Newly Diagnosed Patients: First Year of Care Pathway

At Diagnosis:
Patient centred sessions

1. Explanation of diabetes & treatment*
2. Practical skills*
3. Food, CHO awareness & diabetes*
4. Glucose targets, Insulin, Food & physical activity*
5. Hypo management*
6. Promote positive and consistent messages regarding diet and body image
7. Diabetes at home & school
8. Diabetes during illness/DKA
9. Preparing for home (Consider advanced technology as per national guidance)

*** Essential prior to discharge/at diagnosis**

Team to map the above on current education package & knowledge assessment check list using verbal, written and video resources.
Family provided with emergency contacts (Out of hours etc)

Within first 2-6 weeks

Follow Core Clinic components plus:

- MDT clinic review
- Dietetic review
- Meet diabetes team psychologist
- Level 3 CHO Counting – if not already achieved
- Set up to relevant education apps (Digibete, DeApp etc)
- Review of screening blood results taken at diagnosis
- Explanation of routine diabetes care/annual review/retinal screening/HbA1c/clinic targets/time in range/understanding of DKA/discussion around complications of diabetes
- Information on DLA
- Pre-emptive discussion around remission phase and changing insulin requirements

3 months: OPA (HbA1c)

Follow Core Clinic components plus:

- How to assess and optimise time in range (if applicable)
- Advanced education of diabetes management
- Discuss HbA1c targets
- Discuss the impact of diabetes on the relationship with food and activity

6 & 9 months: OPA (HbA1c)

- Follow Core Clinic components plus:
- Explore data review & support - encourage changes based on self-analysis (if possible)
- Patient centred/led discussion
- Introduce Goals of Diabetes (or equivalent) & annual review
- Review education, knowledge and understanding
- Pre-emptive discussion around remission phase and changing insulin requirements

12 months: OPA (HbA1c)

- Follow Core Clinic components plus:
- Explore data review & support
- Encourage CYP/families to identify 2 relevant educational refreshers e.g CHO counting, hypo management
- Discuss and complete annual care processes - follow with a discussion around complications of diabetes
- Review education on sick day rules and ketone testing
- Dietetic review
- Promote positive and consistent messages

First Week of Care

Ongoing Care: 'How Can The Team Help?', 'What Is Going Well?', 'What Are The Challenges?'

Within the first week (Diabetes Team)

- Family provided with any relevant diabetes resources
- Ensure expectations given to recording blood glucose, insulin and food data (diary or electronic)
- Check biographical details
- Check family email address
- Set up download account, link to any relevant apps and bolus advisor apps
- Set up to relevant education apps (Digibete, DeApp etc)
- Signpost emotional resources (JDRF, MindMate, DUK, Digibete)
- Give details regarding next appointments
- Allocation of named nurse or key worker
- Psychology contact - phone, leaflet, meet and greet if possible
- School care plan completion, training of school staff and contact made with school - ensure completion before returning to education (as per local guidance)
- Education on glucagon and training (If not completed at diagnosis)

On-going support between MDT clinics, examples include:

- Telephone contacts by named nurse & dietitian
- Joint CDSN/Dietitian review
- Electronic or written data review - blood glucose, insulin and food data
- Introduction to data review & support - Set expectations of regular self-review of downloading
- Follow up with school (as required)
- School menus - consideration of CHO counting at school (as per local guidance)
- Follow up with healthy eating, CHO counting, fat and protein and glycaemic index
- Exercise and physical activity
- Check emotional wellbeing
- Support for travel/staying away from home
- Information on relevant peer support groups

Core Clinic Components

1. **Celebrate successful behaviours!**
2. MDT clinic review
3. Data review including HbA1c targets, time in range
4. Discuss data review & support accordingly (including dietetic review) - Check ability to share data remotely
5. Consider advanced technology as per national guidance
6. Check wellbeing and identify any changes - Emotional support resources.
7. Promote positive and consistent messages regarding diet and body image - use resources
8. Promoting healthy lifestyle including food and activity

Diabetes Care Aims and Objectives:

- HbA1c ≤48mmol/mol (by 6 months & maintained)
- Average 14 day glucose < 8mmol/l (sensor data)
- Standard Deviation < 3.0 (sensor data)
- Time in range (4-10mmol/L) 70% (based on 70% sensor usage)
- Ensuring patient centred/led care
- Working in partnership with the CYP and their family
- To discuss each clinic & consider options to facilitate target achievement:
  1. Technology use incl. pump therapy, FGS/CGM, Hybrid Closed Loop
  2. Education required (developmental/age appropriate)
  3. Promote regular data review by CYP/families
  4. Extra appointments/referrals (e.g. social care, psychology)
  5. Injection & infusion sites
  6. Early help referral

Celebrate successful behaviours!
(Not specifically achieving targets)

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