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Sheffield Children's NHS
NHS Foundation Trust



Audit Presentation: Newly Diagnosed Patients with Type 2 Diabetes First Year of Care (FYOC) Pathway

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Introduction

A QI initiative was started in 2022 to develop a new guideline and first year of care (FYOC) pathway for CYP with newly diagnosed T2DM. This was developed based on the national FYOC tool for Type 1 Diabetes, using latest guidance for T2 (ACDC guidelines).

Implemented: 27th June 2022.

Pathway aims:

1. Develop a consistent approach to management of CYP with T2DM from diagnosis
2. Screen for and treat all complications
3. Improve outcomes - Glycaemic control and weight loss
4. Improve engagement with patients and families

Newly diagnosed T2 patients
Timeline for first year of care

At Diagnosis

At diagnosis: Acute or planned admission

- Diabetes autoantibody screen / MODY probability calculator
- TFTs, coeliac, LFTs, Vitamin D, B12, Mg and baseline liver USS, and Urine ACR as inpatient
- 4hrly BP monitoring
- Start Metformin +/- insulin (see NICE NG18)
- New patient starter box
- T2 educational resources and Digibete T2 app (code M931U)
- Education by PDSN - BG testing (decide on frequency) + ketone testing, home downloading of BG data. Libre for two weeks
- Education by diabetes specialist dietitian – lifestyle, diet and physical activity assessment
- Meet with Psychologist, screening tools as required
- Allocation of diabetes educator for regular contact and downloading feedback
- Completion of inpatient T2 diabetes educator checklist
- Supervision of 3 healthy meals with recognition of food groups and recommended portion sizes by diabetes educators
- Set targets HbA1c <48mmol/mol at 3mths, weight loss acc to age and stage of development, and SMART lifestyle goals
- Arrange outpatient education sessions and home visit
- Arrange MDT clinic appointments
- Consider referral to Live Lighter, SHINE
- Consider writing to GP for CEW screening for siblings or DUK T2 'know your risk' for adult family members, NDPP signposting

First weeks at home

- Regular telephone contact with diabetes educator
- Completion of post discharge T2 diabetes educator checklist
- Refer to psychology if not seen
- WhatsApp food pictures to dietitian (as food diary)
- Home visit
- T2 apps and resources
- GlucaGen hypokit training
- School care plan & school training
- Help with downloading at home if needed
- Drive-by downloading if unable to download at home
- Frequent review of blood glucose data with medication adjustment as needed
- Lifestyle target Review
- MDT Clinic appointments at 2 weeks, 4 weeks, 8 weeks, 12 & 16 weeks post diagnosis, then 3 monthly
- Dietitian reviews at 2 weeks, 4 weeks, 8 weeks, 12 weeks, 16 weeks, then 5mths, 7mths, 9mths then 3 monthly, coinciding with MDT appts where possible.

Diabetes targets

- HbA1c ≤ 48mmol/L by 3 months and maintained
- Average 14-day glucose <8mmol/l
- Time in range 3.9-10.0mmol/l 80% (if using CGMS)
- Time in range 3.9-8.0mmol/l 50% (if using CGMS)
- 5% weight loss in first 3 mths for pre-pubertal and pubertal CYP
- 5% weight loss in first 3-6 mths for post-pubertal, and 10% in first year (0.25-0.5 BMI SDS reduction)
- Aiming for BMI <85th centile longer term
- Treatment of complications
- To discuss each clinic and consider options to facilitate target achievement:
  - *Education review*
  - *BG data review, consideration of longer term CGMS*
  - *Downloading and reviewing data at home*
  - *Medication review, and treatment to target escalation*
  - *Lifestyle review – diet, exercise, school and sleep*
  - *Psychology*
  - *More frequent appointments*
  - *Early help or social care referral*
  - *Elective admission*
  - *Improving HbA1c pathway*
  - *Consideration of CEW service input*

Celebrate successful behaviours (not specifically achieving targets)

Outpatient Care: 'How can the team help?', 'What is going well?', 'What are the challenges?'

2-week OPA & Dietitian

- BMI & BP & WC
- Glycaemic control
- Medication review
- Diagnosis blds as above if not done
- Baseline Liver USS if not done **+/- referral to hepatology**
- **Screen for OSA**, consider home oximetry +/- respiratory or sleep nurse referral
- Urine ACR if not done
- **Screen for PCOS**
- **Smoking** – offer cessation
- **Oral health** - check registered with dentist
- Dietitian lifestyle review

1-month OPA & Dietitian

- BMI & BP
- Glycaemic control
- Medication review (NG18)
- **Review BPs as inpatient, at 2 week OPA and now – if persistently abnormal consider ambulatory BP monitoring**
- Dietitian lifestyle review

2-month OPA & Dietitian

- BMI & BP
- Glycaemic control
- Medication review
- Average BG >8mmol/L – is more support required
- Dietitian Lifestyle Review

3-month OPA & Dietitian

- BMI & BP
- Glycaemic control
- Medication review
- HbA1c < 48, taper basal insulin
- HbA1c > 48mmol– is more support or intervention required
- **Review weight loss**
- **Non-fasted blood lipid profile**
- Dietitian Lifestyle Review

4-month OPA & Dietitian

- BMI & BP
- Glycaemic control
- Medication review
- HbA1c > 48, mmol/mol, escalate treatment (NG18) & support
- Dietitian Lifestyle Review

5 and 7-month Dietitian Review

6-month OPA

- BMI & BP & WC
- Glycaemic control
- Medication review
- HbA1c > 48mmol/mol – escalate treatment (NG18) & support
- **If no weight loss, consider a different diet plan**
- **BP still raised consider ACE inhibitors**
- **Consider C-peptide if diagnostic doubt**

9-month OPA & Dietitian

- BMI & BP
- Glycaemic control
- Medication review
- HbA1c > 48, escalate tx and support
- **Repeat Lipids if high at 3 mths, consider statins**
- Dietitian Lifestyle Review

12 months OPA & Dietitian + ANNUAL REVIEW

- BMI & BP & WC
- Glycaemic control
- Medication review
- HbA1c > 48mmol/mol – is more support or intervention required
- Annual review bloods (lipids, Vit D, TFTs, LFTs, (Vit B12, Mg), injection sites, urine ACR, vaccination reminder, smoking, dentist, consider CGM
- Wellbeing questionnaire (PAID T2, PEDS-QL, or PHQ-2 (ADO-BED for binge eating) +/- referral to psychology
- Foot exam from 12 years
- Retinopathy from 12 years
- Liver USS every 3 years
- Weight targets and trajectory
- Dietetic Annual Review
- Structured Education

Meet with psychology team within the first 6 months

Audit Aims and Standards

AIM:

To review our clinical practice in all patients with a new diagnosis of T2DM since the FYOC pathway was implemented.

Objectives:

- Collect patient demographic data
- Assess practice against all areas of pathway: Diagnosis, screening of complications, first few weeks of care, out-patient care
- Assess patient outcomes (Glycaemic control, BMI, Weight loss)
- Recommend suggestions for improvements to the FYOC pathway and service for patients

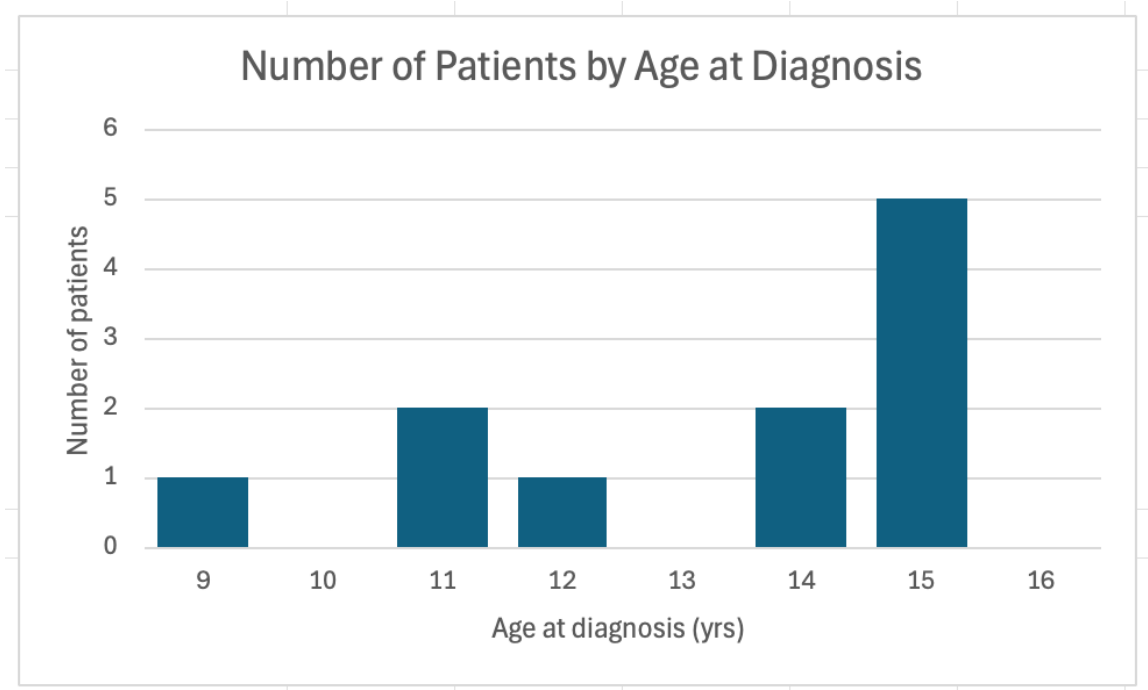
STANDARDS: Aiming for 100% completion of all health care checks and management of complications within initial treatment period.

