

Paediatric diabetes services in England since the introduction of the Best Practice Tariff: A national survey of clinical psychologists' time, roles and ways of working. Part 2

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Article points

1. This article is the second of two reporting the findings of the first national survey focusing specifically on psychological services in paediatric diabetes services since the introduction of the Best Practice Tariff across England.
2. Content regarding referrals, service provision, management, meetings, consultation, training, supervision and challenges is presented and discussed.

Key words

- Best Practice Tariff
- Clinical Psychology
- Service provision

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Since the introduction of the Best Practice Tariff (BPT), there has been a varied increase in psychological provision within paediatric diabetes services (PDSs). This article is the second of two that summarise findings from a national survey to which 43 clinical psychologists working in PDSs across England responded. Descriptive data are presented and discussed regarding referrals of children and young people with type 1 diabetes to psychology, and how respondents and the multidisciplinary team deliver psychological provision so as to satisfy the BPT criterion of “access to psychological support as appropriate”. Management, training and supervision relating to psychologists working in PDSs are also considered, along with the challenges psychologists experience. The findings reflect a diverse and varied approach to the provision of psychological care within PDSs and highlight a range of difficulties concerning capacity, role definition and infrastructure, which may require greater consideration at inception.

This article reports the second part of a survey into psychologists' ways of working since the introduction of the updated Best Practice Tariff (BPT) in April 2013. The BPT, as outlined in the Department of Health's (DH, 2013) *Payment by Results Guidance for 2013–14*, stipulates that children and young people (CYP) with diabetes should receive annual assessments as to “whether input to their care by a clinical psychologist is needed, and access to psychological support, which should be integral to the [multidisciplinary] team as appropriate”. Prior to this, few PDSs provided access to psychological support (Gosden et al, 2010; Kime and Carlin, 2012), despite some limited literature on the reciprocal relationship between diabetes and psychological well-being (Nardi et al, 2008).

The first article in this series considered the service background of respondents and findings regarding whole-time equivalents (WTEs) and

assessment aspects (Binney and Roswess-Bruce, 2015). In the second part, we discuss referrals to PDS psychology services, provision of care by psychologists working in PDSs, consultation, training and the challenges of providing a psychology service for CYP with type 1 diabetes.

Methods

An opt-in questionnaire exploring the provision of psychological care within PDSs was designed by the researchers and distributed to prospective respondents working in PDSs in England. The data were collected between July and August 2014. For more detailed information regarding the survey design and administration, see Binney and Roswess-Bruce (2015).

Data analysis

Forty-three questionnaires were returned and included in the analysis, with an approximated

Table 1. Age ranges of the most commonly cited referrals of children with type 1 diabetes to psychology ("check all that apply" question; 42 respondents, 132 cases).

Age range (years)	Percentage of cases (n)
<5	17.4% (23)
5–11	30.3% (40)
12–16	31.8% (42)
≥17	20.5% (27)

response rate of 30–36%. As in the first article, responses were assessed and analysed question by question, first for a response and then in terms of whether the response could be interpreted clearly within the context of the question. Thematic analysis was used to evaluate the qualitative questions broadly based on the Braun and Clarke (2006) method. The survey was wide-ranging, but owing to difficulty interpreting some responses and space limitations, not all data are reported in the results section. All figures are given to one decimal place.

As in the first article, data have been grouped by Paediatric Diabetes Network region in order to maintain the anonymity of respondents and services. Where questions employed "check all that apply" responses, this is noted and percentages reflect this.

Results

Referrals

The top three most commonly reported themes of referral to psychology are shown in *Figure 1*.

The most common referrals for CYP with type 1 diabetes fell into the age ranges shown in *Table 1*. Some respondents commented they did not see young people aged ≥17 years as these clients were seen by the adult psychology practitioners.

Service provision

Table 2 shows the variety of ways respondents provided direct support to CYP with type 1 diabetes and their families, with one-to-one/family appointments outside of the multidisciplinary team (MDT) clinic most frequently cited (29.7% of 123 cases).

