

Children and Young People's West Midlands Diabetes Network Annual Report 2014-2015



This report has been sent to all members of the Children and Young People's West Midlands Diabetes Network, all Chief Executives of member trusts, the National Clinical Lead for Paediatric Diabetes, NHS England, CCG's, Strategic Clinical Network for West Midlands.

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Figure 1: Map of the West Midlands county included in the West Midlands Paediatric Diabetes Network

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Introduction:

It gives me great pleasure to introduce the Annual Report of the West Midlands Children and Young People's Diabetes Network for 2014-15.

The introduction of BPT and the impact of Regional Peer Review continue to impact on positively on Paediatric Diabetes services in the region.

The network has successfully embarked on a number of projects including the schools project, sick day rules project has completed and guidelines ratified, and a work stream on transition will commence in early 2015. Regional BPT Benchmarking data (June 2014) collection is complete and report will be circulated in 2015.

We have had a poster presentation at ISPAD September 2014 on the work of the network and improvements in staffing.

The Network performed well in the National Network peer reviews. In addition 4 Hospital Trusts also elected to take part in the national peer review process.

We have incorporated trainees and primary care into the network. Parent's representatives are members of the steering group and are actively engaged in work at regional and national level and the network coordinators project to support parent representatives in this role received particular commendation in the peer review process.

The network continues to promote research, outlining support and projects that can be accessed via DGH units.

The education events have been well received. Professional discussion groups occur to address challenges faced by clinical teams

Challenges

- To support the trusts with medical cover 24 hours Out Of Hours.
- To look towards addressing the parents' wishes of 24 access to diabetes nursing advice
- To prepare most of the network trusts for national peer review
- Addressing the issues with psychology access commitments

Since the introduction of Best Practice Tariff (BPT) we are starting to see the results of the service improvements made possible by the tariff. In particular, staffing levels have begun to rise, and network meetings have seen the increased presence of dietitians and psychologists allied to diabetes teams.

We are communicating with Clinical Commissioning Groups and have established contacts within the local Strategic Clinical Network and last but not least we have contributed to the national strategy for paediatric diabetes through the national network meetings.

Challenges for the year ahead involve continuing the good work and to bring the network up to the same high standard as other networks across England. We need to ensure we continue the work of supporting and ensuring all units continue to receive BPT and submit data to the NPDA as well as continue with work for the National Peer Review process.

Dr Melanie Kershaw, Consultant Paediatric Endocrinologist and Chair, Children and Young People's with Diabetes West Midlands Network

Background:

The West Midlands Paediatric Diabetes Network was established in 2009.

In 2011 a network coordinator was appointed, funded by NHS Diabetes, and the network became more formalised and membership extended. For the last year there has not been a permanent network coordinator following the discontinuation of NHS Diabetes Funding. The network is now funded by all member trusts and a new permanent coordinator commenced in September 2013.

Since this time the membership of the network has grown and now has a truly multi-disciplinary approach with representation, not only from paediatric diabetes teams across the region, but with parents and carers, commissioners, the voluntary sector, the Strategic Clinical Network and NHS England as members.

The West Midlands network meets 4 times a year, three times as the West Midlands Network and once a year the East and West Midlands join together for a meeting to share practices across the Midlands region. There has been a Network funded network coordinator since September 2013.

The meetings to date have been fully sponsored by industry, however due to industry sponsorship having their budgets tightened the financial agreements for each trust now incorporate meeting costs. Meeting attendance has increased within the last year with each meeting now attracting about 60 participants. The region did have 15 trusts with 21 sites, however Mid-Staffordshire NHS Foundation Trust have amalgamated with University Hospitals of North Staffordshire NHS Trust and have now become the University Hospitals of North Midlands NHS Trust as of November 2014. All of the 14 trusts are fully engaged in the network.

The trusts that are included in the West Midlands are below, along with the name of the lead clinician, and lead nurse or number of PDSN's if no lead nurse. There are nominated representatives for each unit that attend the meetings.

