

Sharing of practice can support best practice tariff



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British Society of Paediatric Endocrinology and Diabetes (2009) *BSPED Recommended DKA Guidelines 2009*. Available at: <http://bit.ly/LNv3cT> (accessed 09.05.12)

Department of Health (2004) *National Service Framework for Children, Young People and Maternity Services*. London, DH

Her Majesty's Stationery Office (2004) *Children Act 2004*. Available at: <http://bit.ly/qVxuA9> (accessed 09.05.12)

NHS Diabetes (2010) *Joint British Societies Inpatient Care Group Management of Diabetic Ketoacidosis in Adults*. Available at: <http://bit.ly/1XOcSR> (accessed 09.05.12)

NHS Information Centre (2011) *National Diabetes Paediatric Audit Report 2009-2010*. NHS Information Centre, Leeds. Available at: <http://bit.ly/qSQmzH> (accessed 09.05.12)

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April heralded the start of the best practice tariff (BPT) for paediatric diabetes but for some, including ourselves, its arrival was met with frustrations. There are no new staff in post, systems to collect the required data are not complete and primary care trusts, themselves in transitional arrangements, state that there is no new money and BPT is to be unpicked from the block contracts already in place.

There is an urgent need for BPT to be paid to paediatric diabetes teams immediately. The job is expanding, especially with more children living in multiple households and many enduring high levels of parental unemployment and social deprivation. It is now very noticeable that people are reluctant to take time from work to attend educational programmes for fear of losing their job, and one parent is often not available at the time of diagnosis for essential education.

In the past 2 weeks we have had five newly diagnosed children with diabetes, each with their own unique needs. I know this is a familiar story! Teams are stretched and too much of what we do relies on staff goodwill and dedication.

With BPT, we all need to share good practice and be willing to use other teams' materials. Recently, two structured education programmes have been published: the Leeds team has produced an excellent programme for insulin pump therapy (copies are available through Medtronic); and the Danish *Goals of Diabetes* has been updated for use in the UK, and will be distributed by Novo Nordisk.

With only 14.5% of children and young people currently achieving HbA_{1c} targets (NHS Information Centre, 2011), many are destined to develop complications. Paediatric teams may need to develop expertise in recognising and treating these complications, especially if they are looking after young people for longer as a result of continuing confusion about transitional age.

The National Service Framework for Children (Department of Health, 2004) and the Children Act 2004 (Her Majesty's Stationery Office, 2004)

imply transition should be from 18–19 years old. Diabetic ketoacidosis guidance from the British Society of Paediatric Endocrinology and Diabetes (2009) and NHS Diabetes (2010) advises managing those under 18 years on paediatric guidelines.

BPT is paid until 18–19 years, but often paediatric units do not admit young people over the age of 16 years. Without clear transitional policies this causes bed managers and A&E colleagues a headache whenever a young person with diabetes is admitted to hospital.

Young people in transition are known to be at risk for "lost to follow-up"; this has recently been demonstrated to our team by a recent case. This case was an acute admission aged under 18 years (locally all those under 18 years old are managed by the children and young people's team). She had been lost to follow-up from another area and had a long-standing history of poor control and engagement. During the 8 months she has been with our team, she has been diagnosed with a series of complications – peripheral neuropathy, autonomic neuropathy including gastroparesis, lying-and-standing blood pressure problems, autonomic bladder resulting in the need for self-catheterisation, diabetic retinopathy including maculopathy requiring laser therapy, and nephropathy. She currently has follow-up and is now cared for by our young adult team after careful, coordinated transition. We are all aware of young people like this.

A suite of tools for transition has been developed by a subgroup of the North West Paediatric Diabetes Clinical Network to aid units to develop their own transitional policies. This is described in this supplement and is a welcome toolkit for units who need to develop this extremely important area of their practice. The barriers to attendance need to be explored with young people, and strategies developed to facilitate engagement with services. It is hoped that transition will become a workstream of NHS Diabetes, with a Diabetes UK campaign to raise awareness of this lost group. ■