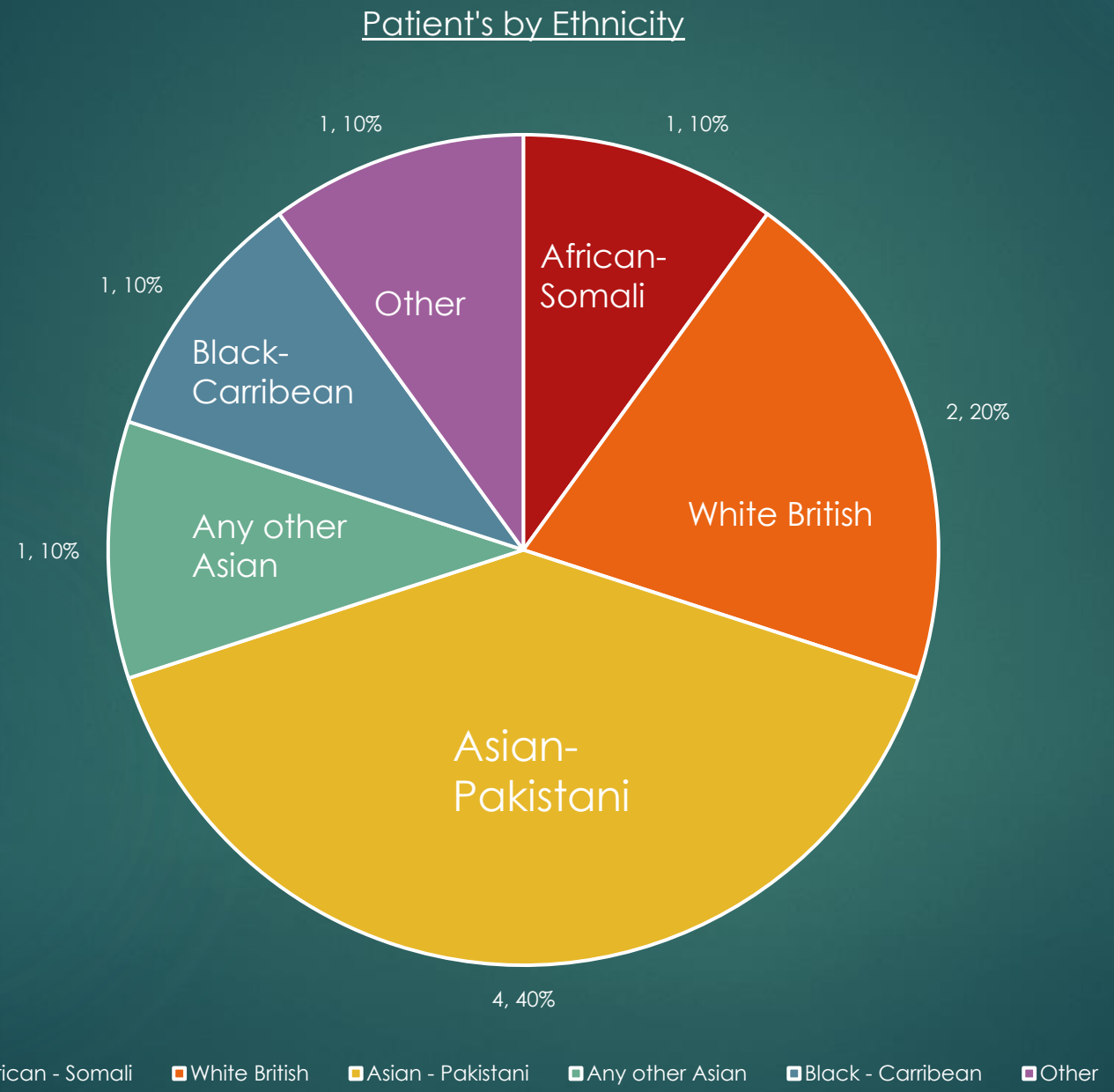
Patient Demographics

Patient demographics

Since FYOC introduced

- 11 patients
- 10 female, 1 male
- 1 excluded as diagnosed and cared for elsewhere, seen here as under SCH Oncology Team
- All patients have a family history; 60% have a first degree relative with T2DM

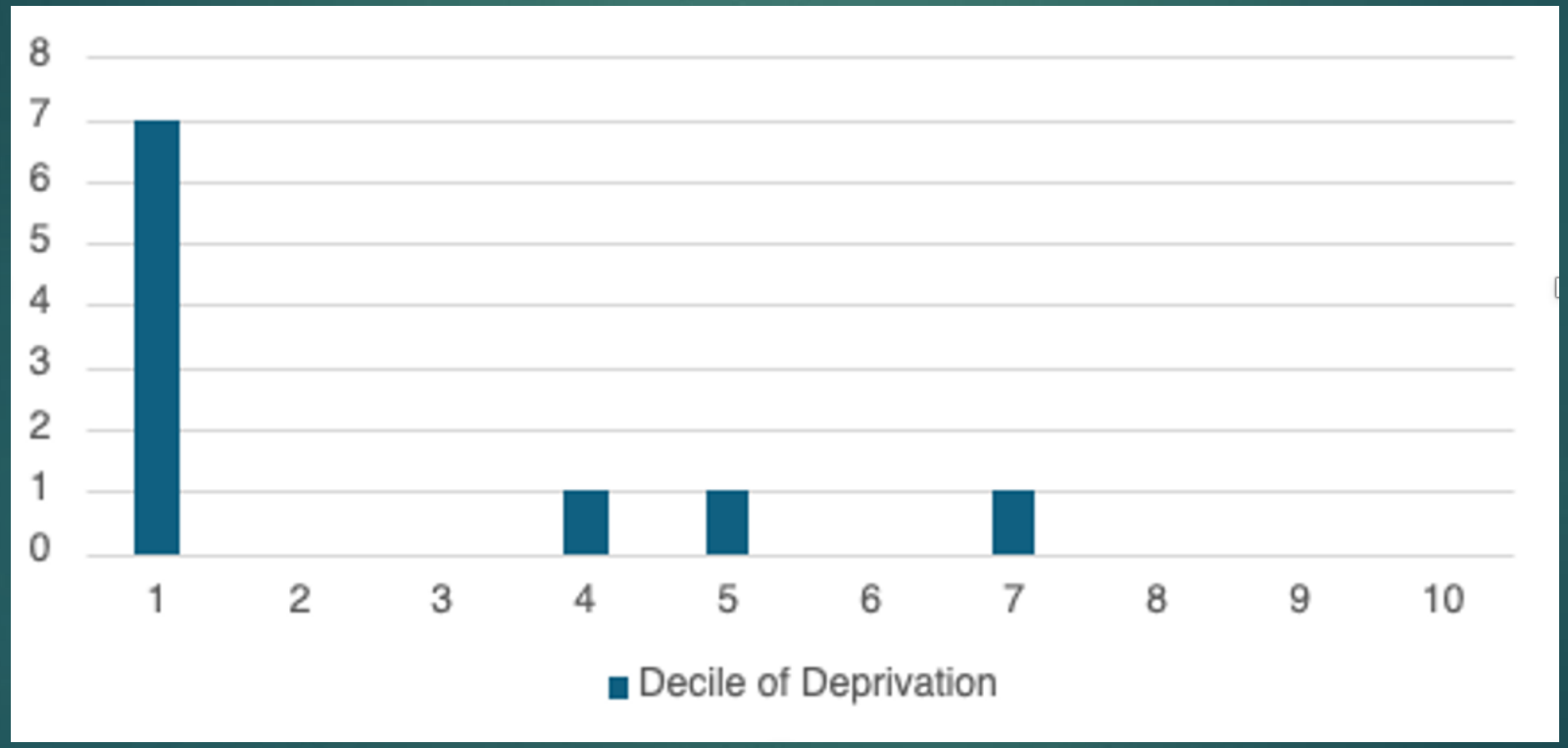




70% patients in ethnic group of higher risk of T2DM

Patients by Deprivation Index

Number of Patients by English Index of Multiple Deprivation Decile



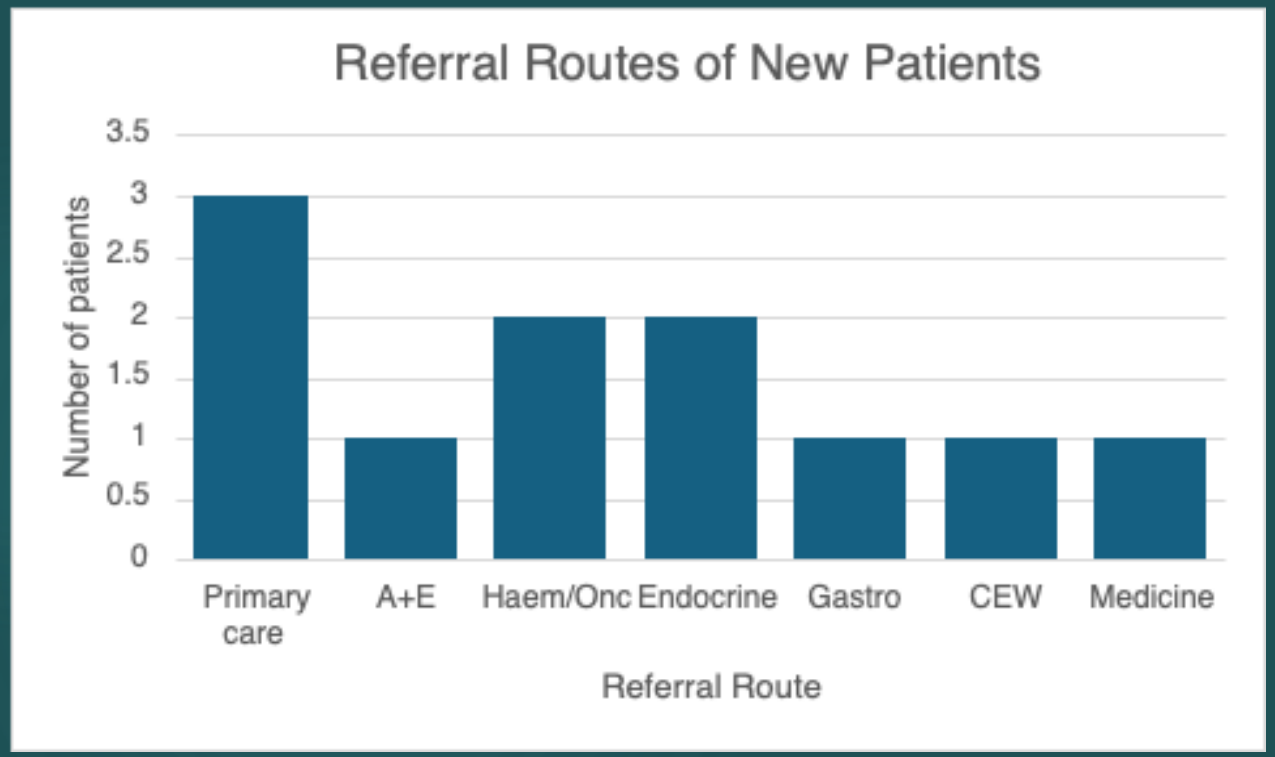
Decile 1 = Most Deprived Decile 10 = Least Deprived

Patient co-morbidities

Audit number	Co-morbidities
1	Sleep disordered breathing
2	BMT for Amegakaryocytic Thrombocytopaenia, GvHD. Parotid carcinoma. Complications from BMT
3	Hodgkins lymphoma
4	None
5	PCOS, obesity, acanthosis nigricans
6	Homozygous PLA2G6 mutation, progressive complex degenerative neurological disorder, known to palliative care, autonomic instability, PEG fed. Gene mutation associated with type 2 diabetes
7	Polygenic Hypercholestrolaemia, selective mutism
8	Orofacial digital syndrome, agenesis of corpus callosum, cleft lip, seizures, obesity, autism
9	Obesity
10	Obesity
11	Obesity, fatty liver disease, possible OSA

AT DIAGNOSIS

How did patients present?