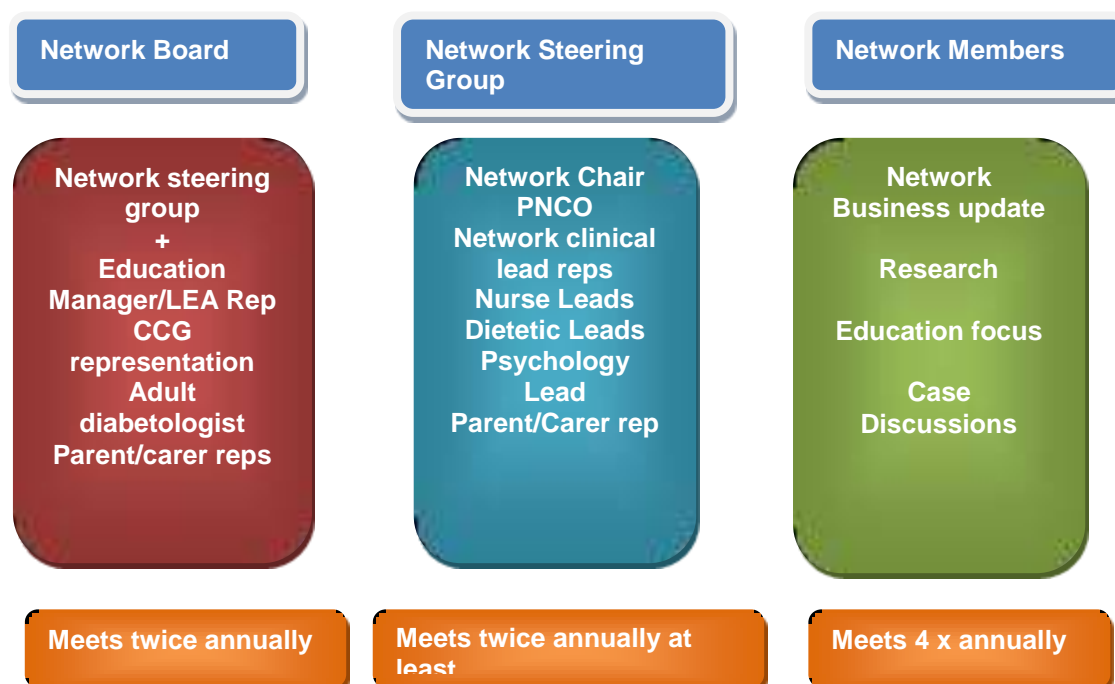
Trust	Lead Clinician	Lead Nurse
Birmingham Children's Hospital NHS Foundation Trust	Dr Melanie Kershaw	Lesley Drummond
Burton Hospitals NHS Foundation Trust	Dr Jacob Samuel	Jane Humphries
Dudley Group of Hospitals NHS Foundation Trust	Dr Anand Mohite	Hayley Weekes
George Eliot Hospital NHS Trust	Dr Radhika Puttha	Christine Brown and Jeanette Diegnan
Heart of England NHS Foundation Trust	Dr Stephen Rose	Paitra Sparkes
Hereford Wye Valley NHS Trust	Dr Shital Malik	Mark Weston
The Royal Wolverhampton Hospitals NHS Trust	Dr Nisha Pargass	Gill Salt
Sandwell and West Birmingham Hospitals NHS Trust	Dr Chizo Agwu	Lizbeth Hudson
Shrewsbury and Telford Hospital NHS Trust	Dr Kathryn McCrea	Amanda Stephenson
South Warwickshire NHS Foundation Trust	Dr Gillian Lyder	Denise Main
Walsall Healthcare NHS Trust	Dr Muhammad Shabab Javed	Deborah McCausland
Worcester Acute Hospitals NHS Trust	Dr John Scanlon	Diane Cluley

University Hospitals Coventry and Warwickshire NHS Trust	Dr Ambika Karthikeyan	Andy Orzechowska
University Hospital of North Staffordshire NHS Trust	Dr Parakkal Raffeeq	Tracy Fallows

Meetings

The network meets every 3 months and combines a business meeting, held first, and an education section. Before the Network Meeting there is either a full Network Board Meeting or a Steering Group Meeting. Below is the structure of the network meetings.

Network structure and meeting schedule



Wider representation

This includes parents and carers, industry representatives and people from the voluntary sector. Industry representatives sponsoring meetings are rotated to ensure that there is no bias in the sponsorship and also to vary the presentations to give clinical members the maximum exposure to industry updates.

Parental involvement and patient satisfaction

Originally we recruited three parent representatives to the network and they commenced this voluntary role in March 2014; one parent representative has subsequently stepped down. The existing parent representatives decided to continue to share the role between the two of them, however this will be reviewed. At present, parent representatives are volunteers. Expenses are paid by the network to attend the regional meetings, whilst for the National Network meetings, parents expenses are covered by Diabetes UK.

The parent representatives for the West Midlands Network have set up a West Midlands Paediatric Diabetes Parents Facebook page. We are pleased to report we have 180 members in this group. Flyers regarding the Facebook group have been displayed by Trusts to promote the group and membership. We also asked all teams to include this group in their

newly diagnosed information booklets. The group is aimed for parents/carers of children with Diabetes to help with networking across the West Midlands and also to help raise any concerns from the various parents/carers across the region. Feedback is collated by the parent representatives and raised with the Chair and Network Coordinator. Parent representatives also use the page to provide parent feedback from the regional and national meetings. The parent representatives who attend the meetings are members of well-established local groups and through these groups feedback to other parents and seek their views on aspects of the network's work. All the parents are also members of the Families with Diabetes National Network.

