams.
- Developmental continuity – proactively encouraging the young person to grow into a more independent adult.
- Flexible continuity – support is responsive to individual need.

Table 2 summarises the five different models of transition care arising from Allen et al.’s study.

The study tried to identify measures that would enhance the continuity within each of these categories. Continuity of relationships over time was key to a successful transition and this seemed to facilitate other aspects of continuity including cultural, flexible and management continuity. Clearly, this would include all members of the multidisciplinary team – doctors, nurses, dietitians and, in many cases, administrative staff. The balance between developmental and flexible continuity was recognised as difficult to achieve. However, young people and their families had greater satisfaction with the service and improved quality of life when there
was greater emphasis on flexible continuity. The models with a high level of relational, flexible and cultural continuity achieved a smooth transition with relatively low cost, informal management and information systems.

Interestingly, the main difference between young people and their carers regarding the aspects central to a smooth transition was the involvement of mothers. As the process of transition proceeds, mothers (and fathers) can feel cut off from the advice needed to support their child as well as not having access to their own support as they reduce contact with health care providers.5

Other research has confirmed an association between the involvement of primary carers and the outcomes of people with T1DM (glycaemic control, adherence, quality of life etc.).35 High levels of collaboration between young people and their parents (or primary carer) were associated with a lower HbA1c and more involvement in the young person’s diabetes care. Whether this could lead to an intervention has yet to be proved. However, carers and parents tend not to be included in national policies, potentially missing an important part of the relational structures that influence the outcomes for young people with diabetes.

Putting some of this theory into practice, some examples of good practice in transition care in the UK were identified by NHS Diabetes and ABCD.10 These services reflected some of the aspects of continuity identified by Allen et al. Examples included: • The development of a ‘suite of tools’ in the North West Paediatric Diabetes Network to help units assess transition processes, write their transition policy and develop a transition plan. • The use of this suite of tools in Alder Hey leading to the introduction of a patient held transition plan from the age of 11 through to adulthood. Transition is introduced to

<table>
<thead>
<tr>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
<th>Model 5</th>
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</thead>
<tbody>
<tr>
<td>No. of transition stages</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Relational continuity</td>
<td>Relational separation between paediatric and adult service</td>
<td>Relational separation between paediatric and adult service</td>
<td>Joint adult and paediatric DSN role provides good relational continuity</td>
<td>Joint adolescent clinic</td>
</tr>
<tr>
<td>Informational continuity</td>
<td>Letters, information leaflets, transfer home visit</td>
<td>Website, letters, information leaflets, handover clinic</td>
<td>Built into consultations</td>
<td>Built into consultations</td>
</tr>
<tr>
<td>Management and cultural continuity</td>
<td>Pre-clinic briefing, ongoing handover, transition nurse, cross boundary working of adult DSN</td>
<td>De-brief after clinic, clinical summary sent to family, transfer letter, joint consultation as required, shared ethos</td>
<td>Concurrent running of paediatric and young person’s clinics, formal handover, DSNs span boundaries, joined up philosophy and ethos</td>
<td>Shared office accommodation, pre-brief and de-brief meetings, cultural discontinuity between adult and paediatric services acknowledged</td>
</tr>
<tr>
<td>Developmental and flexible continuity</td>
<td>Structured approach, milestone and risk factors, intensive support in young adult services with formal education, home visits, continue to involve parents</td>
<td>Checklist of education, clinic summary sent to family, website, leaflets, group education, shared clinical environment, email system, realistic, non-judgemental approach</td>
<td>Patient centred, non-judgemental approach, high levels of ongoing support in between clinics, continuing engagement with parents</td>
<td>Developmental milestones, parents remain welcome, nurse-led young adult service, home visits, choice and flexibility of service</td>
</tr>
</tbody>
</table>


Table 2. Five different models of transition care (Allen et al.)33
young people at an early age, and talked about at the ‘summer days’ when children move from primary to secondary school.

- A flexible multidisciplinary process in Bury, recognising that transition is a process and not a one-off event, requiring tailoring to each individual patient and family.
- A one-day training programme for staff who have contact with young people in Northumbria is run for staff at all grades across the trust – the aim being to consolidate core skills across the organisation so that a young person receives an age-appropriate service wherever and whenever they access trust services.
- The involvement of a podiatrist to provide education for young people in Pennine Acute Trust to help them actively monitor and care for their feet.
- Transition clinic appointments are held at the same time as the young adult clinic in Leeds, allowing all young people to mix and attend at the same time. Joint meetings between the paediatric team responsible for transition and the young adult team every six to eight weeks allow specific patients to be discussed and the service reviewed. Young people’s views are taken into account and the hope is to appoint a transition team including two transition diabetes specialist nurses and a diabetes dietician specifically for 16–19-year-old people.

**Goals of transition care and measuring transition care quality**

It has been widely assumed that the goal of transition is independence from carers, with dependence perceived as ‘childish’ and a move towards independence essential in transferring to the adult services. Attaining independence is often seen as a marker of a successful move from child-based care to adult care; however, as more and more young people continue to live with their parents during college and into their 20s, there is often a need for increased rather than reduced parental support at this time. Others have suggested that interdependencies may be a more helpful way of thinking about relationships at this time of the young person’s life. Research continues to show the important role of parental involvement in supporting self-management.