Presentations
Polyuria/polydypsia
Recurrent infections
Obesity screening bloods
Under other speciality for complications of obesity - fatty liver, PCOS, noted acanthosis nigricans
Raised glucose when unwell

Investigations at diagnosis

Audit Number	HbA1c (mmol/mol)	Fasting gluc (mmol/l)	OGTT result (mmol/l)	Ketones at diagnosis ?
1	107	13.6 Random	Not done	3
2	Not done	4.7	Yes 12.6	No
3				
4	129	Random 15.5	Not done	0.8
5	46	7.3	Yes 13.9	No
6	44	9.5	Not done	0.1
7	93	10.4	Not done	0.1
8	50	7	Not done	Not done
9	43	6.8	Yes 11.2	Not done
10	54	Not done	Not done	0.2
11	67	6	Not done	<0.1

Diagnosis and education location

2 ADMITTED ACUTELY – THOUGHT TO BE **T1DM**

1 ADMITTED ACUTELY FOR LRTI (INCIDENTAL DIAGNOSIS OF RAISED GLUCOSE)

4 ELECTIVE WARD ADMISSIONS

2 CLINIC

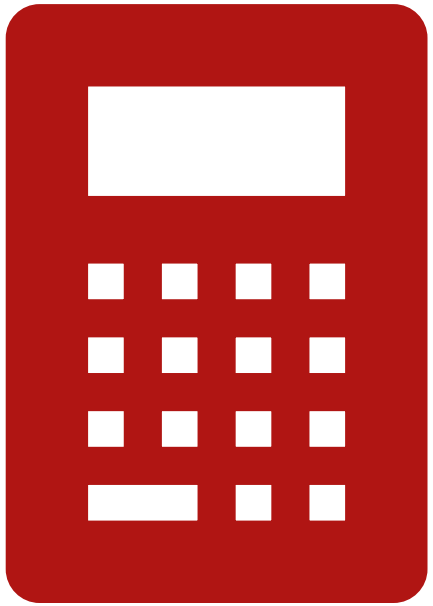
1 OP EDUCATION DAY

Diabetes Auto-antibodies

- 8/10 sent at time of referral to Diabetes Team
- 2 sent several months later – both complex patients seen in clinic
- 5 pts had all 4 abs tested (Pancreatic islet cell, Anti-GAD, Anti Zn T8, Islet cell antigen 2A)
- 4 pts only 3 Abs sent, 1 pt only 2

- Of all bloods sent only 1 positive ab

Mody calculator done?



YES IN 40% OF PATIENTS

NO IN 60%

(1/2 NO FIRST DEGREE RELATIVE WITH DIABETES)

Initial Pharmacotherapy

8/10 started immediately on Metformin.

2 thought initially to be Type 1 (had HbA1c of 107 and 129), started s/c insulin. Started Metformin later once diagnosis of type 2 confirmed

1 started on metformin and insulin at diagnosis (HbA1c 93)

Patients with delayed diagnosis

Patient 1:

- 9yo female, Somalian family
- Presented to ED: polyuria, polydypsia, weight loss
- Gluc 15.0, Ketones 3, pH 7.39
- HbA1c 107
- BMI 26.2 (just over 99.6th centile)
- FHx: 2 cousins T1DM, 2 x G'parents T2DM
- Large doses of insulin needed noticed on ward
- All diabetes abs negative
- Diagnosed 6 weeks after initial presentation

- Patient 4:
- 15yo male, Asian – Pakistani family
- Presented to GP: polyuria, polydypsia, weight loss,
- Random glucose 15mmol/l, ketones 0.9 pH 7.34
- FHx: Second degree relatives with T2DM (2 x aunties)
- HbA1c 128
- BMI 26.8, just above 98th centile no acanthosis nigricans
- Suspicion from beginning of T2, initial abs then negative
- Extended ab screen sent + started on Metformin whilst awaiting "likely type 2 in clinic letter"
- When all 4 negative diagnosed T2 in Clinic
- Diagnosed 8 weeks after initial presentation

Initial Glucose Monitoring

- 5/10 Flash glucose Monitoring
- 3/10 Continuous Glucose Monitoring
- 2/10 Finger prick monitoring

Education at Diagnosis

- Only 1 pt had T2 checklist uploaded on EDMS – this proved all education done except SMART lifestyle goals/ target HbA1c

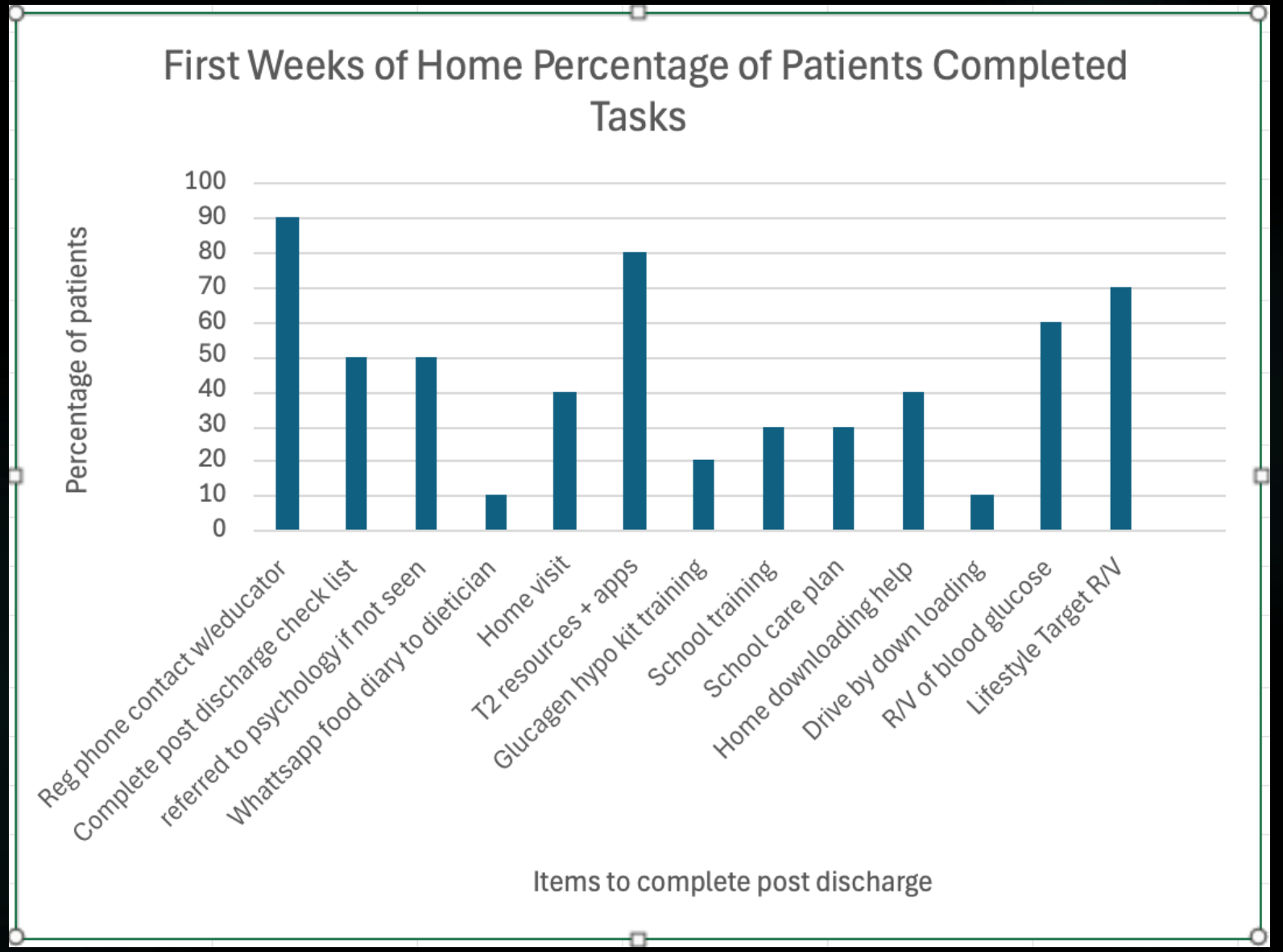
Education	% Patients documented as completed
New Type 2 Starter box	10
T2 resources + Apps provided?	20
BG testing	90
Ketone testing	60
Home downloading	20
Lifestyle/diet/exercise assessment	90
Met with psychology	30
Allocate educator	50
Complete Type 2 Checklist	10 *
Supervise 3 meals	30
Set SMART lifestyle goals	0
Set target HbA1c < 48 at 3/12	0
Set weight loss target according to age	30

