Paediatric and Adolescent Diabetes Operational Policy
**Policy Title:** Paediatric and Adolescent Diabetes Operational Policy

**Executive Summary:** The Children’s Diabetes Multidisciplinary Team (MDT) is a multi-professional team serving the population of East Cheshire and the surrounding area. The team offers care in line with national and international guidance. This policy sets out how care is delivered.

**Supersedes:** Paediatric and Adolescent Operational Policy Version 1

**Description of Amendment(s):** Names and training removed of core staff and added as an appendix. Document updated in line with current regional, national and international guidance.

**This policy will impact on:** Paediatric diabetes services, Adult diabetes services

**Financial Implications:** Non Known

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**APPROVAL RECORD**

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Appendix 1 Added 30/10/2012
Appendix 2 Added 14/01/2014

Paediatric Diabetes Team, ECNHST November 2015
Operational Policy for the Children’s Diabetes MDT

Introduction
The Children’s Diabetes Multidisciplinary Team (MDT) is a multi-professional team serving the population of East Cheshire and the surrounding area. The service supports a childhood population base of over 83,000 people across East Cheshire.
The core team comprises:

- 1 consultant paediatrician with a special interest in diabetes (1PA)
- 1 band 7 paediatric diabetes specialist nurse (PDSN), 1 band 6 PDSN (1.5 wte),
- 1 paediatric dietitian with a special interest in diabetes (0.21 wte)
- 1 clinical psychologist (0.2 wte)
- Diabetes administrator (0.1 wte)
- Support from medical secretary.
The extended team comprises:

- 1 consultant diabetologist who runs the young person clinic
- Staff on the children’s ward at East Cheshire NHS Trust

Our service is affiliated with the North West Children and Young Peoples Diabetes Network.

Referral Arrangements and Facilities – D12-2A-104/106
East Cheshire NHS Trust at Macclesfield District General Hospital has a 24 hour 7 day a week paediatric inpatient ward and children’s outpatient facility. The ward is managed and staffed by paediatric nursing and medical teams. There are currently no dedicated high dependency beds. Children who require intensive care would need to be discussed with NWTS who will facilitate the transfer of critically ill children with diabetes should this be required as for all other children in need of specialist intensive care. Any child suspected of having diabetes should be referred to the paediatric department immediately. If unsure please contact the on-call registrar or consultant to discuss. Guidelines for the management of newly diagnosed diabetic patients are on streamline, the shared drive and Intranet. This includes the management of patients presenting in Diabetic Ketoacidosis (DKA).
Flow chart for management of new referrals where diabetes is suspected

1. Diagnosis of Diabetes suspected either from Primary Care or A+E
2. Urgent referral to Children’s Ward via On-call team or MDT
3. Diagnosis confirmed
4. Initial treatment plan discussed with Consultant (with special interest) or PDSN’S (on- call consultant if out of hours using escalation policy)
5. Admission to children’s ward for initiation of treatment
6. If child well without signs of DKA, follow treatment of well child with newly diagnosed diabetes protocol. Commence treatment with MDI insulin regime
7. If child unwell with signs of DKA, follow BSPED DKA guidelines
8. Child reviewed within 24 hours by Consultant and PDSN from MDT. Further treatment decision made by MDT and education commenced at appropriate time for family.
9. Dietetic review on the ward prior to discharge. Decisions on timing of discharge made by MDT in conjunction with family. Follow-up arrangements made prior to discharge
Purpose of the MDT  Members of the MDT – D12-2A-103/105

The aim of the MDT is to help ensure a coordinated approach to the diagnosis, treatment and on-going care for all children and young people diagnosed with diabetes in East Cheshire. The MDT is committed to achieving the highest standard of care and patient outcomes through:

- A consistent and integrated approach.
- Providing evidenced based high quality care.
- Providing comprehensive support and age appropriate education to children, young people, families and carers.
- Involvement of patients in the assessment and redesign of the service.
- The collection of high quality audit data and submission to the national audit for children and young people with diabetes.
- The involvement in local, national and international research studies.

The Operational Policy for the MDT will be reviewed every 2 years at the Diabetes MDT meetings or more frequently according to service needs/changes.

Service Specification

It is the intention of the East Cheshire CYPD MDT to work within the framework of local, regional, national and international diabetes guidelines.

Telephone advice service

There is direct telephone access to a member of the diabetes team from 8.00am to 5.00pm five days a week. A designated team email address is available to all families. Contact details for the team are made available to new patients at the time of diagnosis or on transfer into the service and is written on all patient information leaflets. In the evenings and at weekends families have access to advice via the children’s ward and the on-call paediatric registrar and on-call consultant.

The diabetes consultant is part of a local 24 hour on-call agreement (see Paediatric Diabetes Escalation Policy) with a neighboring hospital for specialist advice. The PDSN will contact the ward after the weekend to see if any patients have been admitted over the weekend and will inform the consultant if further advice is required.
Leadership Arrangements and Responsibilities – D12-2A-101

Responsibilities of the Lead clinician:

- Lead the clinical activity of the multidisciplinary team, working to agreed guidelines, ensuring a high quality integrated service which meets local, regional and national targets.
- Attend and contribute to the North West Paediatric Diabetes regional network meetings or send a representative.
- Ensure that the clinical management guidelines are produced and revised regularly.
- Organise “management meetings” of the MDT and ensure deliberations are recorded.
- Establish an audit programme and review of outcomes.
- Support and engage with local and national research studies relating to children and young people with diabetes.
- Ensure an annual report for the CYPDN is produced.
- Lead on or nominate lead for service improvement.
- Overall responsibility for ensuring that MDT work towards meeting peer review quality measures.
- Ensure that the outcomes of the meeting are clearly recorded and clinically validated and that appropriate data collection is supported.
- To ensure that guidelines and the Diabetes Network recommendations are reviewed and implemented locally.
- Take overall responsibility for the function of the MDT.
- To provide 24 hour on-call specialist advice (Escalation Policy) via a rota with a neighboring hospital.

