

Are we nearly there yet? Reflections on the progress of the paediatric service improvement plan



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As the new year is upon us, it is a great opportunity to reflect on the progress of the National Paediatric Diabetes Service Improvement Delivery Plan that was published in 2013. Its aim was to achieve better outcomes for children and young people with diabetes and their families by improving the quality of planning, delivery and commissioning of services (NHS Diabetes, 2013). Its primary quantitative outcomes were:

- A reduction in median HbA_{1c} in England and Wales by 11 mmol/mol (1.0%) within 5 years and by 16 mmol/mol (1.5%) within 10 years.
- A reduction in the proportion of children presenting with diabetic ketoacidosis (DKA) at diagnosis.
- A reduction in admissions for diabetes-related acute complications (DKA and hypoglycaemia).

Looking at these outcomes, the results of the latest National Paediatric Diabetes Audit (NPDA) are due in early 2017, and early indications show that there has been a continued improvement in the median HbA_{1c} nationally. Of concern, however, is the variability in results between different centres. The NPDA statistically adjusts the results taking into account social deprivation and ethnicity, so teams cannot continue to use the excuse that their population is more deprived than those of neighbouring hospitals.

Unfortunately, the Royal College of Paediatrics and Child Health (RCPCH), which runs the NPDA, has struggled to obtain statistical data on hospital episodes for the last few years, but it will be producing a combined report of several years' admissions once data have been received and analysed. All teams are required to monitor their admissions as part of their Diabetes Quality Improvement Network System (DQuINS) standards. Locally, we have noticed a reduction in DKA admissions on diagnosis overall, but not

in the youngest age group. Reflecting on many years of service, we also have fewer recurrent DKA "regulars" than when I first started in my role, which is probably a direct result of better education, helplines and use of blood ketone monitoring.

Service standardisation

The national and regional paediatric diabetes networks have continued to thrive, with funding coming from the Best Practice tariff (BPT). One of the visions in the service improvement plan was for the networks to support units that did not meet the BPT standards. This vision has been extended by the DQuINS and the National Peer Review Programme. The desktop exercise initially followed by the peer review visits in 2014 enabled services to convince Trusts to invest in the workforce, with more consultants, specialist nurses, dietitians and clinical psychologists being employed. There has been a repeat of the desktop exercise in 2016, and action plans have been requested by regional networks for all hospitals. The regional network leads and the network co-ordinators have recently attended some Quality Improvement training hosted by the RCPCH to help strengthen the support that they can provide to local services and address the issue of outliers. Quality improvement collaboratives have been shown to improve national HbA_{1c} levels in Sweden through this structured approach (Samuelsson et al, 2016).

The DQuINS programme, along with the new NG18 guideline from NICE (2015), has helped to standardise the services and care provided. Work on transition has continued in collaboration with adult colleagues, and many services have now improved this experience for those transferring to young adult services.

Another example of standardisation of practice has been the introduction of the Individual Healthcare Plans in schools. The care plan

was originally designed for use in the North West Network but has been developed into a national document supported by the two main voluntary organisations, Diabetes UK and JDRF (Singleton, 2015). The Individual Healthcare Plan fulfils all national guidance documents for the care of children with diabetes in schools, and more information can be found at: <http://bit.ly/2hqCGZW>.

Standardised, accredited and structured education for healthcare professionals

The original *National Curriculum for the training of Health Care Professionals who care for Children and Young People with Diabetes Mellitus* (Allgrove and Waldron, 2013) also laid the foundation for improvement in training for healthcare professionals. Teams could benchmark themselves against the standards and identify areas needing development. A basic level 1 online module has been developed to ensure all team members have this minimum basic standard of education (available at: <http://bit.ly/1S5UwQX>).

In this issue of the Journal, Frances Hanson outlines the recently published paediatric dietitians' curriculum. We as nurses also need to ensure that we continue to review the available guidance about our role and qualifications, in view of the changes to how services are delivered and the need for more advanced qualifications. On a personal level, I do not think it is possible to fulfil the specialist nursing role effectively without being an independent nurse prescriber, especially when you are part of 24-hour helplines providing expert advice to fellow healthcare professionals.

Standardised, accredited and structured diabetes self-management education for children, young people and their families

Progress has also been made with individualised structured education. The *Goals of Diabetes Education* programme (Novo Nordisk, 2016) has been created for children and young people with type 1 diabetes. It is designed to facilitate patient-centred learning and enable children to gradually take charge of their diabetes over time. It describes the minimum age-related competencies expected from 6 to 18 years of age. In addition, SEREN, the all-Wales structured education programme, has been developed for newly

diagnosed young people aged 11–16 years (SEREN Project Group, 2016), and training sessions have been completed for both programmes so that teams can deliver them in their local areas.

The twin articles by Helen Mulhearn and Chloe Brown in this section are about involving the diabetes service user and families/carers. They describe the Type 1 Kidz project, in which active participation by the users has helped develop group sessions which provide not only peer support but also educational opportunities, as well as all-important service user feedback. This project won a Quality in Care Diabetes award in 2016, with the judges commenting:

“This is a fantastic project which has clearly achieved a lot in 18 months. It is a true multidisciplinary effort, with young people driving the agenda and a multidisciplinary team of health professionals and youth workers making it happen. They are all working together, supporting peer learning to ensure there is factually correct information available.”

Technologies

The last few years have seen a greater uptake of pumps and continuous blood glucose monitoring (CGM) systems, although there remains a postcode lottery for the provision of the latter. There has been the innovation of flash glucose monitoring but, unfortunately, this is still not available for NHS reimbursement. NICE technology guidance has attempted to address the question of CGM but, to date, cash-strapped Clinical Commissioning Groups are still not applying this guidance equitably.

Are we there yet?

In summary, massive progress has been made since the National Paediatric Diabetes Service Improvement Delivery Plan was outlined in 2013. Dr Fiona Campbell has continued to champion its cause along with like-minded professionals, but we must not lose momentum, especially in this time of change with the reconfiguration of services. Our children and young people depend on us to deliver high standards of care, and we must continue to have high expectations. As nurses, we should reflect on the progress and ensure we are helping drive the quality improvement initiatives along with our teams, ensuring unified targets and treatment regimens for all. ■

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References

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