Screening

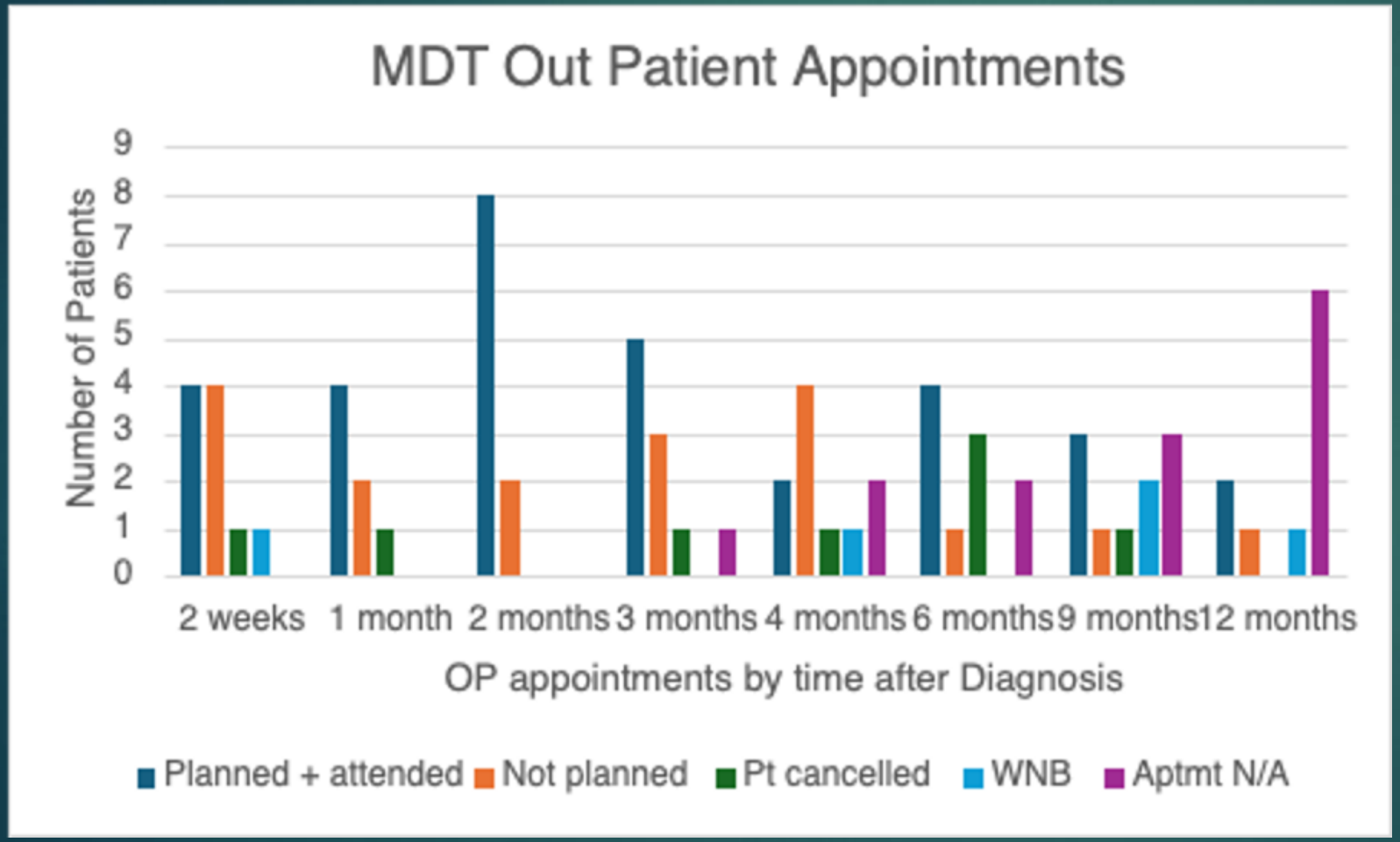
- Consider referral to Live Lighter/Shine
  - 7/10 No,
  - 1 diagnosed in CEW
  - 1 already referred,
  - 1 referred by us

- Consider writing to GP for CEW screening for siblings 0/10
- Signpost families to DUK T2 know your risk for adult family members 0/10
- Signpost families to NHS Diabetes Prevention Programme 0/10

OUT PATIENT CARE


First Weeks of Home Percentage of Patients Completed Tasks
Percentage of patients
100
90
80
70
60
50
40
30
20
10
0
Reg phone contact w/educator
Complete post discharge check list
referred to psychology if not seen
Whattsapp food diary to dietician
Home visit
T2 resources + apps
Glucagen hypo kit training
School training
School care plan
Home downloading help
Drive by down loading
R/V of blood glucose
Lifestyle Target R/V
Items to complete post discharge

Schedule of OP appointments according to FYOC Pathway (Total Patient Number =10)



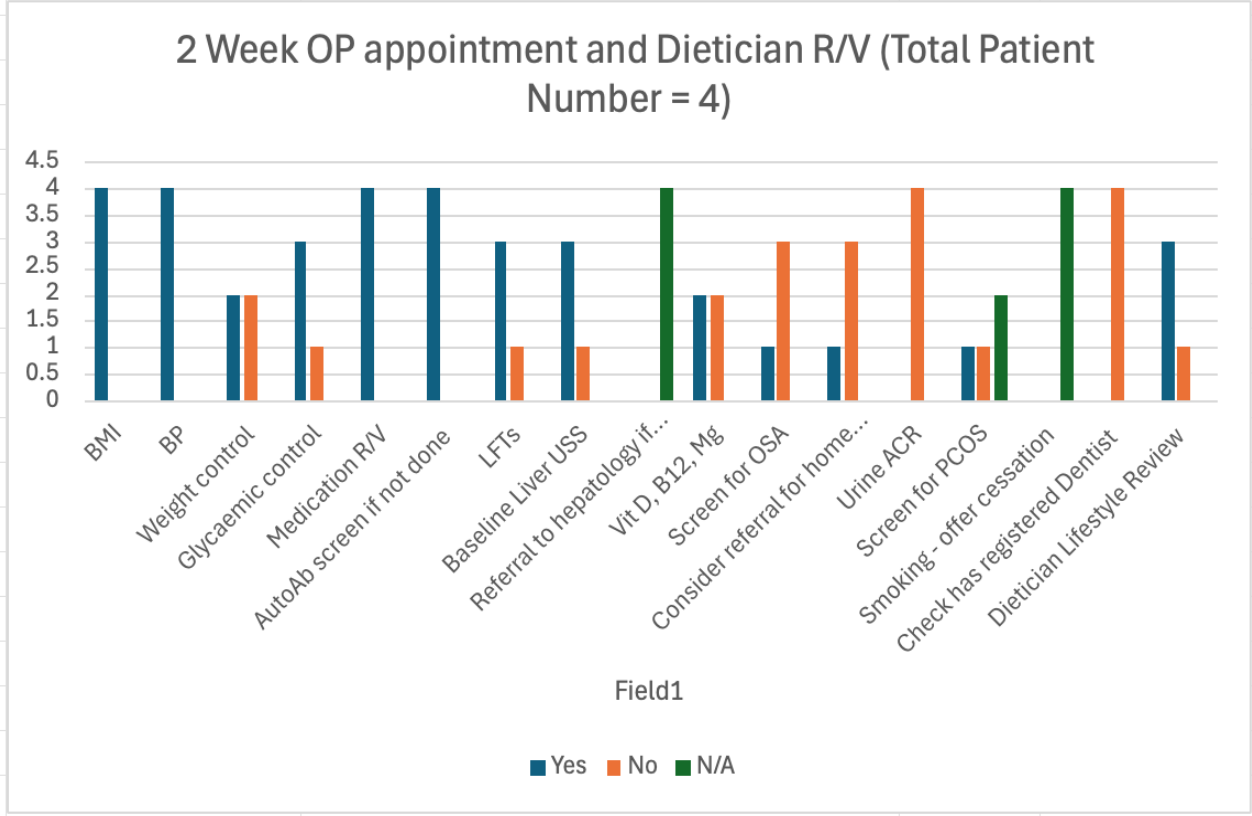
- Aptmt N/A = this time post diagnosis not reached
- Not planned:

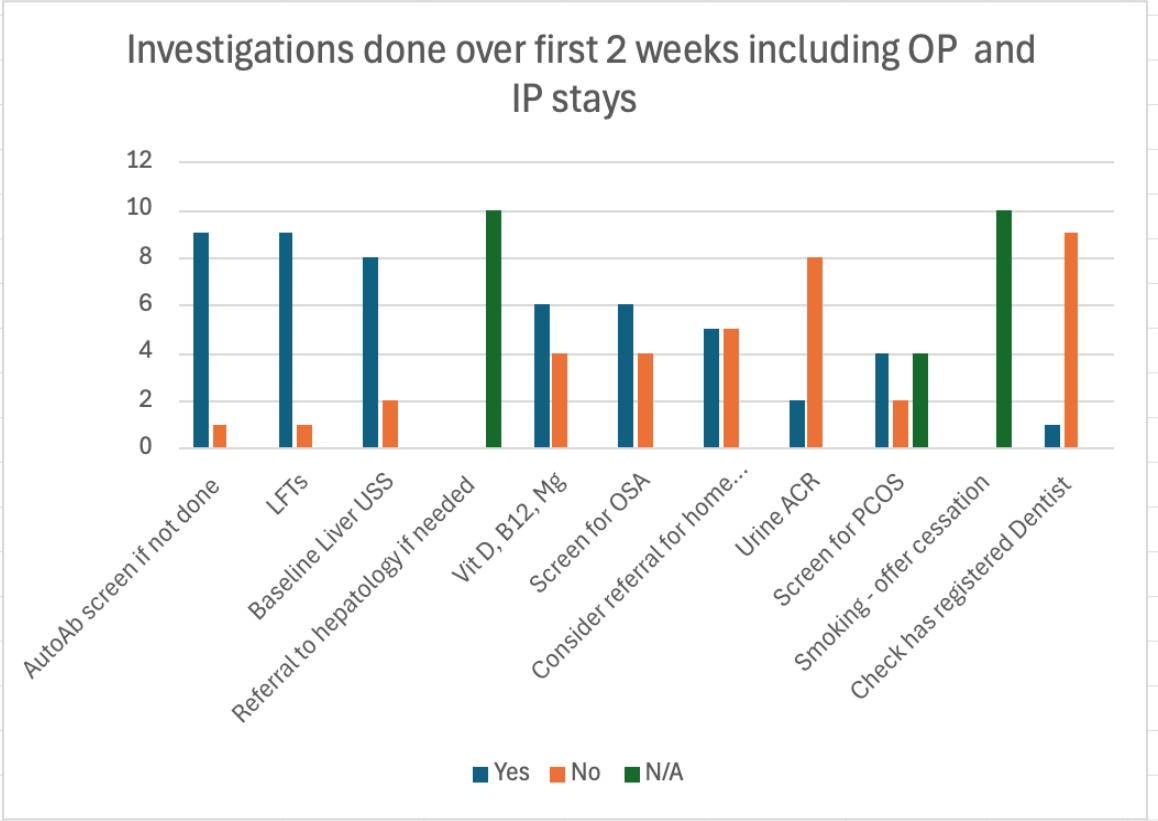
Some complex pts eg palliative care/oncology

Doing well and plan to see later

Seen by junior Drs

First OP review and Investigations done within 2 weeks of diagnosis





Only 4/10 pts had an OP apmt at 2 weeks.
2 of these pts were still thought to be T1DM.