CYPDN Membership – D12-2A-102

The Lead paediatric diabetes clinician will attend the North West Paediatric Diabetes Regional Network meetings or facilitate the attendance of a nominated representative. The MDT will participate in the activities and endeavor to implement developments suggested by the CYPDN.
Core Nurse Members

The lead nurse for the children’s diabetes MDT is a Band 7 Paediatric Diabetes Nurse Specialist and is supported by a Band 6 Paediatric Diabetes Nurse. Cover is provided from the Children’s Community Nursing Team for support for newly diagnosed children and young people.

Responsibilities of the Lead PDSN

- Working closely with and supporting the lead Physician in their role.
- Contributing to the multidisciplinary discussion and patient assessment/care planning decisions of the team at their regular meetings.
- Providing expert nursing advice and support to other health professionals in the nurses’ specialist area of practice.
- Is an independent and supplementary prescriber.
- Is educated to masters’ level.
- Involvement research studies supporting lead consultant.
- Leading on patients’, carers’ and relatives’ communication issues and co-ordination of the patients’ pathway for patients referred to the team.
- Facilitating access to members of the MDT where requested by patients and their carers’.
- Contributing to the management of the service.
- Utilising research in the nurses' specialist area of practice.
- Act as a role model and expert nurse providing in-depth highly specialist clinical knowledge to colleagues through MDT meetings, for patients and carers/relatives.
- Lead on audit, identifying areas that require auditing to develop and improve services.
- Promote and support the holistic needs assessment in the management of diabetes care within the children’s MDT.
- Act as a resource for health care professionals by being visible, available, and accessible for support, counseling and advice in relation to the management of young people with diabetes.
- Ensure competencies for registered and unregistered nursing staff are in place and up to date. Assess nursing staff competencies’.
- To act as link between primary and secondary care in the implementation of local and national guidance or service initiatives.
- Develop links with other specialist areas of care to ensure on-going improvements in the service provision for children with diabetes in line with national guidance.
- Provide education and support to schools, nurseries and colleges.
- Support the Peer Review process and ensure that service development is supported by specialist nursing.
- Has completed nationally recognised CSII training course.

**Responsibilities of the PDN**

- Working closely with and supporting the lead physician and lead nurse in their role.
- Contributing to the multidisciplinary discussion and patient assessment/care planning decisions of the team at their regular meetings.
- Providing specialist nursing advice and support to other health professionals in the nurses’ specialist area of practice.
- Involvement in clinical audit.
- Facilitating access to members of the MDT where requested by patients and their carers’.
- Utilising research in the nurses’ specialist area of practice.
- Act as a role model and specialist nurse providing in-depth clinical knowledge to colleagues through MDT meetings, for patients and carers/relatives. Promote and support the holistic needs assessment in the management of diabetes care within the children’s MDT.
- Act as a resource for health care professionals by being visible, available, and accessible for support, and advice in relation to the management of young people with diabetes.
- Assist lead nurse in assessing competencies in ward staff in relation to diabetes.
- To act as link between primary and secondary care in the implementation of local and national guidance or service initiatives.
- Develop links with other specialist areas of care to ensure on-going improvements in the service provision for children with diabetes in line with national guidance.
- Provide education and support to schools, nurseries and colleges.
- Support the Peer Review process and ensure that service development is supported by specialist nurses.
Responsibilities of the Core Dietician

- Contributing to the multidisciplinary discussion and patient assessment/care planning decisions of the team at their regular meetings.
- Providing expert dietetic advice to young people and their families from diagnosis.
- Providing expert dietetic advice and support to other health professionals in the dietician’s specialist area of practice.
- Leading on the implementation of carbohydrate counting and dose adjustment.
- Providing advice and training for staff on the ward, and school staff on issues relating to dose adjustment and carbohydrate assessment.
- Involvement in clinical audit.
- Contributing to the management of the service.
- Utilising research in the dietician’s specialist area of practice.

Educational training sessions – 012-2A-111.

- Teaching is provided for nursing and medical staff as part of their induction and on-going professional training.
- Members of the MDT will attend relevant study days/conferences/ courses and online training to comply with continuing professional development.

Outpatient Services

- Weekly MDT clinic. 13.30-18.00 hours.
- Weekly nurse led clinic 08.00-12.30 hours.
- Monthly young person’s clinic 03.00-18.00 hours.

MDT and nurse led clinics are held in the children’s outpatient department, Macclesfield Hospital for paediatric and patients using continuous subcutaneous insulin infusions (CSII). Young people aged 16-18 years old using multiple daily injections will be seen by the MDT in adult outpatients at Macclesfield Hospital. This is due to the current lack of adult diabetes pump service in East Cheshire.

Clinic appointments are for 30 minute duration, if additional time is required then home or school visits are offered. Additional appointments with the dietitian or psychologist may also be offered as appropriate.