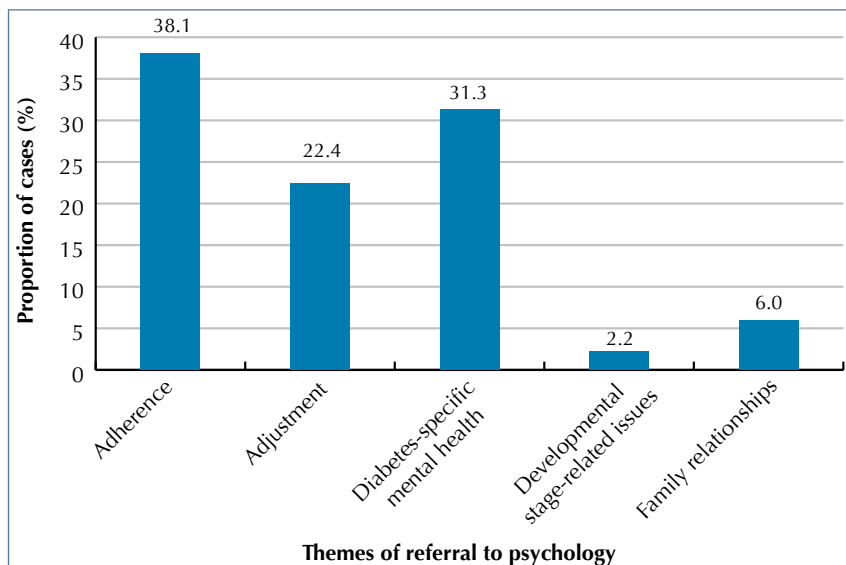


Figure 1. Top three most commonly cited themes of referral to psychology (respondents cited multiple responses to this question; 134 cases).

Respondents held psychology appointments in a variety of different locations, including hospital-based rooms (46.2%), dedicated psychology rooms (26.9%), community rooms (17.9%) and families' homes (9.0%).

Among the 42 respondents (147 cases), cognitive behavioural therapy (CBT), systemic or family-focused therapy and motivational interviewing (MI) were the most commonly used therapeutic approaches, comprising 23.7%, 21.6% and 16.9% of respondents' top three choices, respectively (*Figure 2*). Solution-focused therapy (15.5%) was also commonly used.

High numbers of respondents reported seeing CYP with type 1 diabetes for diabetes-related issues (*Table 3*). However, in addition, around half of respondents stated that they saw CYP with type 1 diabetes and/or their families for non-diabetes-related mental health problems (53.5%) and non-diabetes-related self-harm (41.9%).

Overall, 27 respondents (62.8%) stated they were involved in the transition of young people with diabetes to adult services. These respondents were involved in transition in a range of different ways, the most common being to attend the transition clinic (48.1% of cases; *Table 4*).

Thirty respondents (73.2%) reported that they specifically or routinely had contact with newly diagnosed patients. This contact occurred in a variety of ways (*Table 5*).

“This is the first formal survey since the introduction of the Best Practice Tariff to ask psychologists contributing to paediatric diabetes services about their role and ways of working.”

Table 2. Methods of direct support provided by psychologists in order of most commonly cited (“check all that apply” question; 43 respondents, 123 cases).

Type of support	Percentage of cases (n)
One-to-one/family appointments outside of MDT clinic	30.9% (38)
Group work	6.5% (8)
Online support	2.4% (3)
Seen in MDT clinic by psychologist alone	22.8% (28)
Seen jointly in MDT clinic with MDT staff	25.2% (31)
Telephone advice	13.0% (16)

MDT=multidisciplinary team.

Table 3. Types of issues for which psychologists provided interventions (“check all that apply” question; 43 respondents).

Psychological issues	Percentage of respondents (n)
Diabetes-related mental health issues	95.3% (41)
Diabetes self-care issues	97.7% (42)
Diabetes-related quality of life issues	100.0% (43)
Diabetes-related self-harm	90.7% (39)
Non-diabetes-related mental health issues	53.5% (23)
Non-diabetes-related self-harm	41.9 (18)

Of the 11 respondents who reported not having specific or routine contact with newly diagnosed patients and their families, three (27.3%), commented that individuals were made aware of psychology services within the PDS through literature and verbal information passed on via

members of the MDT, and two (18.2%) reported that CYP and their families were contacted if particular concerns were raised by either the family or the MDT at diagnosis.