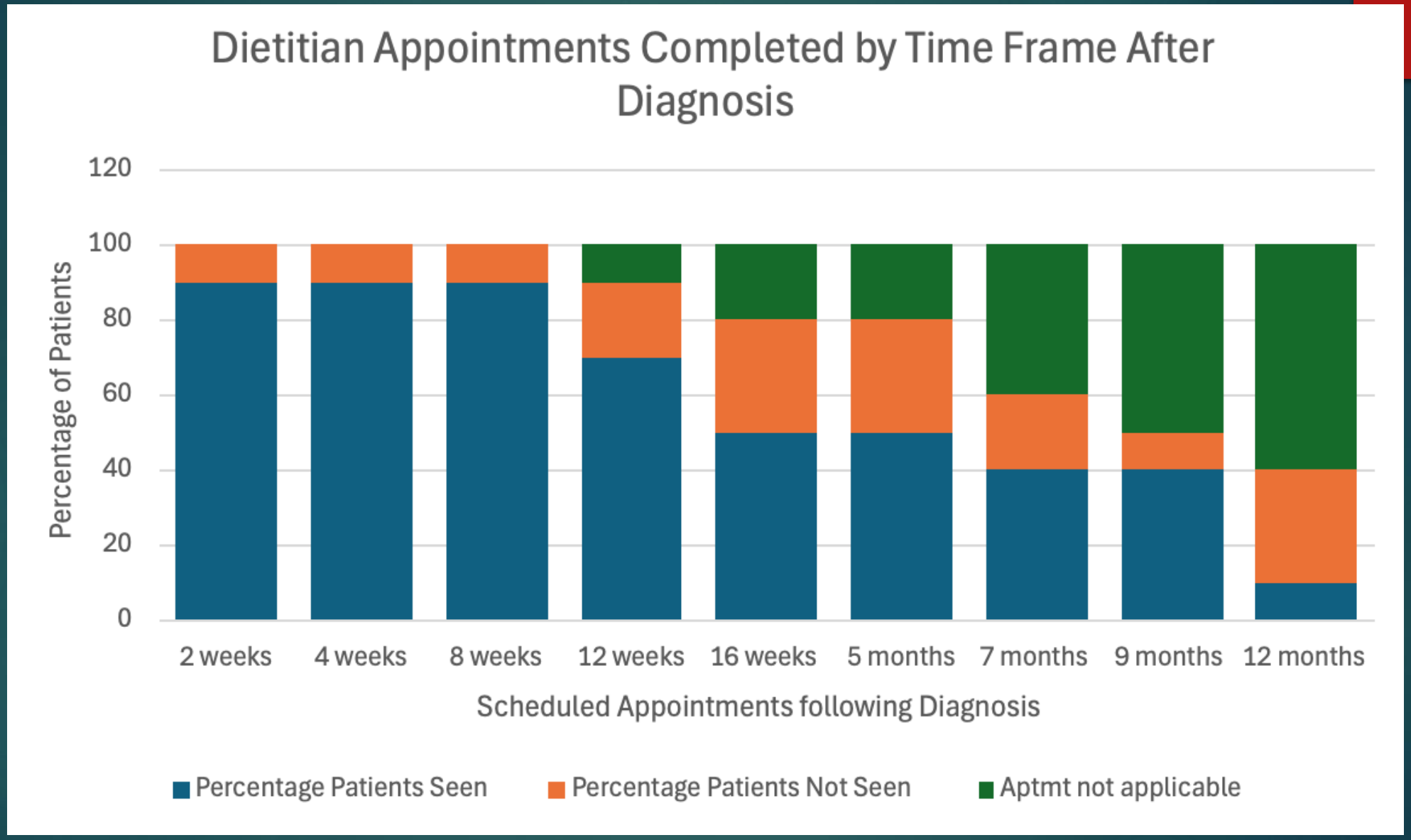
Many of the patients if not seen at 2 week apmt had investigations done whilst an IP

OP Clinic Review Summary

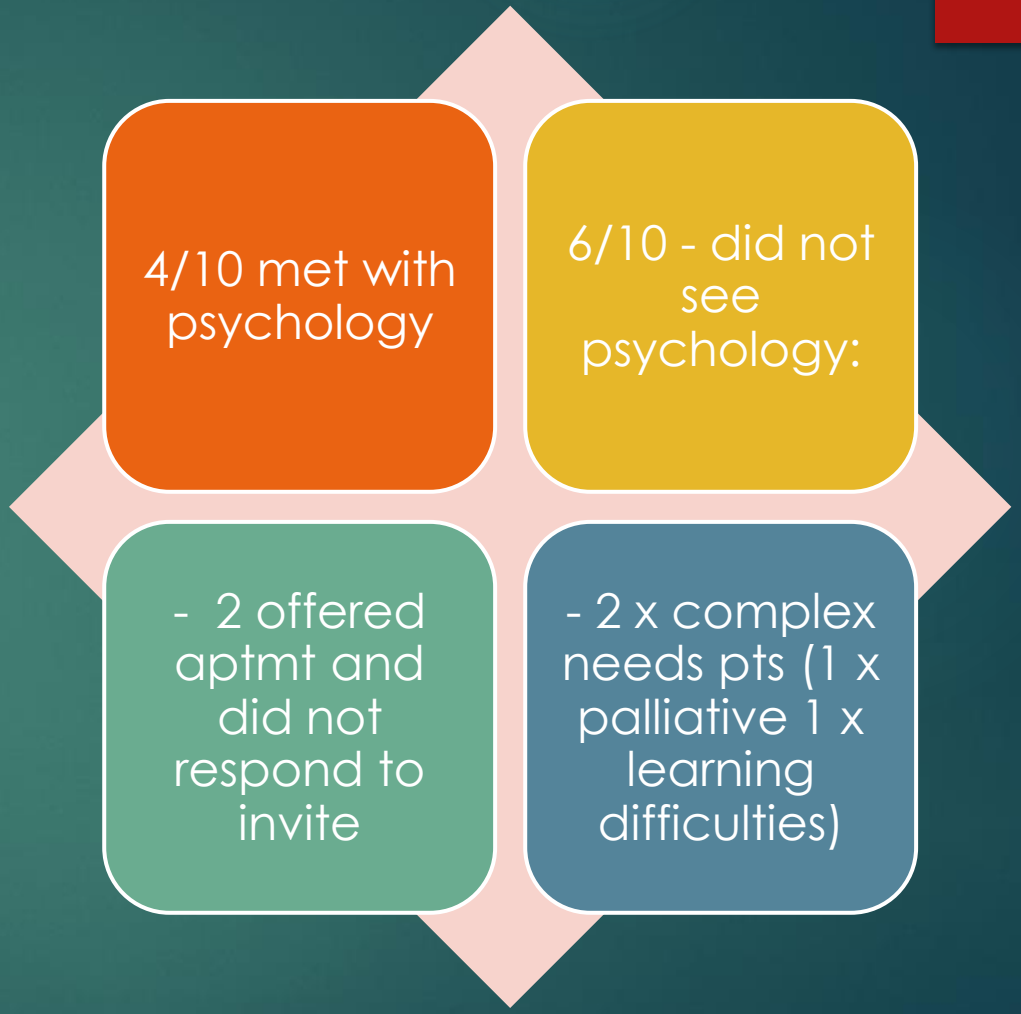
Nearly all patients had: BMI, BP and Glycaemic control (HbA1c), and pharmacotherapy assessed in all clinics if possible.

Areas for improvement:

- Missed opportunities to see dietitians in clinic
- Blood reviews at appropriate times: Non-fasted lipids at 3 months with repeat if abnormal at 9 months, Lipase/Amylase at 6 months.

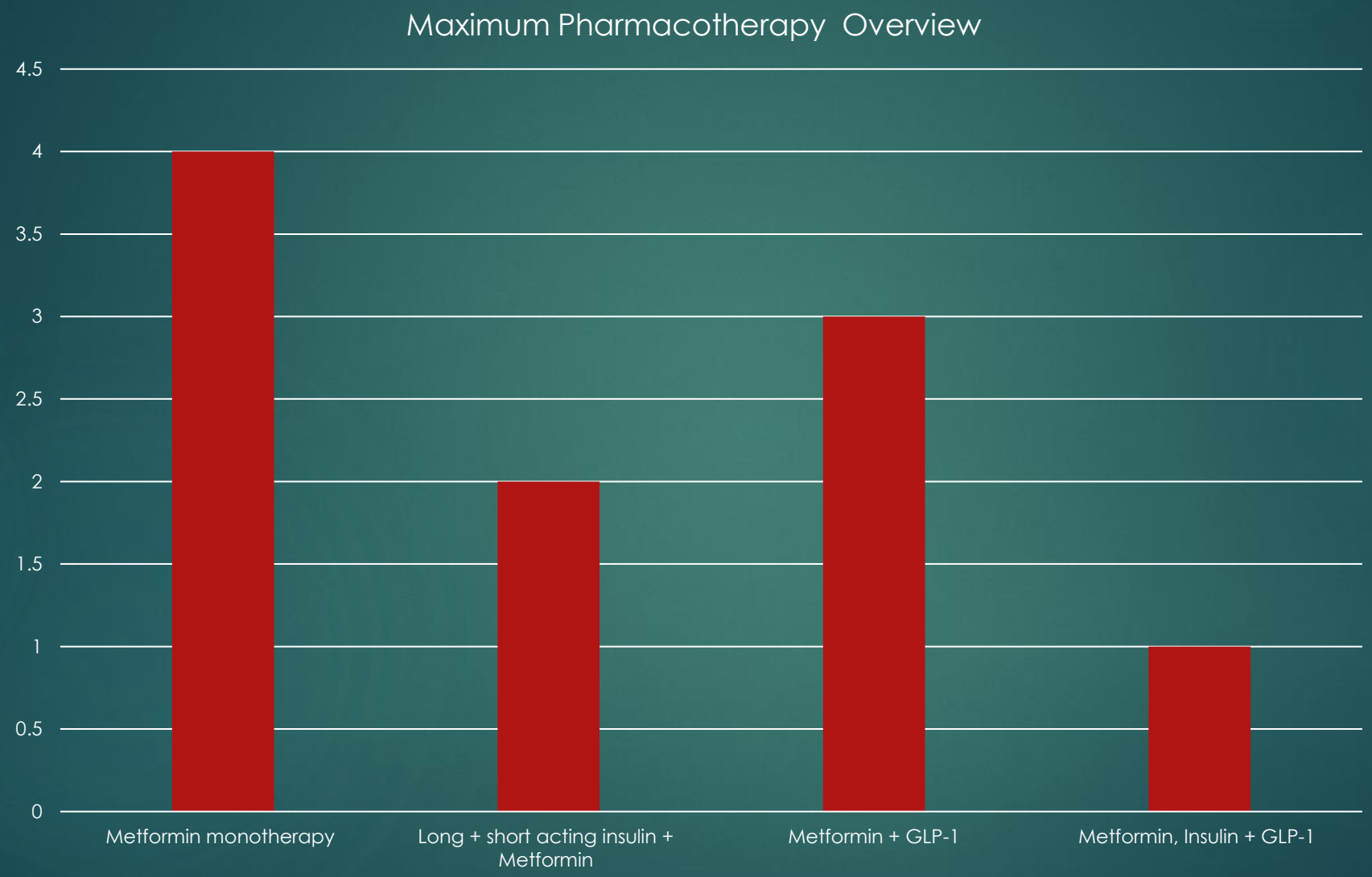

Dietitian Appointments Completed by Time Frame After Diagnosis
120
100
80
60
40
20
0
Percentage of Patients
2 weeks
4 weeks
8 weeks
12 weeks
16 weeks
5 months
7 months
9 months
12 months
Scheduled Appointments following Diagnosis
Percentage Patients Seen
Percentage Patients Not Seen
Aptmt not applicable

Met with Psychology in first 6 months?