Additional Contacts MDT – 09A-2A-116

The MDT is available via phone and email for patients & parents to contact. The PDSN’s are
able to do school and home visits as required. The team will ensure that each patient receives at least 8 additional contacts per year. This will also include newsletters and invitations to/attendance at local educational meetings.

**Additional Contacts with Dietitian – DA -2A-115**

During the MDT clinic, patients will be offered an additional appointment for annual dietary assessment which can take place on the same day after the MDT appointment or arranged for an alternative date & time. The dietetic management will be provided according to local guidelines based on national consensus and recorded in dietetic notes and clinic records including the electronic record.

**Transition clinics** (Please see Transition policy)

There is a monthly young person clinic, on the 4th Wednesday of the month for Young people from ages 16 to 18 who are treated with multiple daily injections. This is attended by an adult diabetologist, consultant paediatrician and PDSN. The young person is seen by the paediatrician, adult consultant and PDSN or all 3.

Patients are referred to the transition clinic in school years 11-12 after their GCSE’s (age 16). It is hoped that these appointments allow young people the opportunity of meeting the adult team while still feeling supported by the paediatric team. At the discretion of the MDT it may be decided that young people will remain with the paediatric service beyond year 12 or that they will remain in the transition service for longer than 1 year. This is particularly relevant to young people who are attending the Child Development Clinic or are attending a special school.

All young people are invited by letter from Mid-Cheshire NHS Hospitals who manage the adult diabetes service. Insulin pump (CSII) patients are referred at the age of 18 to Manchester Royal Infirmary or Royal Stoke Hospital depending on patient choice.

The PDSN aims to attend the first clinic appointment with the patient on CSII and with the adult community DSN.
All Clinics – D12-2A-112/113

- Patients are all invited by letter to the next MDT outpatient appointment as per hospital policy for booking appointments. Macclesfield District General Hospital (MDGH) has the responsibility to ensure letters are sent confirming follow up appointment dates and times.
- At all clinics patients have near patient testing of their HbA1c, so that results are available at the time of their consultation.
- The MDT requests that patients are offered appointments at least every 3 months in line with national guidelines.
- New patients are seen on a more regular basis initially, dependent on need. Existing patients may be seen earlier by the MDT if required.
- Core members of the MDT will be present at all outpatient clinics and patients will have access to a member of the MDT at all times.
- At the beginning of each clinic all patients from clinic are discussed within the MDT.

Patients who do not attend 2 appointments will have communication from the team via telephone, email and letter. The GP will also be informed. Every effort will be made to re-engage contact with the family and additional support mechanisms will be implemented if appropriate.

The nurse led clinic can be booked by the MDT members via the booking centre at MDGH, or directly by patients themselves via the hospital switch board who will transfer to the booking centre.

Inpatient care

Newly diagnosed children and young people with type 1 diabetes

- Please see the Paediatric Diabetes Newly Diagnosed Clinical Guideline.
- Children requiring an inpatient stay will be cared for on the Children’s Ward.
- If the young person presents out of hours the initial management should be discussed with the on-call consultant via the escalation policy who will advise about treatment.
- If the young person is well they will usually be commenced on multiple daily injections of sub-cutaneous insulin.
- If they are unwell they will be managed on the guideline for the treatment of ketoacidosis. (Please refer to Paediatric Diabetes DKA Guideline) prior to commencing multiple daily injections of sub-cutaneous insulin.
- All new patients are reviewed by the Diabetes Consultant or PDSN within one working day or discussed with the paediatric diabetes team within 24 hours.
- All new patients will have an assessment and basic education on dietary management by the dietitian. This will include introduction to carbohydrate counting.
A structured education programme will be commenced and this will be continued at home following discharge.

All young people will be introduced to the clinical psychologist.

The young person’s GP will be contacted to inform them of the diagnosis and to request a prescription for supplies.

A discharge summary will be sent detailing the admission and follow up arrangements.

Children and young people up to 18 years presenting with DKA will be nursed on the children’s ward with full monitoring and appropriate nursing cover. This will include 1:1 nursing if required. Full paediatric resuscitation equipment and a fully equipped stabilisation room are available on the paediatric unit based on children’s ward. Children presenting in DKA, who are seriously unwell will be discussed with North West and North Wales Transport Service regarding possible Intensive Care.

The ward is staffed by a team of paediatric trained nurses and has 24 hour paediatric medical cover.

A consultant paediatrician is on-call at all times.

The ward team should also inform the PDSN of any known diabetic patients admitted to the ward.

We aim for intensive management to achieve optimal control shortly after diagnosis in line with recent evidence showing improved prognosis for these young people.

**Children and young people with known diabetes**

- Children and young people under 16 years will be admitted to the paediatric ward if they require inpatient care.
- Any child admitted with diabetes will be discussed with a member of the MDT and advice will be given on management of their diabetes while in hospital.
- Any inpatients will be reviewed by a member of the MDT within 24 hours of admission to hospital unless the admission is over a weekend, then it will be the next working day.
- Out of hours care of children with diabetes will be managed by the on-call paediatric registrar and consultant.
- A consultant specialising in the care of CYPD will be available for advice as stated in the Escalation Policy.
- CYP with DKA and who are under 18 years of age will be admitted to the paediatric ward and follow the paediatric DKA policy.
- Children and young people who are admitted for routine surgery will have already been discussed with the MDT after the child has been seen in the surgical pre admission clinic. This will be documented in the medical notes. Please refer to the "Paediatric Diabetes Clinical Guidelines for Children and Young People with..."
Diabetes requiring Surgery”.
Guidelines for the management of diabetes during surgery are available on the intranet and shared drive.

