GROUP 4. Diabetes Care Pathway

Interventions to be discussed; **I: 'One-stop shop' clinics (integrated DES and diabetes care) AND** **E: Transition clinics between children's and young people and adult diabetes care**	
Susannah Rowles	Honorary General Secretary ABCD & Lead for Transitional Care
Sarinda Millar	Consultant Diabetologist, Paediatric Lead
Hamish Courtney	Diabetes Lead (Northern Ireland)
Mike Black	National Programme Coordinator
Helen Bone	Sunderland and South Tyne Screening Programme
John Anderson	Consultant Diabetologist (EROS team member)
Emma Bostock	Young adult with Type 1 diabetes (EROS Patient and Public Involvement panel)
Sebastian Grimston	Young adult with Type 1 diabetes

	Prioritized interventions	**Barriers and/or enablers that the proposed intervention addresses**	**Components of the intervention that could be addressed**	**Issues identified in Event 1 (30th June 2021)**
I	**'One-stop shop' clinics.** (Integrating eye screening with other diabetes services).	DES appointments and other diabetes care appointments are not co-ordinated **Representative quotes from YA** *"They're just, all my appointments are just random. Nothing lines up it's all just, they just come at random."*	• Easier for YAs to arrange and monitor attendance and progress. • Improving integration and communication between provider teams i.e., automatic transfer of results/screening attendance between primary care,	• DES is not a screening programme; it is care pathway' • Covid has presented opportunities for new ways of working (including integrated care) • Increased and better communication between provider teams would be beneficial to be able to see a better all-round view of the management of the YA and see what appointments are getting missed

			secondary care, and DES service	• May not improve attendance but improve DES experience (once attended, more likely to attend again) • Could include counselling and mental health support • Scotland has a national diabetes management system (SCI-DC) interfaces with DES software • Senior grader in 1-stop to provide provisional result (intervention M) **CHALLENGES** • Very popular with people with diabetes but very challenging to set up and run • Restrictions on suitable venues for 1 stop • Challenges with IT -systems don't talk to each other (DES is a dedicated IT system) • If mydriasis needed, at what stage should the drops be given (beginning or end of clinic?) • Navigating around the clinic after mydriasis • Different budget code for different aspects of diabetes care • May need to travel further for this facility • May be an issue with shift to biennial screening in low-risk individuals
E	**Transition clinics between children's and young people and adult diabetes care.**	Education or training received by YA with diabetes did not cover DES in detail	• DES starts at 12 years, a potential role for screening in children's/young people's clinics?	• Once lose parental support and the YA takes on responsibility may lead to non-attendance and this is a key time to

		Transitioning from paediatric to adult care and transient living in early adulthood (e.g., moving around for work, university) negatively impacts DES attendance **Representative quotes from YA** *"Yes, there was a period of time somewhere around the transition, maybe even at university actually and the transition out of university where I didn't go because I'd just fallen off the list a bit and at that point wasn't really engaged with it."*	• Diabetes UK suggest that many YA 'do not get a good experience of transition and so do not have such good management of their diabetes'. Education, information and support critical at this time? • Transition clinics/DESPs should use multiple communication channels to advise YAs about appointments (e.g., text reminders, phones calls, email, letters) from the age of 16 Check that contact details (phone number, email address, residential address(es)) are reconfirmed at every appointment to up to date.	deliver interventions too improve DES uptake • Transition to self-management • Fundamental place to get care right • Key stage to deliver education • Link to 1-stop (intervention I) and tailored communication/education (A) • Having DES alongside transition clinic would ensure that the waiting room is not full of old people (barrier EROS research) • Young adult clinic would include YA with T1 and T2 diabetes • A better transition would be good but I don't know what that looks like **CHALLENGES** • No standard transition protocols. • May require a YA (intermediate) clinic which is difference from transition clinic • How to support T1 with later diagnosis and YA with T2 • YA clinics could reduce capacity to offer other services.

DES – Diabetic Eye Screening **DR –** Diabetic Retinopathy **HCP –** Health Care Professional **YA –** Young Adult with diabetes (Type 1 or 2)