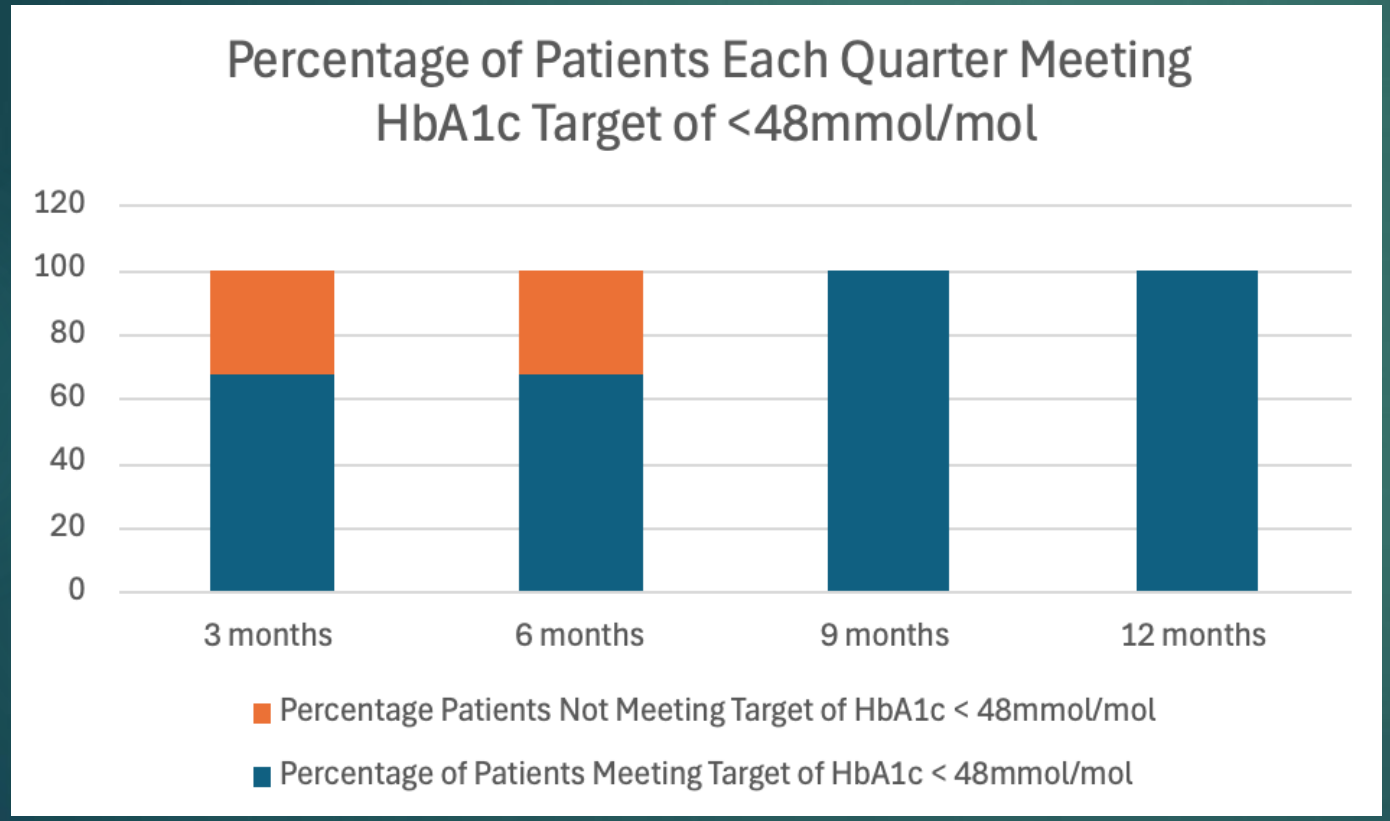
Pharmacotherapy Overview

Patient	Initial Pharmacotherapy	Escalation?			Outcome so far
1	Long + short acting insulin	Long + short acting insulin + Metformin	Weaning insulin, add Liraglutide	Lost to follow up	Lost to f/u
2	Metformin	Metformin stopped (11 months after diagnosis)			Off all treatment
4	Long + short acting insulin	Long + short acting insulin + Metformin	Inc metformin, Stop Levemir, continue Novorapid	Metformin stopped Off all treatment (9 m post diagnosis)	Off all treatment
5	Metformin	Metformin + Tirzepatide			Metformin +GLP1 Ag
6	Metformin				Metformin
7	Metformin + long acting insulin	Metformin, long-acting insulin, add Semaglutide			Metformin +GLP-1 +Insulin (poor engagement)
8	Metformin	Stopped Metformin (6 months after diagnosis)			Off all treatment
9	Metformin + semaglutide	Stopped metformin + semaglutide, start Tirzepatide			Off Metformin on GLP1 Ag for weight
10	Metformin				Metformin
11	Metformin	Metformin + Semaglutide			Metformin + GLP1-Ag


Maximum Pharmacotherapy Overview
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
Metformin monotherapy
Long + short acting insulin + Metformin
Metformin + GLP-1
Metformin, Insulin + GLP-1

PATIENT OUTCOMES & DIABETES TARGETS

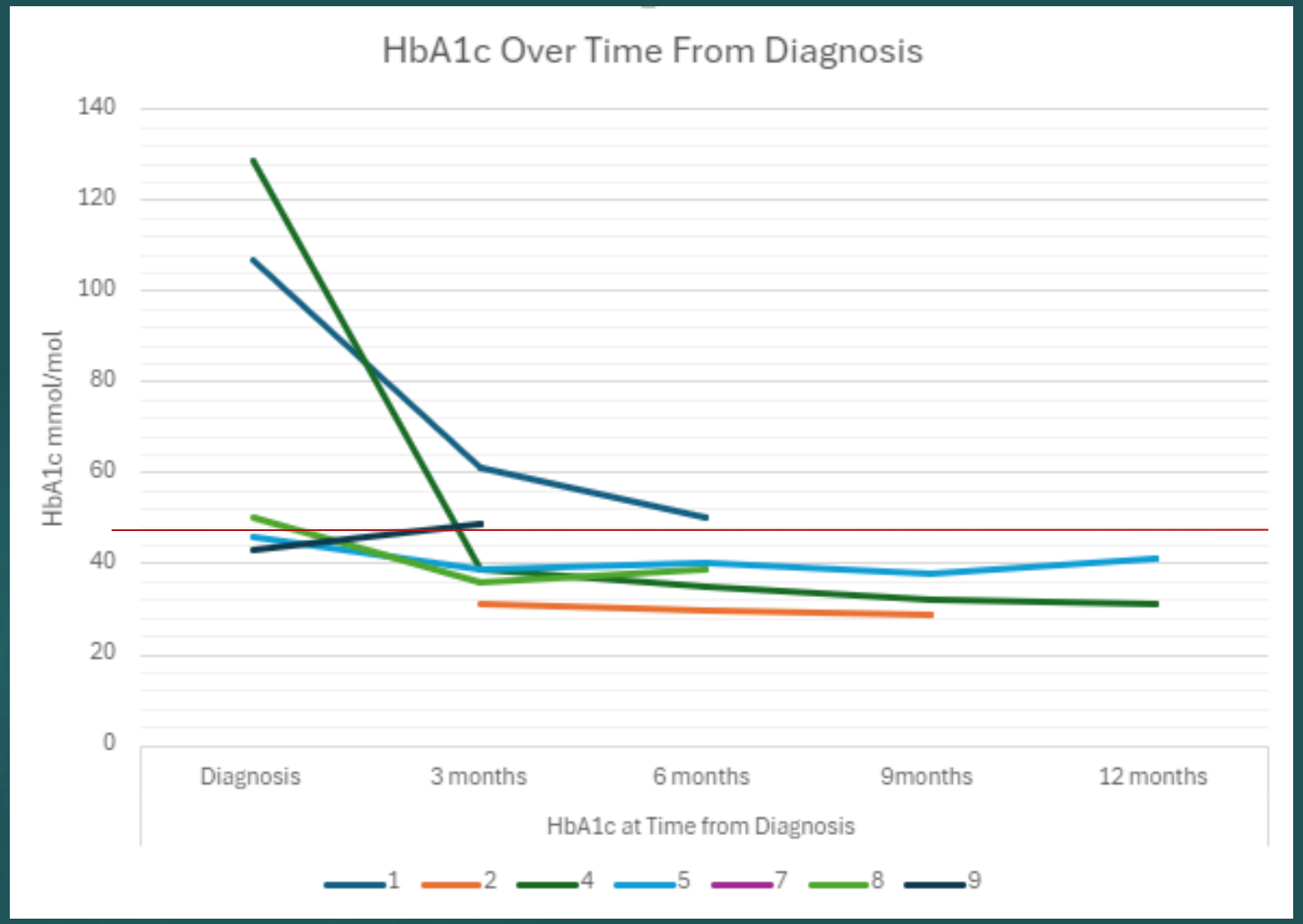
Targets: HbA1c < 48mmol/mol at 3 months and maintained



Patient Number at 3 and 6 months = 6
9 months = 3 patients
12 months = 2 patients

