

Which model of care will deliver the improvements we seek?



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The publication of the Royal College of Paediatricians National Paediatric Diabetes report for 2010–2011 still demonstrated that only 16.4% of males and 15.1% of females have HbA_{1c} levels <7.5% with the majority still with an HbA_{1c} between 7.5% and 9.5% and the remaining third over 9.5%. An encouraging sign is that the total percentage achieving an HbA_{1c} of less than 7.5% has increased slightly from 14.5% in 2009–2010 to 15.8% in 2010–2011 (Royal College of Paediatrics and Child Health, 2012).

This result could be a reflection of the slow increase in the use of insulin pump therapy, which was demonstrated by the recent insulin pump service audit (Diabetes Health Intelligence, 2010). On this occasion, 95% of paediatric units submitted data to the audit. Our own locally released data showed that within an average UK clinic of 156 patients, there will be 30 children and young people undergoing insulin pump therapy; this is still representative of less than 20% of clinic populations. However, it is worth noting that this is an improvement from the data published in 2010 showing only 8% using this technology (Diabetes Health Intelligence, 2010).

The Best Practice Tariff (BPT) will become mandatory in April and teams are busy gearing up to deliver the standards outlined. However, in some areas they have struggled to access the funds to allow for investment and recruitment for their teams (NHS Diabetes, 2012). There has been a flurry of paediatric diabetes nurse posts advertised nationally, along with paediatric dietitians, and some areas appear to be struggling to recruit suitably qualified individuals. The care outline is a minimum standard of care, but smaller teams may fail to deliver in time and we may see the demise of some local services rather than investment. Within the UK, children with diabetes have their condition managed at home upon diagnosis with those well enough being discharged on the

same day. As paediatric nurses, we aim to provide family-centred care, taking into account the needs not only of the child or young person but the family as a whole. It is noticeable within my own practice that there are more children and young people living between several households due to separated families and childcare arrangements. It is therefore interesting that within a recent Cochrane review of family-centred care models, the only positive effects are demonstrated in the adequacy of the children's care, parental satisfaction and costs. For other indicators such as clinical outcomes and children's behaviour there was no significant difference between the family-centred care model and standard inpatient care. There was no harm reported in the review (Shields et al, 2012).

The Hvidøre Study Group showed significant differences in HbA_{1c} between centres but concluded that diabetes education, management from the onset of the disease, different attitudes within diabetes teams and different levels of patient empowerment were the factors explaining the differences (Danne et al, 2001). It may be necessary for us to revisit models of care with robust evidence-based studies to ensure we deliver the required clinical outcomes.

Moving all care to bigger regionalised units could, if enough staff are not recruited, lead to depersonalisation of care. In my experience, families value that you know them as individuals and patients with long-term conditions can struggle with the concept of target-driven care. Paediatric diabetes nurses provide valuable support and guidance not only at the time of diagnosis for children, young people and their families but during the transition from childhood to adulthood diabetes (Royal College of Nursing Paediatric Diabetes Special Interest Group, 1998). Some families also seek additional support via support groups. Newell and Hahessy's ethnographic study published in this featured section (pages 27–31)

explores the significance of social support for parents living with children who have type 1 diabetes. Their observation about parental emotional distress and the need for interventions to decrease it leads us back to our current model of family-centred care.

We therefore may need to focus on patient empowerment more and embrace the technologies that young people use, such as smartphones and the Internet. Young people are increasingly conversing via text and email, and are great users of social media. Staff utilising these technologies need to be working within the Information Governance Framework and Data Protection Act, but with care and good clinical documentation these methods can be used (Royal College of Nursing, 2012).

Jones et al provide us with an excellent guide featured in this section (pages 20–6) to what we should know in relation to apps and online resources. By embracing this technology, we may be able to empower young people to improve their clinical outcomes but also fulfil our additional eight contacts per year as required by the BPT. ■

Danne T, Mortensen HB, Hougaard P et al (2001) Persistent differences among centers over 3 years in glycemic control and hypoglycemia in a study of 3,805 children and adolescents with type 1 diabetes from the Hvidøre Study Group. *Diabetes Care* **24**: 1342–7

Diabetes Health Intelligence (2010) *Insulin Pump Audit – Findings for England*. DHI, Yorkshire and Humber Public Health Observatory. Available at: <http://bit.ly/vynVyx> (accessed 09.01.13)

NHS Diabetes (2012) *Paediatric diabetes teams struggle to secure due funding*. NHS Diabetes, Newcastle Upon Tyne. Available at: <http://bit.ly/ToyCLD/> (accessed 09.01.13)

Royal College of Nursing Paediatric Diabetes Special Interest Group (1998) *Specialist nursing services for children and young people with diabetes*. RCN, London. Available at: <http://bit.ly/vLLj9> (accessed 09.01.13)

Royal College of Nursing (2012) *Using technology to complement nursing practice*. RCN, London. Available at: <http://bit.ly/MCGWCX> (accessed 09.01.13)

Royal College of Paediatrics and Child Health (2012) *National Paediatric Diabetes Audit Report 2010–11*. RCPCH, London. Available at: <http://www.rcpch.ac.uk/npda> (accessed 09.01.13)

Shields L, Zhou H, Pratt J et al (2012) Family-centred care for hospitalised children aged 0–12 years. *Cochrane Database Syst Rev* **10**: CD004811

“By embracing new technology, we may be able to empower young people to improve their clinical outcomes but also fulfil our additional eight contacts per year as required by the Best Practice Tariff.”



The author comments that paediatric nurses aim to provide family-centred care, taking into account the needs not only of the child or young person but the family as a whole.