The network coordinator has also set up a support mechanism for the parent representatives in the form of Skype meetings. The network coordinator and the parent representatives go through the agenda for the Regional Network meetings in advance, and discuss any potential issues, and then support is also given at the time of the network meeting. Parents have an allocated slot on the agenda to provide feedback on their issues or any national developments. After the regional meeting, a further Skype meeting is held to review the minutes to ensure that everything was covered and understood. The parent representatives' then feedback to the parents across the region via social media. Whilst we understand that everybody is not on social media this is the easiest method to communicate with vast numbers of parents and carers across a big geographical area. Ideas are being discussed about how we can engage parents and carers that do not use social media.

We have written a bid for the Quality in Care (QiC) Awards based on the exemplary support mechanisms for user involvement as highlighted in the regional peer review report based on the use of Skype and other digital sources to communicate.

The network also devised a parents/carers survey, promoted in clinics and via social media to ask parents what they wanted to see achieved. This survey closes at the end of May 2015 and the network will use this to support the parent's agenda in the region.

As per the annual report last year there is still a major gap in representation and this is around children and young people with diabetes and their views. This will be addressed by bringing together the children and young people who have diabetes providing the opportunity to ask for their views. Priority has been given to establishing the parents network first and to ensure this is fully working before starting to engage children and young people however work has already taken place with the idea of adding a children's panel to the parents meeting where parents can ask children with diabetes and their siblings questions about what is important to them and we can take this feedback on board and try to incorporate it and feed it back to the network members. The network coordinator will be working on this with the parent representatives in the first instance.

All Trusts have been encouraged to increase their patient and parent involvement and many run successful parents' groups. This has been further supported by the network as information on initiatives such as PREMS linked to the NPDA has been presented and promoted at the network. The PREMS report for 2012/13 was severely delayed due to the volume of responses that the RCPCH received however the report was published in March 2015 along with the latest NPDA 2013/14 report. For the network meeting in June 2015 all the PREMS and NPDA reports for the member trusts will be looked at and action plans devised.

At present there is no representation at the network meetings from education services but working with schools is one possible area of future work. Each unit has been encouraged to engage with their local education authority/s. The network coordinator has identified a

regional representative that is involved in our Diabetes in Schools Network Project and they are invited to our network meetings.

Role of the members and Trusts that make up the network

Each network member needs to send a clinical lead and have a nominated deputy from the core team to attend the network; they either send a representative or nominated deputy with the authority to make decisions. This person needs to be able to make decisions and commit resources such as staff time at the network. This responsibility is outlined in the terms of reference attached as [Appendix 3](#).

Membership

The membership of the network members meeting is made up of representation from each trust as well as the lead people as below:

Role	Name
Chair	Dr Melanie Kershaw
Vice Chair	Dr Swati Karandikar
Network Coordinator	Marie Atkins
Lead PDSN's of network	Paitra Sparkes and Gill Salt
Consultant diabetologist from adult services	Dr Sailesh Sankar
Local Service Specialist, Birmingham, Black Country and Solihull Local Area Team NHS England	Vandna Najaran
Strategic Clinical Commissioning and Senate for West Midlands	Kate Burley
Lead Dietitians	Jennie Brown and Alison Bone
Lead Psychologists	Dr Ashley Reynolds and Dr Julia Twynholm
Parent and carer representatives	Christine Gardner Stephen Paxton
Voluntary sector members	Peter Shorrack (Diabetes UK)

The membership of the Steering Group Members is made up of:

Role	Name
Chair	Dr Melanie Kershaw
Vice Chair	Dr Swati Karandikar
Network Coordinator	Marie Atkins
Consultant	Dr Chizo Agwu
Dietitian	Alison Bone
Dietitian	Jennie Brown
Consultant	Dr Kathryn McCrea
Consultant	Dr Parakkal Raffeeq
Psychologist	Dr Ashley Reynolds
PDSN	Gill Salt
Consultant	Dr John Scanlon
Lead Paediatric and Young Person Diabetes Specialist Nurse	Paitra Sparkes
Consultant	Dr Heather Stirling
Psychologist	Dr Julia Twynholm
Parent/Carer Reps	Christine Gardner
Parent/Carer Reps	Steve Paxton