The MDT Meetings

Weekly Meetings
Weekly meetings are held before the Monday clinic to discuss all the patients on the clinic list. This includes patients who did not attend their appointment the week before. These meetings also give the opportunity for discussion of other patients who are having diabetes related problems or are requiring extra input. These meetings are attended by the core members of the MDT.

A similar meeting takes place before the transition clinics and includes the adult diabetes team. At the weekly meetings we have the opportunity to discuss other non-patient related issues relevant to the MDT.

Trust Wide Diabetes Meeting
These are three monthly meetings in which the core and extended MDT members are invited along with the service director for children and women’s health.

Cheshire Wide Diabetes Meetings
A member of the paediatric MDT will attend bi monthly meetings with Cheshire adult and paediatric diabetes services. Minutes will be shared to core MDT members.

Core members Attendance
Core members of the MDT, are expected to attend at least two-thirds of the MDT meetings. Attendance will be recorded in the minutes of each meeting. At least two members of the MDT should be present at all meetings.
Key Worker Policy – D12-2A-107

The Key Worker is defined as the main contact and responsible person for the child and family throughout their pathway of care, with the overall aim of ensuring the child and family are provided with holistic care and support to meet their individual needs.

The main elements of the Key Worker role include:

- The provision of practical and emotional support to the child/young person and family. The co-ordination and the provision of information that is timely and tailored to the age of the child or young person and the needs of the family, and understood.
- Liaison with educational institutions and support reintegration for the child or young person as well as teaching practical aspects of diabetes care.
- The teaching and acquisition of skills for the child, young person and family as needed.
- The contact point for the family or young person for advice or support when required. The child or young person’s key worker will be the lead PDSN and she will be the families’ first port of call. She will be supported in her role by the other core members of the MDT at all times. She will also on occasions seek help and advice from extended members of the team or from outside the MDT should the need arise.

Data Collection

Audit – D12-2A-130

The Diabetes MDT takes part annually in the National Paediatric Diabetes Audit. We will seek assistance in the submission of data from the Trust. At the present time we have 5.50 hours per week provided for the collection of this data. The MDT also submits data to other national diabetes audits and surveys.

The MDT currently collects local data on an annual basis for audit purposes. Audit data is then discussed at our MDT service meetings.
Admissions Information

Data can easily be accessed through streamline database on new patient admissions, DKA admissions, admission relating to poor diabetic control, and admissions unrelated to diabetes such as routine or acute surgical problems. This data is collected as part of our National Paediatric Diabetes Audit and can be accessed from the Accu Chek 360 database and from our admin support.

Additionally, we record any admissions during the previous 12 months at the time of patients’ yearly reviews.

Patient and Carer Feedback and Involvement

We are involved in a patient experience and feedback questionnaire as part of our NPDA (PREM). There is an active Diabetes UK local support group. A PDSN will attend meetings when invited.

Treatment, Follow up and Screening – D12-2A-124/125

NICE (NG18 2015) have developed guidelines for the management of a number of different aspects of paediatric diabetes care. The MDT has tried to implement these recommendations into our working practices. We endeavor to provide a service as detailed in the guidelines where resources allow.

Treatment:

All children and young people will be assumed to have type 1 diabetes mellitus on diagnosis. Treatment will be by sub-cutaneous insulin via MDI or CSII therapy. Currently we use the NICE guidelines to aid our decision making on when we can offer CSII therapy.

We endeavor to make accurate diagnoses for all our patients and often liaise with national or international experts for advice on the management of these more uncommon types of diabetes.

Targets:

These are assessed individually for each child and young person but we will strive for:

- 4-8mmol/l pre meal
- 6-9mmol/l post meal
- 48mmol/mol HbA1c

Follow up care:

- Frequent home and school visits with the PDSN.
- Family visits in the outpatients department with PDSN and dietitian as applicable.
This contact will continue until the families are comfortable and confident with the initial diabetes management.

- Outpatient clinics offered 4 times a year with MDT (more frequent if appropriate).
- Hba1c obtained at each visit.
- Height, weight, blood pressure recorded at each visit.
- Assessment and issues with diabetes management discussed.
- Blood glucose meters and insulin pumps are downloaded for analysis.

All patients will have an annual review.

This will consist of:

- Coeliac antibodies at diagnosis and if symptomatic in future.
- Thyroid function tests in all children and young people.
- Blood Pressure
- Height and weight

In addition young people over 12 years will have:

- Lipid levels assessment
- Microalbuminuria
- Foot assessment
- Psychological assessment
- Retinal screening

As recommended by NICE (NG18 2015) we have the facilities to conduct blinded and real time continuous blood glucose monitoring.

For young people who are experiencing problems with their diabetes we will endeavor to provide increased support with a view to improving motivation, independence and control. This will include home and school visits plus telephone or email support. Please see High HbA1c Policy.

**High HbA1c Policy – D12-2A-123**

Children and young people that have HbA1c's above 75mmol/mol are offered extra support and interventions to help improve control. This is done in collaboration with the family and young person and an individual plan is negotiated. These plans incorporate, trouble shooting, further diabetes education, insulin regimen change, more frequent contact via phone, email and home visits. Continuous Glucose Monitoring for diagnostic reasons may be offered if felt by the MDT that it will be helpful. Letters are sent to patients to inform them of the care planning.
All contacts are recorded under “High HbA1c contact” for audit and identification purposes. Children and young people with persistent high HbA1c’s who are not engaging with their diabetes treatment are assessed to see if psychology or CAMHS support is required.