Allen and Gregory also draw a helpful distinction between the purpose of a transition service in either helping young people move smoothly between two services or alternatively ‘in providing a service that meets the needs of young people with diabetes at this stage of their life course’. This latter goal of the transition service focuses the clinician’s attention to the experiences and needs of the young people in their own right and helps develop a health system based around adolescent health. Early reports have started this process of understanding the health needs of this age group.

Several documents have drawn up a list of how to measure the quality of transition services for young people with diabetes. More recently, NHS Diabetes published a set of Quality Standards for Transition (Appendix 1 [available online at www.practicaldiabetes.com]) which provides a checklist against which a service can ensure that it is providing a good quality transition service. However, there are no quantifiable measures in these standards, and no national standards against which a service can benchmark itself. Other documents have suggested the following data should be collected and audited in order to provide assurance of a high-quality diabetes transition service.

‘Making Every Young Person with Diabetes Matter’:
- Service user satisfaction.
- Attendance rates pre- and post-transition.
- HbA1c pre- and post-transition.
- Named key worker.
- Audit to explicitly identify diabetes care provider between age 16 and 25.
- Transition plans audit.
- Inpatient processes and policy.

‘Diabetes transition: Assessment of current best practice and development of a future work programme to improve transition processes for young people with diabetes’:
- A joint paediatric/adult transition policy – including record of safeguarding training, CRB checks, when transition is introduced and takes place, patient choice, dealing with complex issues.
- Evidence of consultation and user involvement in the policy development.

- Experience of care audit.
- Competency measure such as assessment through individual transition plan.
- An identified lead for transition in each paediatric and adult diabetes service.
- Evidence of use of a shared care planning template.

**Other resources**

Several websites provide helpful guidance and further information both for professionals and young people. These include:

There is also a free journal for health care professionals caring for children and young people with diabetes – Diabetes Care for Children and Young People (www.diabetesonthenet.com/dccyp).

**Conclusions**

A lot has been published on the importance of good transitional care in the UK for young people with diabetes. However, there is limited evidence to inform clinicians of the best models of transition and which components are essential to provide successful, smooth transition to adult care. A national registry of transition services with agreed outcome measures would be a significant step forward to ensure young people with diabetes receive the best care during this complex and challenging stage of their lives.

**Acknowledgements**

I wish to acknowledge Dr Julie Edge for reviewing the manuscript and providing constructive criticism.

**References**

References are available in Practical Diabetes online at www.practicaldiabetes.com.
References

32. Kime N, Carlin E. ‘Join Us on Our Journey’: Developing a New Model of Care of Children and Young People with Type 1 Diabetes, final report. NHS Diabetes, March 2012.
## Review

### Transitional care for young people with diabetes

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<th>Beneficial features</th>
<th>Minimum standards</th>
<th>Examples/explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person</td>
<td>Transition should be based on developmental readiness not chronological age</td>
<td>Young people will be ready to move to an adult service at different ages; a 17 year old who has been working for a year may be more ready than one still at school</td>
</tr>
<tr>
<td>Parent</td>
<td>Parents’ needs must be considered in the transition process</td>
<td>Parents may need to support or hand over control of diabetes to their child</td>
</tr>
<tr>
<td>Partnership</td>
<td>The young person, their parents and the professional should understand and reach agreement on each step of the process</td>
<td>A competency based checklist for transition should be used. The expectations within this should be explained to young people and parents so they are clear what can be achieved</td>
</tr>
<tr>
<td>Participation</td>
<td>Young people must be invited to share their views about their diabetes service annually</td>
<td>The unit should run a survey or focus group annually. The results must be collated and used to improve the diabetes service with feedback offered</td>
</tr>
<tr>
<td>Professional</td>
<td>The professionals involved in transition should demonstrate an interest in young peoples’ health and wellbeing</td>
<td>Professionals should have received appropriate training in how to communicate with young people, e.g. e-learning for health and tools such as motivational interviewing. A process should be in place to get feedback from young people on each professional’s communication skills. The GMC has a patient feedback questionnaire*</td>
</tr>
<tr>
<td>Preparation</td>
<td>Transition should be introduced at around 12 years of age</td>
<td>In order to prepare young people for the differences in services there should be regular discussions at appointments from 12 onwards</td>
</tr>
<tr>
<td>Planned</td>
<td>Each young person should have a personalised care plan agreed with them</td>
<td>The steps in the transition process should be available for young people and parents. These steps should be agreed with the adult service whether in the acute trust or in the community</td>
</tr>
<tr>
<td>Place</td>
<td>Transition clinics and inpatient care should take place in a young person friendly environment</td>
<td>Implementing the ‘You’re Welcome’ standards. ** A young person should be offered their inpatient stay in a dedicated young persons’ area which could be either the adult or paediatric ward</td>
</tr>
<tr>
<td>Process</td>
<td>It should take at least a year of joint consultation for the young person to transition into adult services</td>
<td>Each team should be represented at each consultation during that year. Young people may choose to move on earlier but it should be standard practice to offer them at least a year’s worth of joint clinic appointments</td>
</tr>
<tr>
<td>Pumps, Pregnancy and Pre-existing conditions</td>
<td>A clear policy for young people who have more complexity in their care plan is needed</td>
<td>Young people with additional needs are often ‘lost’ to the transition process. Adult and paediatric services need to ensure that they have described how the needs of these young people will be met</td>
</tr>
</tbody>
</table>


### Appendix 1

NHS Diabetes Quality Standards for Transition