## Type 1 Diabetes Consolidated Model of Care

### Phase One: Planning (12–14 years)

<table>
<thead>
<tr>
<th>Tasks</th>
<th>Resources/Tools</th>
<th>Designate*</th>
<th>Organisational considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Invitation to transition</td>
<td>Diabetes Transition Progress Sheet (part one)</td>
<td>Diabetes Educator</td>
<td>Are we equipped to begin this journey?</td>
</tr>
<tr>
<td>Skills assessment</td>
<td>Patient Information sheet ‘What is Transition?’</td>
<td></td>
<td>For Rural and Remote clinicians – do we need to consider linking in with a Multidisciplinary team in a Diabetes Centre?</td>
</tr>
<tr>
<td></td>
<td>DPAT (Paediatric version) including PAID-C, PAID-C-Parent</td>
<td>Psychologist</td>
<td>Do we need training in Young Adult Health?</td>
</tr>
<tr>
<td>Clinical Interview and</td>
<td>DPAT (Paediatric version) including PAID-C, PAID-C-Parent</td>
<td></td>
<td>A strengths-based approach to transition</td>
</tr>
<tr>
<td>psychosocial assessment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge Assessment</td>
<td>M-WIKAD</td>
<td>Diabetes Educator</td>
<td>Other recognised Diabetes Knowledge Assessments</td>
</tr>
<tr>
<td>Ensuring primary care</td>
<td>Letter to GP</td>
<td>Paediatric Medical Officer</td>
<td>Does the patient have a GP? Is it possible to arrange shared medical appointments with this GP?</td>
</tr>
<tr>
<td>involvement e.g. GP</td>
<td></td>
<td></td>
<td>Have you advised the GP of the transition process?</td>
</tr>
<tr>
<td></td>
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<td>Have you involved the school or school nurses?</td>
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<td></td>
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<td></td>
<td>Map the resources accessible to the person – the ‘social capital’</td>
</tr>
</tbody>
</table>

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## Phase Two: Preparation (14–16 years)

<table>
<thead>
<tr>
<th>Tasks (what’s involved)</th>
<th>Resources/Resources (to be administered)</th>
<th>Designate*</th>
<th>Organisational considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent or part-independent visits encourage and discussed.</td>
<td>Diabetes Transition Progress Sheet (part two)</td>
<td>Diabetes Educator</td>
<td>Encouraging the young person to become more independent</td>
</tr>
<tr>
<td>Skills assessment</td>
<td>M-WIKAD</td>
<td>Diabetes Educator</td>
<td>Other recognised Diabetes Knowledge Assessments</td>
</tr>
<tr>
<td>Knowledge Assessment</td>
<td>Diabetes Educator</td>
<td></td>
<td>A strengths-based approach to transition</td>
</tr>
<tr>
<td>Skills assessment</td>
<td>Diabetes Educator</td>
<td></td>
<td>A strengths-based approach to transition</td>
</tr>
<tr>
<td>Independent or part-independent visits encourage and discussed.</td>
<td>Diabetes Transition Progress Sheet (part two)</td>
<td>Diabetes Educator</td>
<td>Other recognised Diabetes Knowledge Assessments</td>
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<tr>
<td>Skills assessment</td>
<td>M-WIKAD</td>
<td>Diabetes Educator</td>
<td>Other recognised Diabetes Knowledge Assessments</td>
</tr>
<tr>
<td>Psychosocial Assessment including goal setting and identify any risk factors for poor control.</td>
<td>DPAT (Paediatric version 2)</td>
<td>Psychologist</td>
<td>A strengths-based approach to transition</td>
</tr>
<tr>
<td></td>
<td>Readiness to Transfer Checklist</td>
<td></td>
<td>Are there suitable professionals with relevant training/expertise to deal with this</td>
</tr>
<tr>
<td>Assessment of eating patterns impacting diabetes control e.g. Eating disorders.</td>
<td>Nutritional checklist</td>
<td>Dietitian</td>
<td>Have you ensured all correspondence/communication is addressed to the person as well as the parent/</td>
</tr>
<tr>
<td></td>
<td>Screening for eating disorders or problematic eating patterns – DEPS-R</td>
<td></td>
<td>Has the GP been advised the young person is now part of a transition clinic?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Has the young person been provided with additional details of new clinic including: clinic times, contact details, maps and transport options.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Provide or arrange resources which will support the young person’s needs and support the transition of chronic condition management from the carers to the young person.</td>
</tr>
<tr>
<td>Correspondence addressed to young person as well as parent/carer.</td>
<td>Any standard communication</td>
<td>Paediatric Medical Officer</td>
<td>Has the GP been advised the young person is now part of a transition clinic?</td>
</tr>
<tr>
<td></td>
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<td>Has the young person been provided with additional details of new clinic including: clinic times, contact details, maps and transport options.</td>
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<td></td>
<td></td>
<td>Provide or arrange resources which will support the young person’s needs and support the transition of chronic condition management from the carers to the young person.</td>
</tr>
<tr>
<td>Ensuring primary care involvement</td>
<td>Any standard communication</td>
<td>Paediatric Medical Officer</td>
<td>Has the GP been advised the young person is now part of a transition clinic?</td>
</tr>
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<td></td>
<td></td>
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<td>Has the young person been provided with additional details of new clinic including: clinic times, contact details, maps and transport options.</td>
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### Phase Three: Transfer (16 years or older)