**DNA Policy – D12-2A-117**

The Diabetes team follows the East Cheshire NHS Trust paediatric DNA policy which incorporates safe guarding. A child with diabetes will never be discharged from follow up and every effort will be made to engage the family and young person with services. If a child or young person does not attend or cancels a pre-arranged clinic appointment, another time is given for the next available clinic slot. If this is more than a month the PDSN will arrange to see the child sooner if this is required.

The PDSN will aim to contact the child or young person to see if there are any specific problems that may be preventing them from attending the clinics especially in the case of regular non attendees. If the team has safe guarding concerns these will be discussed with the named nurse for child protection.

**Escalation policy D12-2A-122**

We operate an escalation policy shared with Stepping Hill Hospital. The on-call consultant rota is available in the ward diary and via the hospital switchboard.

**East Cheshire NHS Trust Paediatric Diabetes Guidelines and Policies**

The MDT looks to work within the framework of local, national and international diabetes guidelines, including NICE, Every Young Person with Diabetes Matters, Diabetes NSF, Transition: Getting it right for young people, Department of Health and ISPAD consensus Guidelines.

- Our local guidelines are used by the team for management of all aspects of diabetes care. The guidelines are currently available on the Trust intranet, streamline database and shared drive.
- The guidelines are widely available on trust computers in all areas of the hospital where children and young people with diabetes may be seen.
- The guidelines are presented in a format that allows printed copies to be made and kept in patient records during any hospital admissions.
- The diabetes guidelines also provide advice to non-members of the team who may be contacted out of hours by children or their families. They include advice on the management of illness and our sick day rules. This is to help on-call teams give
appropriate advice at time when the MDT is unavailable such a weekends and at night.

At junior doctor induction sessions access to these local guidelines are discussed so that all medical staff is aware of their existence and how they can be accessed when required.

**Psychosocial Assessment – D12-2A-114**

The Service has adopted the Yorkshire and Humber Paediatric Diabetes Network Wellbeing in Diabetes Questionnaire Tool to help the assessment of psychological need in children and young people with diabetes. Children identified as requiring psychological support are referred to the MDT psychologist or local CAMHS team depending on need.

**Education – D12-2A-126 –**

- Educational programmes will be offered throughout the child and young person’s care with the paediatric team. These will include:
  - Newly diagnosed education.
  - Carbohydrate counting education.
  - Pre CSII education for children and young people about to change to CSII therapy.
  - Annual updates education using Goals for Diabetes programme as part of annual review.
  - “Moving up” transition to high school sessions.
  - School staff education and training.
  - Information evenings will be arranged as required which will include a coping strategy/support session for newly diagnosed families.

East Cheshire NHS Trust educational information leaflets will be available alongside commercial leaflets on diabetes management.

**Provision of patient written information D12-2A-121**

Newly diagnosed children and young people are provided with verbal and practical teaching and are given information leaflets and a copy of the newly diagnosed care pathway. This written information includes advice on hypoglycaemia, hyperglycaemia and sick days.

**Clinical Trials/research**

We are involved with studies through the MCRN for example ADDRESS 1 & 2. We are also enrolled in the Detemir Study. We have close links with the Trust research nurse.
Provision of Patient-Centered Care

The Children's Diabetes MDT acknowledges the importance of sensitive and appropriate communications with patients and their carers'. The team continues to develop a service that regards patients as partners in achieving the best possible outcomes for them as individuals. Young people and their families are taught the skills and knowledge about diabetes and are encouraged to manage themselves with the support of the team.
Appendix to East Cheshire NHS Trust Paediatric Diabetes Team Operational Policy

Evidence Guide for Measuring the Standards of the Paediatric Diabetes Best Practice Tariff

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<td>On diagnosis, a young person with the diagnosis of diabetes is to be discussed with a senior member of paediatric diabetes team within 24 hours of presentation. A senior member is defined as a doctor or paediatric specialist nurse with ‘appropriate training’ in paediatric diabetes. Information as to what constitutes ‘appropriately trained’ is available from the British Society for Paediatric Endocrinology and Diabetes or the Royal College of Nursing.</td>
<td>Recorded on the database[^1]. Evidence of training is available in the peer review folder. Evidence of on-call rota will be available.</td>
<td>On average there are 8 to 12 newly diagnosed children each year. An on-call system (escalation policy) has been agreed with Stepping Hill to cover weekends and bank holidays.</td>
</tr>
<tr>
<td>All new patients must be seen by a member of the specialist paediatric diabetes team on the next working day.</td>
<td>Recorded on the database.</td>
<td>The date of diagnosis and the date of first visit will be recorded on the database and in the patient notes.</td>
</tr>
<tr>
<td>Each provider unit can provide evidence that each patient has received a structured education programme, tailored to the child or young person’s and their family’s needs, both at the time of initial diagnosis and on-going updates throughout the child or young person’s attendance at the paediatric diabetes clinic.</td>
<td>Recorded on the database. Annual review completed and available in notes. Copy of the checklist and the structure of the education programme is available for commissioners to review.</td>
<td>The newly diagnosed guidelines incorporate structured education. When the initial education is completed a signed off copy by parents and staff will be filed in the patients education record and marked on the data base. Each year education is reviewed as part of the annual review process and this is recorded and filed in patient notes. The team will use the Goals for Diabetes Education (A structured educational programme for children and young people with diabetes).</td>
</tr>
</tbody>
</table>