Of 41 respondents, 73.2% stated that their role included other responsibilities not already

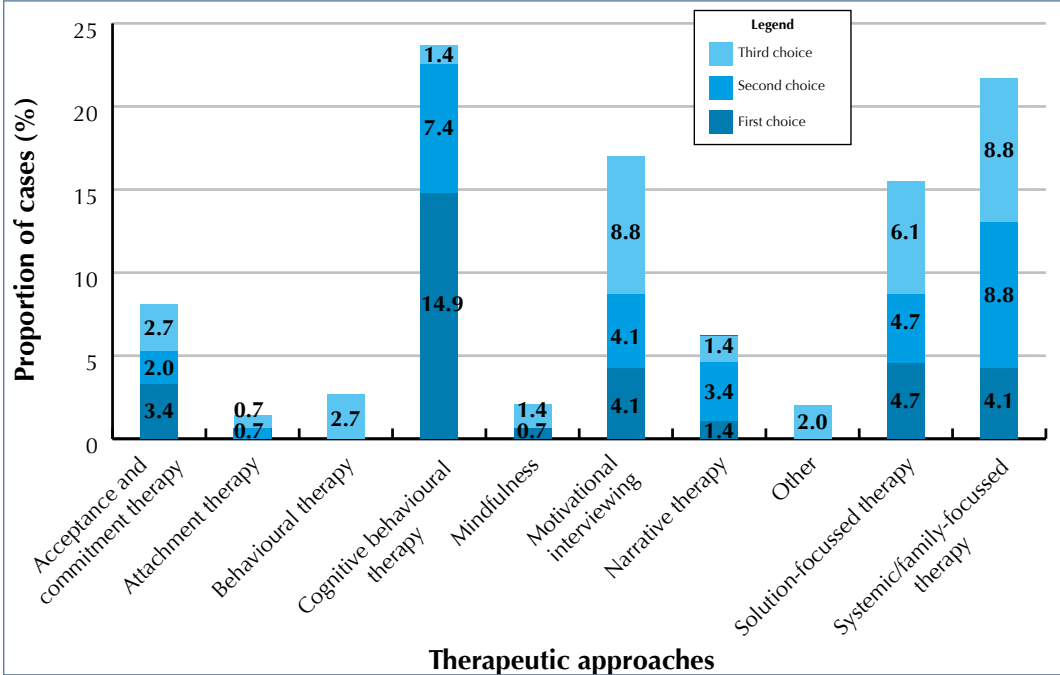


Figure 2. Top three most frequently employed therapeutic approaches used (preferences ranked in order; 42 respondents, 147 cases).

Table 4. Ways in which psychologists contributed to the transition of young people to adult diabetes services ("check all that apply" question; 43 respondents, 27 cases).

Type of involvement	Percentage of cases (n)
Attend transition clinic	48.1% (13)
Contribute only if already involved/needed	7.4% (2)
Liaise with adult services	18.5% (5)
Meeting with individuals prior to transition	14.8% (4)
Production of transition literature	7.4% (2)
Service planning and development	3.7% (1)

mentioned. For this "check all that apply" question, (total cases, 71), pump assessments (22.5%) and conducting groups (including for newly diagnosed CYP and their families; 16.9%) were the most commonly cited. The majority stated that they did not routinely see CYP with type 1 diabetes who were in diabetic ketoacidosis (DKA; 66.7%) or those with high HbA_{1c} (56.1%).

Thirty-three respondents reported that other members of the MDT utilised a range of psychologically informed approaches in the support they provided to CYP and their families, the most common being general emotional support (41.3%; n=33) and MI (22.5%; n=18).

Management, meetings, consultation, training and supervision

Overall, 24 respondents (55.8%) reported that they provided no formal teaching to the MDT. Of the 19 respondents who did (Figure 3), most provided training on specific psychologically informed interventions (63.2%; n=12). Nineteen respondents (45.2%) stated that they provided supervision. Most of these provided supervision (including peer supervision) to other clinical psychologists (Table 6).

Overall, 38 respondents (88.4%) reported participating in MDT or psychosocial case discussions. The frequency of such meetings varied

Table 5. Forms of direct contact provided by clinical psychologists to newly diagnosed children with diabetes and their families (41 respondents).

Method of contact	Percentage of respondents (n)
Routine contact as part of the wider multidisciplinary team	
Seen by the psychologist at their first outpatient clinic appointment	31.7% (13)
Seen during attendance at structured education groups	4.9% (2)
Specific contact	
Offered a face-to-face appointment	19.5% (8)
Seen in the inpatient ward prior to discharge	34.2% (14)
Telephone contact if not seen on the ward	4.9% (2)

from less than monthly to multiple meetings per week. Forty-one respondents (95.3%) stated they provided one-to-one consultation to the MDT. Those who provided specific details reported that this consultation was purely *ad hoc* in 42.9% of cases (n=39). Consultations took place either face to face or over the phone.