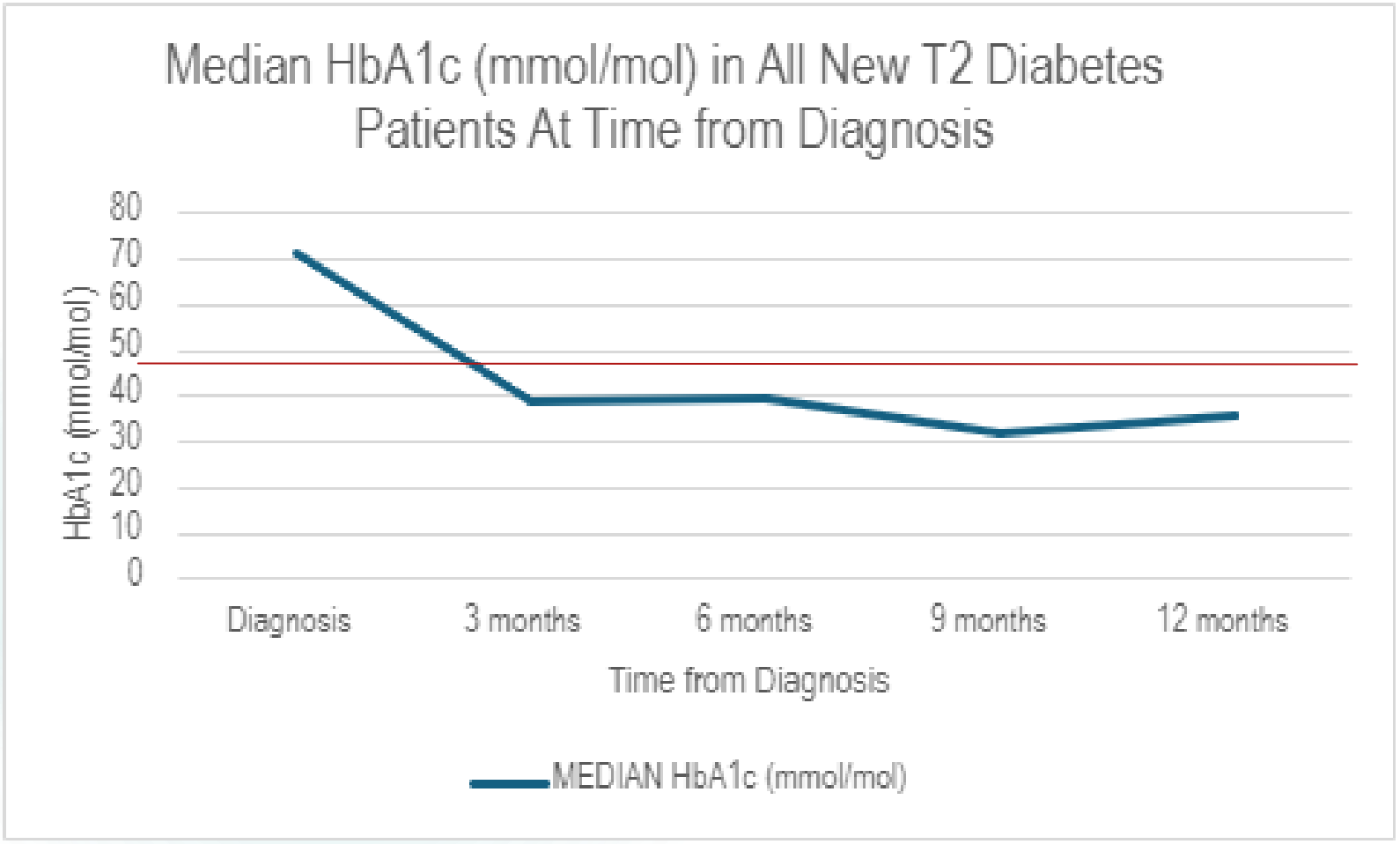
Lower numbers due to

1. Refusal of HbA1c
2. Oncology patient undergoing treatment
3. Time



SUMMARY of RESULTS

Target HbA1c of < 48mmol/l in all patients



Median HbA1c of all T2 patients

Aim for median HbA1c for all patients to be <48mmol/mol

Target:
Average 14 day Glucose:
< 8mmol/L

At 3 months: 100% Patients. Pt Number =8 (no data for 2)

At 6 months: 80% Patients (1 patient 8.2mmol/l) Pt Number = 5

9 months: 100%. Pt Number = 3

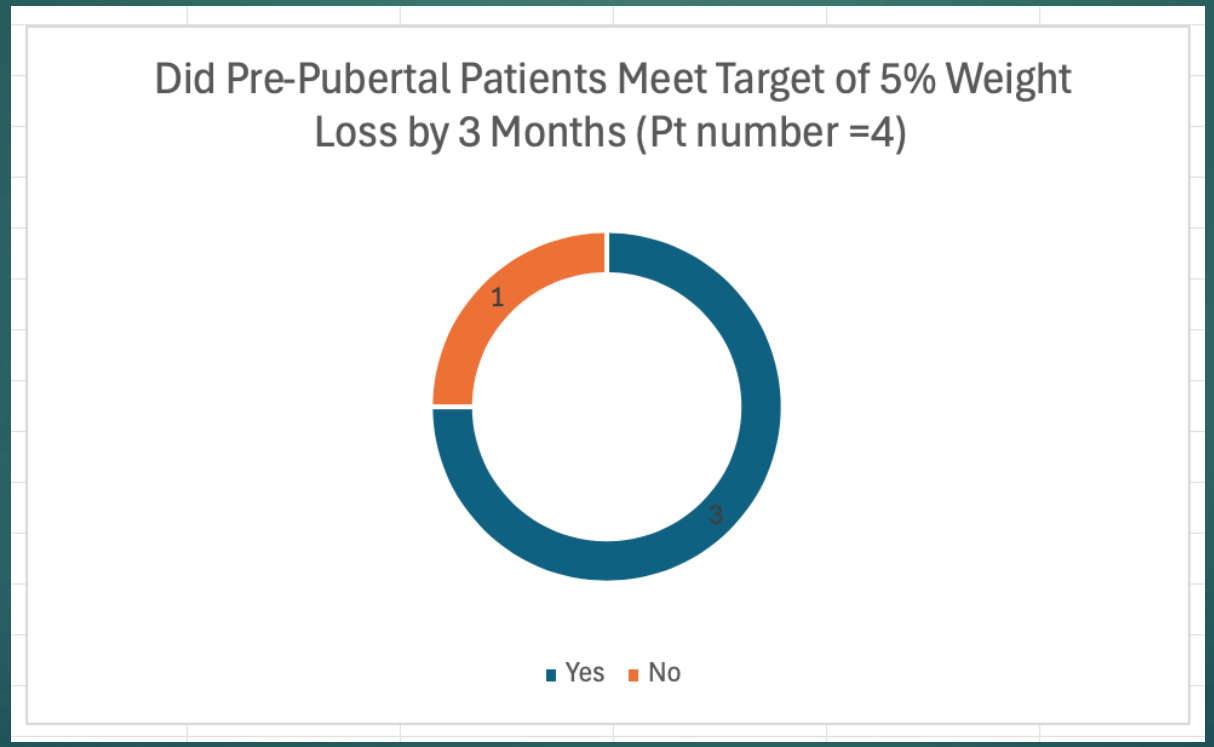
12 months: 100%. Pt Number = 2

Target:
80% Time in Range 3.9-10.0mmol/L if using FGMS

- 3 months: 75% patients (Pt number = 8), 1pt 79%, 1 73%
- 6 months: 80% patients (Pt number =5) 1 pt 77%
- 9 months:100% (Pt number =2)
- 12 months: 100% (Pt number = 2)

Targets: Weight Loss

Pre-Pubertal patients weight loss target of 5% in 3 months

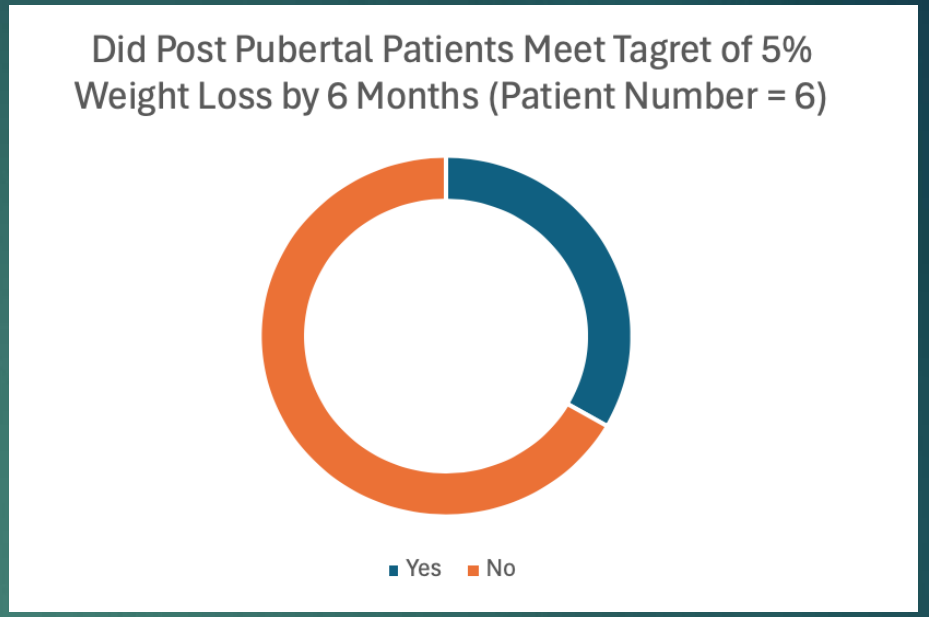


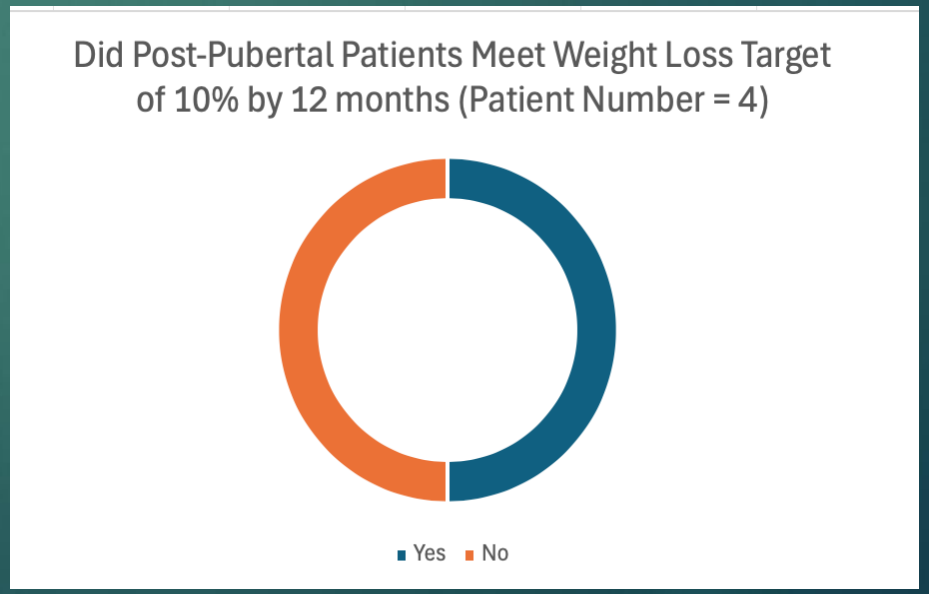
Target: Weight Loss

Post-Pubertal weight loss targets:

1. 5% in first 3-6 months
2. 10% in first 12 months

Note by 12 months one of the CYP had lost 8%.





