

A diabetes legacy plan for children and young people



Helen Thornton

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This is the year of the London Olympics, the Queen's Diamond Jubilee and, most importantly, the formal recognition that the care of children and young people with diabetes is a specialist service in its own right, with the creation of its own unique financial streams based on providing a quality service. For those who have championed this cause for many years, this is as significant as the Olympics and will also have a lasting legacy.

As we wait for the final version of the mandatory Best Practice Tariff (BPT) to be published by the Department of Health, many of us have been benchmarking our services against the various drafts. It does appear that not everyone will be able to fulfil all the qualifying criteria initially. There will be a 1-year transitional period of pre-BPT funding, enabling services to work with their commissioners to ensure everything is in place for 2013/14.

Problems will occur in smaller units when the paediatrician with special interest in diabetes also has general on-call paediatric duties. Between on-call duties and annual leave, additional qualified staff may need to be recruited to ensure that clinics meet the criteria of a multidisciplinary clinic. Job plans may also need to be reviewed. There is an urgent need for caseload profiling and review of staffing levels.

It is vitally important that teams work with management to enable them to understand the tariff and that the income is to provide services for children and young people with diabetes and is not just to be used as general income. These are not small amounts of money. The final amount is yet to be announced, but it could be £3500 per patient per year. This equates to a national paediatric diabetes budget of £80.5 million, based on the Royal College of Paediatrics and Child Health (RCPCH) estimate of 23 000 children and young people under the age of 18 years old with diabetes (RCPCH, 2009). This translates to £455 000 for an average district general hospital with a caseload of 130 people,

with tertiary units receiving £1.05 million for 300 people. These are budgets far beyond what our services have previously had to manage.

Systems and processes need to be developed to enable us to demonstrate that the BPT criteria are being met. Although there are some commercially available tools, not everyone currently has this software and hospital patient systems will not reliably collect the required data.

But we all need to focus on why this is occurring. Children with diabetes still have poor control and suffer the effects of acute and long-term complications. The mean HbA_{1c} has been 72 mmol/mol (8.7%) since the advent of the National Paediatric Diabetes Audit (NHS Information Centre, 2011). The 2010/11 data are now being analysed and the data set is currently being reviewed (RCPCH, 2011). RCPCH is seeking permission to collect some patient identifiable data such as date of birth. One of the previous anomalies has been collection of BMI rather than weight and height. The inclusion of controversial fields such as cholesterol screening may continue in light of emerging evidence. (Howard and Allgrove, 2008)

The articles in this current supplement reflect the current need for service analysis in light of BPT. Gwendoline Sewell discusses the caseload in Leeds and their staffing levels. She discusses the important impact of social deprivation on diabetes management, a theme which has been discussed at the RCPCH for future audit data analysis. The lack of personnel, especially DSNs, is discussed with a suggested model for training future staff to meet their needs.

Ashutosh Kale discusses the issue of 24-hour specialist telephone support and the business case that he has produced to provide such a service. The model is interesting, but once BPT is established, this service will have to be incorporated into the tariff. The team will no longer be able to charge £22 per telephone consultation because the tariff covers eight contacts per patient per year outside of clinic. ■