[^1]: Each child or young person
| Each patient is offered a minimum of four clinic appointments per year with a multi-disciplinary team (MDT), i.e. a paediatric diabetes specialist nurse, dietitian and doctor. The doctor should be a consultant or associate specialist/speciality doctor with training in paediatric diabetes or a specialist registrar training in paediatric diabetes, under the supervision of an appropriately trained consultant (see above). The dietitian should be a paediatric dietitian with training in diabetes (or equivalent appropriate experience). | Clinic appointments offered are available on the hospital PAS system. | All children and young people are invited to attend clinic

Children that cancel or DNA are rebooked for the next available clinic and followed up by the PDSN

Clinics will be held if the Consultant and another member of the team are available. If the consultant is unavailable and with patient/parent agreement the clinic will be led by the lead paediatric diabetes nurse.

- Record on database
- Composition of the MDT recorded
- Evidence of adequate cover available.

| Each patient is offered additional contact by the diabetes specialist team for check-ups, telephone contacts, school visits, troubleshooting, advice, support etc. Eight contacts per year are recommended as a minimum. | Recorded on the database. | The team will monitor contacts on a quarterly basis however to ensure that two contacts are made to patients in between clinic visits. If patient declines the contact then this will be demonstrated on data base and discussed within MDT for appropriate course of action to be taken.

Contacts will include home visits, phone contact, email contact, school visits, nurse led clinic appointments newsletters and invitations to education meetings held by the team.

- Evidence of sufficient capacity with the team to deliver this will be available.

| Each patient is offered at least one additional appointment per year with a paediatric dietitian with training in diabetes (or equivalent appropriate experience). | Recorded on the database. | This will be demonstrated as a separate input on the database.

- Evidence of sufficient capacity with the team to deliver this will be available.

| Each patient is offered a minimum of four haemoglobin HbA1C measurements per year. All results should be available and recorded at each MDT clinic appointment. | Recorded on the database. | The recording of HbA1Cs will be on the database and will link to clinic appointments.

- Evidence of sufficient capacity with the team to deliver this will be available.

| All eligible patients should be offered annual screening as recommended by | Recorded on the database. | The team will inform the retinopathy service of all

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Paediatric Diabetes Team, ECNHST  November  2015
Retinopathy screening should be performed by regional screening services in line with the national retinopathy screening programme, which is not covered by the paediatric diabetes BPT and is funded separately. Where retinopathy is identified, timely and appropriate referral to ophthalmology should be provided by the regional screening programme.

<table>
<thead>
<tr>
<th>Action</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Each patient should have an annual assessment by their MDT as to whether input to their care by a clinical psychologist is needed, and access to psychological support as appropriate.</td>
<td>Recorded on the database and as part of the annual review process. Questionnaire will be filed in patient notes.</td>
</tr>
<tr>
<td>The team use the Yorkshire and Humber Paediatric Diabetes Network assessment of Psychological need in children and young people with diabetes tool. Any issues identified will be discussed within the team and if appropriate referred to psychology or CAMHS. Note that completion of the annual review in the last 15 months will be demonstrated.</td>
<td></td>
</tr>
<tr>
<td>Each provider must participate in the annual Paediatric National Diabetes Audit.</td>
<td>Available from the network facilitator. Audit Report. Participation levels available from network facilitator and details of results available from RCPCH.</td>
</tr>
<tr>
<td>Each provider must actively participate in the local Paediatric Diabetes Network. A minimum of 60% attendance at regional network meetings needs to be demonstrated.</td>
<td>Available from the network facilitator. Minutes from the meeting will be available to view.</td>
</tr>
<tr>
<td>Each provider unit must provide patients and their families with 24 hour access to advice and support. This should also include 24 hour advice to fellow health professionals on the management of patients with diabetes admitted acutely, with a clear on-call rota needed. Monitor and record advice provided – both to own patients and to any other</td>
<td>The diabetes team arrange annual leave so that the service is always covered. Families have 24 hour access to advice from the children's ward. There are protocols</td>
</tr>
</tbody>
</table>

Diabetes in children and young people (Type 1 and Type 2) in children and young people: Diagnosis and Management (August 2015), available at [http://www.nice.org.uk/NG18](http://www.nice.org.uk/NG18) and TA151 Diabetes - insulin pump therapy (July 2008), available at [http://www.nice.org.uk/TA151](http://www.nice.org.uk/TA151)
<table>
<thead>
<tr>
<th>Escalation policy as to when further advice on managing diabetes emergencies should be sought.</th>
<th>Trust as appropriate. Available for any telephone advice given is recorded. There is clear guidance and protocols for the management of children acutely unwell with diabetes.</th>
<th>Each provider unit must have a clear policy for transition to adult services.</th>
<th>Policy due update due to service changes. Audit of the application of the policy. The date that young people are transferred to the transition clinic or out of the service will be entered onto the database and the spreadsheet updated for the PCT.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Each unit will have an operational policy, which should include a structured ‘high HbA1C’ policy, a clearly defined DNA/was not brought policy taking into account local safeguarding children board (LSB) policies and evidence of patient feedback on the service.</td>
<td>Policies available. Audit of the application of the policy will be available in the Annual report. Feedback from evaluation of education meetings available. Evidence of patient feedback on service.</td>
<td>With BPT funding</td>
<td>Patients that cause concern due to missed appointments or due to high HbA1c’s will be discussed by the team and action plans detailed in the notes.</td>
</tr>
</tbody>
</table>
Equality Analysis (Impact assessment)
Please START this assessment BEFORE writing your policy, procedure, proposal, strategy or service so that you can identify any adverse impacts and include action to mitigate these in your finished policy, procedure, proposal, strategy or service. Use it to help you develop fair and equal services. Eg. If there is an impact on Deaf people, then include in the policy how Deaf people will have equal access.