Complications and Co-morbidities

80% patients have NAFLD

20% hypertension awaiting further investigation

30% raised cholesterol+/or triglycerides

10% Raised Albumin-creatinine ratio

20% confirmed OSA, further 20% awaiting overnight oximetry as concerns on screening

43% post-pubertal females have diagnosed PCOS

Only 1 patient had Diabetic eye screening so far – no retinopathy

No documented concerns re neuropathy

Outcomes so far... the positives!

Of the 10 patients, so far 3 patient's Diabetes in remission:

- 1pt lost 11 kg of weight, HbA1c 31. Off treatment. OGTT repeated 6 months off treatment – peak 8.4mmol/l -> Discharged.
- 1 pt at 12 months: HbA1c 31mmol/mol, Ave BG 5.4mmol/l, 100% TIR off treatment. Lost 8% of their body weight.
- 1 pt lost 5% body weight (pre-pubertal), HbA1c 39 mmol/mol with ave BG 5.4mmol/l. However, came off metformin as raised lactate, now putting on weight again.

DISCUSSION

DISCUSSION: At diagnosis

- In patient admission works well – Complex education and management by MDT, emphasises the importance of the condition, enables screening of complications and family members.
- Many patients have complications at diagnosis, (in keeping with T2 spotlight audit report)
- More screening has taken place since FYOC but room for improvement
- Sibling screening – felt to be a good thing to do but some logistical complexities as these are not our patients
- Need to be clear on HbA1c targets and Weight loss targets from the start

- AREAS FOR IMPROVEMENT:

1. Setting clear targets for HbA1c/ weight loss
2. Remember siblings/family screening
3. Ensure we do MODY calculator

DISCUSSION: FIRST WEEKS AT HOME

The team work very hard with these patients, get a lot of contact and input from all the MDT. The strengths included regular phone contact with team members with regular lifestyle review and sign posting to T2 apps and resources which were done in nearly all patients.

Areas for improvement included:

1. School plan and school training
2. Whatsapp Food Diary to dietitian

Discussion: OP care

- Established processes mean nearly all patients have HbA1c, BP, BMI, Medication R/V
- Several patients complex and need individualised care plan (don't fit in the box for audit), care showed flexibility
- Some patients seemed to miss opportunity to see dietician in clinic and then followed up by dietetic team
- Easy to forget additional bloods needed: non-fasted lipid profile at 3months, amylase + lipase at 6 months

Discussion outcomes

- 30% in remission so far... more to come?!
- Nearly all patients meeting targets for HbA1c and target blood glucose
- Need to aim for BMI < 85th centile longer term
- Room for improvement with weight loss targets

RECOMMENDATIONS

- Admission – emphasises severity of diagnosis and facilitates screening of complications. Mind shift for team and family.
- CGM- from diagnosis was a useful educational tool
- FYOC additions: Add Pharmacotherapy, Ix and screening for complications during admission, referral for Retinopathy screening at diagnosis
- Sibling screening – Mini project to assess siblings of these 10 patients + assess feasbility to include sibling screening (height and weight) for future patients.
- Type 2 Diabetes Education Checklist and Starter box to be finalized
- Training of junior doctors
- Re-audit

Newly diagnosed T2 patients Timeline for first year of care

At Diagnosis

At diagnosis: Acute admission or planned MDC bed or day's training at Wilkinson St (if metabolically stable)

- Diabetes autoantibody screen / MODY probability calculator
- Start Metformin +/- insulin
- New patient starter box
- T2 educational resources and apps. Digibete clinic code M931U
- PDSN - BG + ketone testing, downloading, CGMS for two weeks
- Dietitian– lifestyle, diet and physical activity goals
- Psychologist, screening tools as required
- Allocation of diabetes educator for regular contact and downloading feedback
- Completion of inpatient T2 diabetes educator checklist
- Supervision of 3 healthy meals with recognition of food groups and recommended portion sizes by diabetes educators
- Set targets HbA1c <48mmol/mol at 3mths, weight loss acc to age and stage of development, and SMART lifestyle goals
- Arrange outpatient education sessions and home visit
- Arrange MDT clinic appointments
- Consider referral to Morelife, SHINE, CEW
- Consider writing to GP for CEW referral of siblings or DUK T2 'know your risk' for adult family members, NDPP sand NHS Digital Weight Management Programme signposting
- BMI, BP, WC, LFTs, Liver USS, Vit D, Vit B12, Mg, urine ACR, screen for OSA, PCOS, smoking, with referrals as appropriate (home oximetry, sleep SN, resp, gastro, 24hr bp)

First weeks at home

- Regular telephone contact with diabetes educator
- Completion of post discharge T2 diabetes educator checklist
- Refer to psychology if not seen
- WhatsApp food pictures to dietitian (as food diary)
- Home visit
- T2 apps and resources
- GlucaGen hypokit training (if on insulin)
- School care plan & school training
- Help with downloading at home if needed
- Drive-by downloading if unable to download at home
- Frequent review of blood glucose data with medication adjustment as needed
- Lifestyle target Review
- MDT Clinic appointments at 2 weeks, 4 weeks, 8 weeks, 12 & 16 weeks post diagnosis, then 3 monthly
- Dietitian reviews at 2 weeks, 4 weeks, 8 weeks, 12 weeks, 16 weeks, then 5mths, 7mths, 9mths then 3 monthly, coinciding with MDT appts where possible.

GLP-1s – Liraglutide (od) or Dulaglutide (weekly) 10-12 yrs, Semaglutide 12-16yrs and Tirzepatide >16yrs (both weekly)

Diabetes targets

- HbA1c ≤ 48mmol/L by 3 months and maintained
- Average 14-day glucose <8mmol/L
- Time in range 3.9-10.0mmol/L 80% (if using CGMS)
- Time in range 3.9-8.0mmol/L 50% (if using CGMS)
- 5% weight loss in first 3 mths for pre-pubertal and pubertal CYP
- 5% weight loss in first 3-6 mths for post-pubertal, and 10% in first year.
- Aiming for BMI <85th centile longer term
- Treatment of complications
- To discuss each clinic and consider options to facilitate target achievement:
  - *Education review*
  - *BG data review, consideration of CGMS*
  - *Downloading and reviewing data at home*
  - *Medication review*
  - *Lifestyle review – diet, exercise and sleep*
  - *Psychology*
  - *More frequent appointments*
  - *Early help or social care referral*
  - *Elective admission*
  - *Improving HbA1c pathway*
  - *Consideration of CEW service input*

Celebrate successful behaviours (not specifically achieving targets)

Outpatient Care: 'How can the team help?', 'What is going well?', 'What are the challenges?'

2-week OPA & Dietitian

- BMI & BP, WC
- Glycaemic control
- Medication review
- Check all blood, urine, USS, and retinopathy screening has been done as above.
- **Oral health** - check registered with dentist (NHS find a dentist)
- Dietitian review
- Refer for retinopathy from 12 yrs

1-month OPA & Dietitian

- BMI & BP
- Glycaemic control
- Medication review, consider GLP-1s
- **Review BPs as inpatient, at 2 week OPA and now – if persistently abnormal consider ambulatory BP monitoring**
- Dietitian

2-month OPA & Dietitian

- BMI & BP
- Glycaemic control
- Medication review
- Average BG >8mmol/L – is more support required
- Dietitian Lifestyle Review

3-month OPA & Dietitian

- BMI & BP
- Glycaemic control
- Medication review
- HbA1c < 48, taper basal insulin
- HbA1c > 48mmol– is more support or intervention required
- **Review weight loss**
- **Non-fasted blood lipid profile**
- Dietitian Lifestyle Review

4-month OPA & Dietitian

- BMI & BP
- Glycaemic control
- Medication review
- HbA1c > 48, **consider GLP-1swith baseline amylase and lipase, and repeat bloods at next clinic**
- Dietitian Lifestyle Review

5 and 7-month Dietitian Review

6-month OPA

- BMI & BP & **WC**
- Glycaemic control
- Medication review
- HbA1c > 48mmol/mol – is more support or intervention required
- **If no weight loss, consider a different diet plan**
- **BP still raised consider ACE inhibitors**
- **Consider C-peptide if diagnostic doubt**

9-month OPA & Dietitian

- BMI & BP
- Glycaemic control
- Medication review
- HbA1c > 48mmol/mol – is more support or intervention required
- **Repeat Lipids if high at 3 mths, consider statins**
- Dietitian Lifestyle Review

12 months OPA & Dietitian + ANNUAL REVIEW

- BMI & BP & **WC**
- Glycaemic control
- Medication review
- HbA1c > 48mmol/mol – is more support or intervention required
- Annual review bloods (lipids, Vit D, TFTs, LFTs, and amylase / lipase if on GLP-1), injection sites, urine ACR, vaccination reminder, smoking, dentist
- Wellbeing questionnaire (PAID T2, PEDS-QL, or PHQ-2 (ADO-BED for binge eating) +/- referral to psychology
- Foot exam from 12 years
- Retinopathy from 12 years
- Liver USS every 3 years
- Weight targets and trajectory
- Dietetic Annual Review
- Structured Education

Meet with psychology team within the first 6 months

CONCLUSIONS

The T2 FYOC Pathway provides a comprehensive guideline for the management of patients with T2DM and screening and treatment of complications during the first year after diagnosis for use by the whole MDT.

- These patients are often complex and frequently have significant co-morbidities and associated complications, requiring substantial input to improve outcomes.
- Admission at diagnosis is a key element of early management
- Initial outcomes are promising but we are still in the early stages, lots of work still to do!

Thank you

- Any questions?