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<tr>
<th>Tasks</th>
<th>Tools</th>
<th>Designate*</th>
<th>Organisational considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessment of readiness to transfer</strong></td>
<td>DPAT (Paediatric version 3) including PAID T and Transition care plan goals, Readiness to Transfer checklist</td>
<td>Psychologist</td>
<td>A strengths-based approach to transition</td>
</tr>
<tr>
<td><strong>Reviewed knowledge and skills assessment</strong></td>
<td>M-WIKAD, Diabetes Transition Progress Sheet (part three)</td>
<td>Diabetes Educator</td>
<td>Other recognised Diabetes Knowledge Assessments</td>
</tr>
<tr>
<td><strong>Comprehensive information transfer</strong></td>
<td>Letter to GP, Letter to Adult team ‘Transition letter template’</td>
<td>Paediatric Medical Officer</td>
<td>Jas the GP been advised of the discharge to the adult service?</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>What do we need to provide to the young person’s GP and Adult team to ensure they are well supported when they transition?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Has the process of transfer been explained in detail? When their referral will be sent, how soon they will likely be seen, who they can call if they are concerned, what the first important appointment will look like and what they should bring with them to it.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Has the young person been provided with additional details of their new service including; contact details, maps and transport options?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Provide an opportunity for the young person to ask questions about the transfer and the new service.</td>
</tr>
<tr>
<td><strong>Assessment of eating patterns impacting diabetes control e.g. Eating disorders</strong></td>
<td>Nutritional checklist, if indicated based on previous screening in Phase 1 or 2, screen for eating disorders or problematic eating patterns using DEPS-R</td>
<td>Dietitian</td>
<td>Are there suitable professionals with relevant training/expertise to deal with this?</td>
</tr>
<tr>
<td><strong>Final appointment with Paediatric Medical Officer if required</strong></td>
<td>Appointment</td>
<td>Paediatric Medical Officer</td>
<td>Has the GP been advised of the discharge to the adult service?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Provide or arrange for services, facilities or resources which will prevent, delay or reduce the young person's need for care and support or the need for the support of carers</td>
</tr>
</tbody>
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Phase Four: Evaluation (16 years or older)

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<th>Organisational considerations</th>
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<tr>
<td>First appointment with adult and paediatric MO</td>
<td>Standard Appointment</td>
<td>Paediatric Medical Officer</td>
<td>Encouraging the young person to become more independent</td>
</tr>
<tr>
<td>Six month Follow-up</td>
<td>Diabetes Transition Progress Sheet (part four)</td>
<td>Diabetes Educator</td>
<td>Are there any outstanding psychosocial needs or treatment consideration that need to be addressed to ensure the young person continues to management their chronic condition independently?</td>
</tr>
<tr>
<td></td>
<td>M-WIKAD</td>
<td>Diabetes Educator</td>
<td></td>
</tr>
<tr>
<td></td>
<td>DPAT (adult version) including PAID Adult</td>
<td>Psychologist</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Screening for eating disorders</td>
<td>Dietitian</td>
<td></td>
</tr>
<tr>
<td>Evaluation</td>
<td>Transition survey</td>
<td>Psychologist</td>
<td>Evaluation feedback will inform future organisation consideration for the ongoing quality improvement of services provided</td>
</tr>
</tbody>
</table>

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