The frequency of supervision that individual psychologists received ranged from weekly to every 6 weeks. Most respondents (59.5%; n=25) stated they received supervision on a monthly basis, although this does not take into account the different WTEs of staff. Most respondents received supervision from a more qualified clinical psychologist (88.1%; n=37) but few specified the service in which their supervisor was based. A few respondents stated they received peer supervision from colleagues in other services (7.1%; n=3).

Thirty-four respondents (81.0%) felt they had appropriate access to continuing professional development (CPD). Fourteen (37.2%) were aware of the National Curriculum for the Training of Healthcare Professionals Who Care for Children and Young People with Diabetes Mellitus (available at: <http://bit.ly/1S5UwQX>), but of these only two had formally completed Level 1 (Basic Awareness) at the time of the survey.

Summary of main findings: Referrals

1. The top three reported issues for referral to psychology were adherence, diabetes-specific mental health and adjustment. Other themes included family relationships and developmental stage-related issues, such as transition to secondary school or adulthood.
2. The main referral age ranges were 12–16 years, 5–11 years and ≥17 years, in descending order of frequency.

Table 6. Type of staff to whom respondents provided clinical supervision (respondents provided multiple responses; 29 cases)

Type of staff	Frequency of cases (n)
Clinical psychologists	48.3% (14)
Consultants	0.0% (0)
Dietitians	10.3% (3)
PDSNs	31.0% (9)
Trainees/assistant psychologists	10.3% (3)

Challenges

The main challenges of providing psychological services are outlined in *Table 7*.

Discussion

This is the first formal survey since the introduction of the BPT to ask psychologists contributing to PDSs about their role and ways of working. Findings revealed that psychologists contributing to PDSs have diverse and varied roles, which include direct therapeutic input with CYP with type 1 diabetes and their families in and outside of clinic;

specific roles contributing to pump assessment and supporting CYP with transition and new diagnoses; MDT consultation, case discussions/meetings, training and supervision; and service development. Several challenges were noted, including issues concerning capacity and demand, engagement of CYP with type 1 diabetes, defining roles and relationships within MDTs and infrastructure to support the psychology provision.

Referrals

The main referral issues revealed in this survey (adherence, diabetes-specific mental health difficulties and adjustment) reflect those often discussed in the literature (Delamater et al, 2014) and in recommendations by NICE (2015) and the International Diabetes Federation/International Society for Pediatric and Adolescent Diabetes (IDF/ISPAD, 2011) regarding matters requiring support. Such concerns are evident in older children and young adults and are linked to increased awareness of the implications of living with diabetes, struggling with aspects of their diabetes regimen in relation to age-specific risk factors (e.g. transitioning to secondary school, socialising) and family conflict (Ellis et al, 2005; Chisholm et al, 2007; Lowes, 2008). Younger