1. What is being assessed?

Paediatric Diabetes Operational Policy

Details of person responsible for completing the assessment:
- Name: Carol Metcalfe
- Job Title: Lead Paediatric Diabetes Specialist Nurse
- Team: Paediatric Diabetes Team

State main purpose or aim of the policy, procedure, proposal, strategy or service:
(usually the first paragraph of what you are writing. Also include details of legislation, guidance, regulations etc which have shaped or informed the document)

The purpose of the Operational Policy is to outline the level of service that is delivered children, young people and their families with diabetes. The following national and international guidance is considered:

http://www.ispad.org/?page=ISPADClinicalPract

http://www.nice.org.uk/guidance/ng18/


2. Consideration of Data and Research

To carry out the equality analysis you will need to consider information about the people who use the service and the staff that provide it. Think about the information below – how does this apply to your policy, procedure, proposal, strategy or service

2.1 Give details of RELEVANT information available that gives you an understanding of who will be affected by this document

Cheshire East (CE) covers Eastern Cheshire CCG and South Cheshire CCG. Cheshire West & Chester (CWAC) covers Vale Royal CCG and Cheshire West CCG. In 2011, 370,100 people resided in CE and 329,608 people resided in CWAC.

Age: East Cheshire and South Cheshire CCG’s serve a predominantly older population than the national average, with 19.3% aged over 65 (71,400 people) and 2.6% aged over 85 (9,700 people).

Vale Royal CCGs registered population in general has a younger age profile compared to the CWAC average, with 14% aged over 65 (14,561 people) and 2% aged over 85 (2,111 people).
Since the 2001 census the number of over 65s has increased by 26% compared with 20% nationally. The number of over 85s has increased by 35% compared with 24% nationally.

**Race:**
- In 2011, 93.6% of CE residents, and 94.7% of CWAC residents were White British
- 5.1% of CE residents, and 4.9% of CWAC residents were born outside the UK – Poland and India being the most common
- 3% of CE households have members for whom English is not the main language (11,103 people) and 1.2% of CWAC households have no people for whom English is their main language.

**Gender:** In 2011, c. 49% of the population in both CE and CWAC were male and 51% female. For CE, the assumption from national figures is that 20 per 100,000 are likely to be transgender and for CWAC 1,500 transgender people will be living in the CWAC area.

**Disability:**
- In 2011, 7.9% of the population in CE and 8.7% in CWAC had a long term health problem or disability
- In CE, there are c.4500 people aged 65+ with dementia, and c.1430 aged 65+ with dementia in CWAC. 1 in 20 people over 65 has a form of dementia
- Over 10 million (c. 1 in 6) people in the UK have a degree of hearing impairment or deafness.
- C. 2 million people in the UK have visual impairment, of these around 365,000 are registered as blind or partially sighted.
- In CE, it is estimated that around 7000 people have learning disabilities and 6500 people in CWAC.
- Mental health – 1 in 4 will have mental health problems at some time in their lives.

**Sexual Orientation:**
- CE - In 2011, the lesbian, gay, bisexual and transgender (LGBT) population in CE was estimated at 18,700, based on assumptions that 5-7% of the population are likely to be lesbian, gay or bisexual and 20 per 100,000 are likely to be transgender (*The Lesbian & Gay Foundation*).
- CWAC - In 2011, the LGBT population in CWAC is unknown, but in 2010 there were c. 20,000 LGB people in the area and as many as 1,500 transgender people residing in CWAC.

**Religion/Belief:**
The proportion of CE people classing themselves as Christian has fallen from 80.3% in 2001 to 68.9% In 2011 and in CWAC a similar picture from 80.7% to 70.1%, the proportion saying they had no religion doubled in both areas from around 11%-22%.
- **Christian:** 68.9% of Cheshire East and 70.1% of Cheshire West & Chester
- **Sikh:** 0.07% of Cheshire East and 0.1% of Cheshire West & Chester
- **Buddhist:** 0.24% of Cheshire East and 0.2% of Cheshire West & Chester
- **Hindu:** 0.36% of Cheshire East and 0.2% of Cheshire West & Chester
- **Jewish:** 0.16% of Cheshire East and 0.1% of Cheshire West & Chester
- **Muslim:** 0.66% of Cheshire East and 0.5% of Cheshire West & Chester
- **Other:** 0.29% of Cheshire East and 0.3% of Cheshire West & Chester
- **None:** 22.69% of Cheshire East and 22.0% of Cheshire West & Chester
- **Not stated:** 6.66% of Cheshire East and 6.5% of Cheshire West & Chester

**Carers:** In 2011, nearly 11% (40,000) of the population in CE are unpaid carers and just over 11% (37,000) of the population in CWAC.

**2.2 Evidence of complaints on grounds of discrimination:** (Are there any complaints or concerns raised either from patients or staff (grievance) relating to the policy, procedure, proposal, strategy or service or its effects on different groups?)