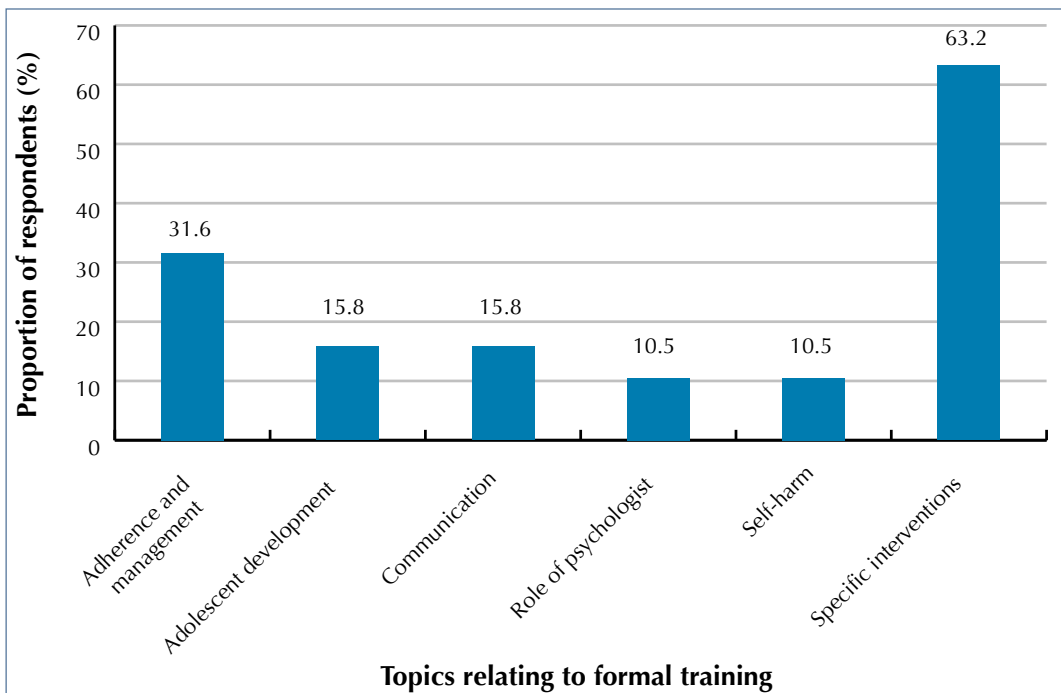


Figure 3. Areas of formal training provided to the multidisciplinary team (“check all that apply” question; 19 respondents).

Table 7. Main challenges of providing psychological services within the PDS (41 respondents).

Themes	Sub-themes	Examples
Complexity of case presentation and role definition relative to CAMHS	Knowing when to refer to other services	“Complex cases with systemic issues and combined mental health problems and diabetes related difficulties” “Being clear about what my role is and when appropriate to refer to another service or CAMHS”
Conflicting needs and desires of stakeholders	Audit	“Addressing patient needs within capacity with competing demands due to NHS Trust requirements or Best Practice Tariff requirements”
Defining role and relationships within the PDS multidisciplinary team	Integrating into existing services with differing practices and protocols	“Getting to know the way the team works and shaping the psychology service to suit while also meeting patient psychological needs”
	Integrating new ideas	“Encouraging team to try new approaches consistently” “Working within a medical model”
	Building relationships and managing resistance	“Lack of understanding from medical team about the role of psychology and appropriate referrals” “Initial resistance”
Difficulties of not sitting solely in the PDS	Conflicting demand	“Competition with other clinical work for other clinical groups”
Engagement and normalising		“High non-attendance/cancellation rate” “Engaging young people” “Breaking down stigma attached to psychology”
Infrastructure	Admin	“Lack of admin support” “Working across hospital sites – access to my clinical notes”
	Having a base and access to rooms	“No allocated office space” “Access to basic facilities in hospital setting (e.g. suitable room to see families in)”
	Access to IT	“Practical issues like phone and computer” “Adequate IT support on the hospital site”
	Absence of planning around infrastructure that enables psychologists to do their jobs efficiently	“Lack of thought-through infrastructure (i.e. admin, office, rooms, access to printer/paper, etc.)”
Service start-up and development	Variety of options	“Knowing what other clinical psychologists are doing with their Tariff input” “Not having clear guidance about how to structure the psychological input into the team” “Finding the ‘right’ outcome/screening questionnaire and it being used meaningfully”
	Expectations and responsibility placed upon more recently qualified	“Being employed as a more junior with very little paediatrics experience to set up the psychological input to a diabetes service”
Time	Demand for direct psychological work	“Not enough psychology time for the population size” “High number of referrals” “Lack of PDSN time = more demand on clinical psychologist” “Insufficient funding and time allocated, meaning insufficient time for preventative work and systemic work within the team”
	Role elements (e.g. admin, CPD, meetings, service development, training and consulting, travel)	“Having the time to keep up with research literature and reading” “Finding enough time to keep on top of the admin generated by the role” “Large geographical spread over three sites”
	Absence of resources	“Closure of local services that would better meet a family’s needs” “Financial pressures on schools which make them less able to support young people with additional needs”

CAMHS= child and adolescent mental health services; CPD=continuing professional development; PDS=paediatric diabetes service.

Summary of main findings: Service provision

1. The top three most commonly employed therapeutic approaches were cognitive behavioural therapy, systemic/family-focussed therapy and motivational interviewing, in that order.
2. Psychologists saw clients for all issues cited in the survey, but the most common were issues of diabetes-related mental health, diabetes self-care and diabetes-related quality of life.
3. Overall, 73.2% of psychologists had routine contact with newly diagnosed children and families through specific scheduled contact on the wards or as outpatients.
4. Most stated that their role involved other activities not included above, such as carrying out pump assessments, in addition to providing some psychosocial care in the form of general emotional support and motivational interviewing.

children, who are more dependent on their parents for their diabetes management, are arguably at higher risk of adherence issues relating to parental diabetes-related stress and anxiety (Chisholm et al, 2007; Lowes, 2008). Such issues may be reflected in the findings of our survey, in which respondents stated referrals were most frequently for CYP aged 12–16 years, 5–11 years and ≥ 17 years, in that order.