None

**2.3 Does the information gathered from 2.1 – 2.3 indicate any negative impact as a result of this document?**

No

### 3. Assessment of Impact

Now that you have looked at the purpose, etc. of the policy, procedure, proposal, strategy or service (part 1) and looked at the data and research you have (part 2), this section asks you to assess the impact of the policy, procedure, proposal, strategy or service on each of the strands listed below.

**RACE:**
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, racial groups differently?

No

**Explain your response:**
Where there is a patient and/or carers whose first language is not English, staff should follow the trust interpretation and translation policy to arrange telephone & face to face interpretation to ensure that parents and young people understand information given to them and to gain consent.

**GENDER (INCLUDING TRANSGENDER):**
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, different gender groups differently?

No

**Explain your response:**
No differential impact identified, treatment is the same for all irrespective of gender.
**DISABILITY**

From the evidence available does the **policy, procedure, proposal, strategy or service** affect, or have the potential to affect, disabled people differently?  
No

**Explain your response:**  
If the patient or carers are deaf, then a British sign language interpreter may be needed and will be accessed in accordance with the trust interpreting policy (in the future staff will have access to an online translation tool used with a webcam). If the patient or carer is blind, then information can be recorded in audio format. If the patient or carer has learning disabilities, staff should ensure information is understood and appropriate methods of communication are used. There is a picture communications book in the Communication Box on the ward/dept and staff should be aware of how to access the health facilitator for children with learning disabilities. Staff should ensure they have accessed trust learning disability awareness training.

Guidance on helping/approaching patients with disabilities can be found in the trust’s ‘Welcoming people with disabilities’ booklet (also in the communications box).

**AGE:**

From the evidence available does the **policy, procedure, proposal, strategy or service**, affect, or have the potential to affect, age groups differently?  
No

**Explain your response:**  
The policy only relates to children and young people and their carers who are the users of this service.

**LESBIAN, GAY, BISEXUAL:**

From the evidence available does the **policy, procedure, proposal, strategy or service** affect, or have the potential to affect, lesbian, gay or bisexual groups differently?  
No

**Explain your response:**  
Care and treatment would be the same regardless of sexual orientation. Same sex couples would be involved in their child’s care in the same way as heterosexual couples. All staff receive equality and human rights training as part of the trust statutory/mandatory training.

**RELIGION/BELIEF:**

From the evidence available does the **policy, procedure, proposal, strategy or service** affect, or have the potential to affect, religious belief groups differently?  
No

**Explain your response:**  
All different faith groups will have access to the same level of care which can be adapted at time of fasting. For example if a patient was unable to come to clinic, alternative arrangements would be made and a home visit done if required.

**CARERS:**

From the evidence available does the **policy, procedure, proposal, strategy or service** affect, or have the potential to affect, carers differently?  
No

**Explain your response:**  
Carers will be involved as appropriate and supported to care for their child.
OTHER: EG Pregnant women, people in civil partnerships, human rights issues.
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect any other groups differently?
No

Explain your response:
Paediatric patients who become pregnant will be transferred to the adult diabetes service. The paediatric MDT do not have the expertise to care for them safely and adequately.

4. Safeguarding Assessment - CHILDREN

<table>
<thead>
<tr>
<th>a. Is there a direct or indirect impact upon children?</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>b. If yes please describe the nature and level of the impact (consideration to be given to all children; children in a specific group or area, or individual children. As well as consideration of impact now or in the future; competing / conflicting impact between different groups of children and young people:</td>
<td></td>
</tr>
<tr>
<td>Policy only relates to Children and their families so will directly impact children who have diabetes. Any information given to children/young people should be age appropriate. Staff are aware that home visits are not to be made to CYPD under 16 years of age without a responsible adult present. There is a picture communications book in the ward communications box.</td>
<td></td>
</tr>
<tr>
<td>c. If no please describe why there is considered to be no impact / significant impact on children</td>
<td></td>
</tr>
</tbody>
</table>

5. Relevant consultation

Having identified key groups, how have you consulted with them to find out their views and that the policy, procedure, proposal, strategy or service will affect them in the way that you intend? Have you spoken to staff groups, charities, national organisations etc?

Paediatric Consultants, multi-disciplinary paediatric diabetes team, Senior paediatric nursing staff, dietitians, Adult diabetes physician , Children and families head of service,

6. Date completed: December 2015 Review Date: December 2018

7. Any actions identified:

Have you identified any work which you will need to do in the future to ensure that the document has no adverse impact?

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Date to be Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newly diagnosed paediatric diabetes guideline is required</td>
<td>Carol Metcalfe</td>
<td>March 2016</td>
</tr>
<tr>
<td>High HbA1c guideline for paediatric diabetes is required</td>
<td>Carol Metcalfe</td>
<td>March 2016</td>
</tr>
<tr>
<td>Paediatric diabetes guidelines for sick day management for children with diabetes</td>
<td>Carol Metcalfe</td>
<td>March 2016</td>
</tr>
<tr>
<td>Paediatric diabetes guideline for hypoglycaemia</td>
<td>Carol Metcalfe</td>
<td>March 2016</td>
</tr>
</tbody>
</table>
8. Approval – At this point, you should forward the template to the Trust Equality and Diversity Lead lynbailey@nhs.net

Approved by Trust Equality and Diversity Lead:

Date: 8.2.16