Service provision

The three most frequently employed therapeutic approaches by psychologists contributing to PDSs seem to reflect existing practice-based evidence of interventions for CYP with type 1 diabetes (Winkley et al, 2006). A diagnosis of diabetes is life-altering for CYP and their family members. Therefore, those experiencing adjustment and adherence challenges may benefit from psychological interventions such as systemic and family-focussed therapies, which consider diabetes in the context of the individuals' lives (Winkley et al, 2006; Jaser et al, 2014). MI and CBT are time-limited, collaborative approaches that empower clients and aim to reframe the way they think and feel about their diabetes, so as to promote more helpful management behaviours. Consistent with respondents' reports, the MDT can also be trained in CBT- and MI-informed techniques so that the psychological support can be reinforced throughout the PDS, fostering cohesive practice (Ramesh and Edge, 2009; IDF/ISPAD, 2011).

While the survey requested an estimation of session time spent on providing various types of psychological support to CYP with type 1 diabetes and their families, respondents' reporting of this varied greatly and were difficult to quantify. This perhaps suggests that these were difficult questions to answer. Therefore, the number of respondents indicating that they provided a particular form of support was reported. While this finding gives an overall impression, it does not illustrate the relative amounts of time spent on each activity, or priorities. Respondents reported providing mostly direct psychological input in the form of psychology-only one-to-one/family appointments outside of clinic and joint appointments with members of the MDT during clinic. Differences in this provision perhaps reflect the context of the

PDSs to which psychologists contributed, although further research would be required to ascertain this.

Respondents also reported additional responsibilities, including input into the transition of young people with type 1 diabetes to adult services, usually occurring at approximately 19 years of age. This can be considered helpful in light of national guidance, which prescribes that a clear policy must be in place outlining the pathway of transition to adult services (DH, 2013), with some literature suggesting input from psychology (Gelder, 2013). Additionally, contact with newly diagnosed CYP and their families, psychologists attending clinics with MDT staff and the use of literature on psychologists' roles in the MDT can all serve to normalise psychology, leading to better engagement in care (Lange et al, 2009), a challenge which was noted by many of our respondents. The new NICE (2015) guidelines for paediatric diabetes, which recommend psychological assessment of CYP with type 1 diabetes who repeatedly present with DKA, may lead to a change in our observation that most respondents did not routinely see CYP with DKA.

A sizeable proportion of respondents also reported psychological provision for non-diabetes-related difficulties. This raises interesting questions about the role and remit of psychology in PDSs and relationships with wider services, such as child and adolescent mental health services (CAMHS). The National Peer Review Programme (2015) documents the first external peer reviews of 138 PDSs by diabetes clinicians, along with the self-assessment of all PDSs in England. Commissioned by NHS England, the report highlights concerns about the difficulty that CYP with type 1 diabetes have in accessing CAMHS, although these findings may have changed since the investigation was carried out.

Some respondents expanded to state that non-diabetes-related difficulties often would not meet the criteria for CAMHS access, and there were also comments relating to the closure of other, arguably better-placed, local services, impacting on remit. Some also elaborated that they worked in both PDSs and CAMHS (Binney and Roswess-Bruce, 2015); therefore, any referrals to CAMHS made from the PDS would likely be allocated to them

in their concurrent CAMHS role anyway. This suggests that, especially for psychologists with dual roles, there is some overlap, and variation in service provision can be a result of the local context.

Dual roles for psychologists contributing to PDSs are likely to be an increasing occurrence owing to the part-time nature of the contracts. This raises questions as to how best to develop a service where CYP with type 1 diabetes are being seen for a range of interacting/co-occurring issues that may or may not be directly related to their diabetes. It may of course be that difficulties are hard to delineate, since it is known that diabetes care, health-related quality of life and mental health difficulties can be intimately and reciprocally linked (Nardi et al, 2008). Focussing on the primary presenting problem is perhaps one way to help consider the best-placed service(s) to respond.

These points highlight the need to develop good communication between local services in a context of increasingly more prescribed service remits.

Management, meetings, consultation, training, supervision and challenges

Psychologists are trained to intervene at a variety of levels encompassing direct and non-direct work (see Paediatric Psychology Network, 2008). As is evident from our data, training other MDT staff can be a common aspect of a psychologist's role, enabling contribution at a systemic level. As opposed to training, many more respondents provided one-to-one consultation to the MDT, complementing the skills base of other MDT staff and enhancing psychologically minded practice to improve service provision and optimise the use of their limited resources. A significant proportion of psychologists (88.4%) also reported participating in MDT or psychosocial case discussions. These meetings have the potential to demand a high proportion of a psychologist's time; however, as with consultation, they are arguably an efficient way of delivering psychological thinking to a higher proportion of CYP with type 1 diabetes within a service, especially for those more frequent but less severe difficulties (see the pyramid model, NHS Diabetes and Diabetes UK, 2010).

Most respondents reported receiving psychological supervision on a monthly basis.

The majority also felt they had appropriate access to CPD, but very few were aware of the National Curriculum for Paediatric Diabetes and even fewer had completed Level 1 of the course. This may change now that this training is promoted more widely via diabetes networks and more individuals have access to it without cost. Greater emphasis is being placed on paediatric diabetes-specific training programmes for healthcare professionals working in PDSs, in line with recommendations for care.

Challenges that respondents experienced were grouped into eight main themes. Some of these were reflected in the results already discussed. Time was a common feature and, in particular, many respondents felt stretched by the needs of their patient population, as demonstrated in part 1 of our survey, in which the WTEs did not seem to reliably correspond to the number of clinic sites or the patient population of the service (Binney and Roswess-Bruce, 2015). The National Peer Review Programme (2015) also highlighted "a lack of dedicated psychological support" in PDSs, seemingly reiterating the experiences of our respondents, although again this may have changed since the review was carried out in response to the BPT. Respondents also felt they were short of time to carry out other aspects of their role, including administration and reading to inform effective service development, that would allow them to do their job more efficiently and effectively.

Respondents felt that "infrastructure" required more consideration when creating psychologist posts in PDSs. This encompassed things like having a base and access to rooms for seeing clients and their families, appropriate parking when moving between PDS clinic sites and administrative support. While perhaps unintentionally forgotten in the planning stages or linked to budgetary considerations, unless such fundamental requirements are considered, provision of efficient services can be hindered.

Some respondents reported difficulties defining their role and developing relationships within the MDT, particularly with regard to an existing, predominantly physical, healthcare model. While the integration of psychology into PDSs through service planning and development, staff training

Summary of main findings: Management, meetings and consultation, training, supervision and challenges

1. Overall, 44.2% of psychologists provided formal teaching for the MDT, with topics mostly covering specific interventions.
2. The majority of psychologists provided one-to-one consultation to other members of the MDT. This was via a mixture of formal and informal face-to-face and over-the-phone consultations.
3. Very few psychologists were aware of the National Curriculum for Paediatric Diabetes or had completed the Level 1 (Basic Awareness) module.
4. The main challenges of providing psychological support within the PDS were complexity of needs and role definition; conflicting needs and desires of stakeholders; defining the role and relationships with the PDS MDT; not solely sitting in the PDS; engagement; infrastructure; service start-up and development; and time.

“The data raise some interesting challenges regarding the further development and evaluation of more widely integrated psychological care for children and young people with type 1 diabetes and their families.”

and direct work with CYP and their families is beneficial (Dovey-Pearce et al, 2007; Jacobs et al, 2012), the above finding suggests it is not without challenges.

Considering the processes and benefits of integrated psychological provision at all levels will help further discussion around paediatric diabetes care. Such discussion may help address the sometimes conflicting desires of stakeholders (e.g. improved quality of life vs. better HbA_{1c} levels). Additionally, this will guide the effective start-up and development of psychology within PDSs while accommodating the myriad of factors influencing local provision, all of which were cited as challenges by respondents.

Limitations and future directions

There are a number of limitations to our study, including the estimated representativeness and subjectivity of the data, which are discussed at length in the first article (Binney and Rosswess-Bruce, 2015). There also remains scope for looking in more detail at the factors affecting decisions about how psychologists configure their contribution to PDSs. As we discussed in the first article, collecting meaningful psychological information through the National Paediatric Diabetes Audit could enhance service development through accurate, national data collection to annually create an image of how psychological healthcare is provided alongside physical care by PDSs. However, inclusive discussion needs to take place with stakeholders, led by psychologists, to establish what information should be collected so as to enable useful and comprehensive “fact finding”.

Conclusion

This survey forms a valuable starting point from which psychologists working within PDSs can inform local service development and evaluation. The data highlight the positives of creatively integrating psychological thinking into the PDS to provide accessible, quality care to CYP with type 1 diabetes and their families as part of the MDT. Additionally, they raise some interesting challenges regarding the further development and evaluation of more widely integrated psychological care for CYP with type 1 diabetes and their families. ■

Binney CJ, Rosswess-Bruce N (2015) Paediatric diabetes services in England since the introduction of the Best Practice Tariff: A national survey of clinical psychologists' time, roles and ways of working. Part 1. *Diabetes Care for Children & Young People* **4**: 63–70

Braun V, Clarke V (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology* **3**: 77–101

Chisholm V, Atkinson L, Donaldson C et al (2007) Predictors of treatment adherence in young children with type 1 diabetes. *J Adv Nurs* **57**: 482–93

Delamater AM, de Wit M, McDarby V et al (2014) ISPAD Clinical Practice Consensus Guidelines 2014. Psychological care of children and adolescents with type 1 diabetes. *Pediatr Diabetes* **15**(Suppl 20): 232–44

Department of Health (2013) *Payment by Results Guidance for 2013–14*. DH, Leeds. Available at: <http://bit.ly/Ne19BP> (accessed 07.01.16)

Dovey-Pearce G, Doherty Y, May C (2007) The influence of diabetes upon adolescent and young adult development: a qualitative study. *Br J Health Psychol* **12**: 75–91

Ellis DA, Naar-King S, Frey M et al (2005) Multisystemic treatment of poorly controlled type 1 diabetes: effects on medical resource utilization. *J Pediatr Psychol* **30**: 656–66

Gelder C (2013) Diabetes in children and young people: Optimising management throughout the care pathway. *Journal of Diabetes Nursing* **17**: 294–301

Gosden C, Edge JA, Holt RI et al (2010) The fifth UK paediatric diabetes services survey: meeting guidelines and recommendations? *Arch Dis Child* **95**: 837–40

International Diabetes Federation/International Society for Pediatric and Adolescent Diabetes (2011) *Global IDF/ISPAD Guideline for Diabetes in Childhood and Adolescence*. IDF, Brussels, Belgium. Available at: www.idf.org/guideline-diabetes-childhood (accessed 07.01.16)

Jacobs K, Titman P, Edwards M (2012) Bridging psychological and physical health care. *The Psychologist* **25**: 190–3

Jaser SS, Patel N, Rothman RL et al (2014) Check it! A randomized pilot of a positive psychology intervention to improve adherence in adolescents with type 1 diabetes. *Diabetes Educ* **40**: 659–67

Kime N, Carlin E (2012) “Join us on our journey”: A new model of care for children and young people with diabetes. *Diabetes Care for Children & Young People* **1**: 31–5

Lange K, Coutant R, Danne T (2009) Paediatric ONSET-study: impaired QoL in children and depressed mood in mothers at onset of DM1 in children. *Pediatr Diabetes* **10**(Suppl 11): 65 (poster 109/FRI)

Lowes L (2008) Managing type 1 diabetes in childhood and adolescence. *Nurs Stand* **22**: 50–6

Nardi L, Zucchini S, D'Alberon F (2008) Quality of life, psychological adjustment and metabolic control in youths with type 1 diabetes: a study with self- and parent-report questionnaires. *Pediatr Diabetes* **9**: 496–503

National Peer Review Programme (2015) *Paediatric Diabetes Services 2013/2014*. London: NHS England. Available at: <http://bit.ly/1ZPKu7N> (accessed 07.01.15)

NHS Diabetes, Diabetes UK (2010) *Emotional and Psychological Support and Care in Diabetes: Report from the Emotional and Psychological Support Working Group of NHS Diabetes and Diabetes UK*. Diabetes UK, London. Available at: <http://bit.ly/REZk34> (accessed 07.01.16)

NICE (2015) *Diabetes (Type 1 and Type 2) In Children And Young People: Diagnosis And Management* (NG18). NICE, London. Available at: www.nice.org.uk/guidance/ng18 (accessed 07.01.16)

Paediatric Psychology Network (2008) *A Guide to Commissioning Paediatric Clinical Psychology Services in the UK: Briefing Paper*. Available at: <http://bit.ly/1THoEjj> (accessed 07.01.16)

Ramesh KP, Edge JA (2009) Clinical services for children with diabetes. *Paediatr Child Health* **19**: 299–303

Winkley K, Ismail K, Landau S, Eisler I (2006) Psychological interventions to improve glycaemic control in patients with type 1 diabetes: systematic review and meta-analysis of randomised controlled trials. *BMJ* **333**: 65