West Midlands Paediatric Diabetes Meeting Attendance 2014-2015						
	Mar-14	Jun-14	Oct-14	Dec-14	Mar-15	Average
Birmingham Children's Hospital NHS Foundation Trust	Y	Y	Y	Y	Y	
Burton Hospitals NHS Foundation Trust	Y	Y	Y	Y	Y	
Dudley Group of Hospitals NHS Foundation Trust	Y	Y	Y	Y	Y	
George Eliot Hospital NHS Trust	Y	Y	Y	Y	Y	
Heart of England NHS Foundation Trust	Y	Y	Y	Y	Y	
Hereford Wye Valley NHS Trust	Y	Y	Y	N	Y	
Mid-Staffordshire NHS Foundation Trust	Y	Y	Y	Y	Y	
The Royal Wolverhampton Hospitals NHS Trust	Y	Y	Y	Y	Y	
Sandwell and West Birmingham Hospitals NHS Trust	Y	Y	Y	Y	Y	
Shrewsbury and Telford Hospital NHS Trust	Y	Y	Y	Y	Y	
South Warwickshire NHS Foundation Trust	Y	Y	Y	Y	Y	
Walsall Healthcare NHS Trust	N	Y	Y	Y	Y	
Worcester Acute Hospitals NHS Trust	Y	Y	Y	Y	Y	
University Hospitals Coventry and Warwickshire NHS Trust	Y	Y	Y	Y	Y	
University Hospital of North Staffordshire NHS Trust	Y	Y	Y	Y	Y	
Number of Yes	12	15	15	14	15	14.2
Total	15	15	15	14	14	15
%	80%	100%	100%	100%	100%	95%

Commissioners

As a network we are still establishing commissioning links whilst the CCG's are undergoing restructuring. The Maternity and Children's Network Manager for the West Midlands has been really supportive of the network.

Business/Service managers

Business/Service managers attend the meetings and are on the mailing list for the monthly newsletter. At the joint East and West Midlands Network meeting in December 2014, all business/service managers were invited to attend and plans are to include them and have a dedicated slot for issues they have at each joint meeting annually.

Who is involved?

Chair

The Chair works with the network coordinator to set the agenda for each meeting and then to chair the network meeting itself and follow up relevant actions from it. The Chair works to the job description shown in [Appendix 1](#) and has a key role in providing clinical authority to the meeting and supporting the network coordinator. The network coordinator now reports to the Chair in the new structure put in place from April 2013.

Vice Chair

In March 2015 we also appointed a vice chair to help in the role of developing the network. The vice chair will deputise for the chair as necessary and will start to work closely on network projects in the coming year.

Network Coordinator

The network coordinator (CYPNCo) carries out the majority of the day to day work of the network. Alongside the chair they set the agenda and meeting dates. They also coordinate the meetings and chair the work of the task and finish groups which come from the agreed work programme. They also fulfil the secretarial role of the network including booking venues and ensuring attendance, sharing agendas and writing and sharing the minutes. This role is a joint network coordinator role with the East Midlands network.

The network coordinator acts as the central point of communication for all network related information. This includes answering specific queries, especially from team members and also being the point of contact for industry, voluntary sector and parents and carers. Finally, they are responsible for creating many of the key documents for the network such as locally agreed service specifications and also draft policies and other documents that teams can then adapt and use locally.

Feedback from the network

In order to ensure the work of the network reflects the views of its members the network coordinator conducted a survey in December 2014 for the West Midlands network requesting views on the network and what can be achieved better in the future with this. Network members highlighted that the network PNCO ensures:

- More readily accessed sharing of information amongst sites. Better networking with colleagues at other sites.
- Regular communications about network issues.
- Updates on guidelines and policies
- Support for trusts
- Greater understanding of how out network works.
- A sense of involvement in the decisions that are made.

- Excellent support for preparation for the national diabetes peer review.
- A clear contact for support/advice and coordination.
- Opportunity for parents to be heard, a bridge between parents and medical professionals.
- Maintenance of up to date practice, sharing of experiences and problems.
- Organisation of the regional network as a whole.
- Newsletter.

We also asked what they would like the network to achieve over the next five years, the answers were:

- Network guidelines for trusts – in the past year, these have been agreed for:
 - Care of children and young people newly diagnosed with diabetes; ACDC Guideline
 - Care of children and young people with diabetes undergoing surgery; ACDC Guideline
 - Care of children and young people with diabetic keto-acidosis (DKA); BSPED Guideline
 - Care of children and young people with hypoglycaemia; ACDC Guideline
 - Optimising glycaemic control; Specifically written for the CYPWMDN Guideline
 - Care of children and young people with an HbA1c greater than 75mmol/mol (9%); Specifically written for the CYPWMDN Guideline
- Sick day rules. Specifically written for the CYPWMDN Guideline
- Reduce % of high HbA1c's
- Increase % of patients within target HbA1c
- Higher recruitment to clinical trials
- Nurse/dietitian exchanges – go and shadow a clinic/education session in another hospital to share ideas.
- Formalised network wide structured education programme
- Maintain a sense of support between units, not rivalry or jealousy, continue to be caring and sharing towards each other.
- All units to deliver an excellent quality of care with good outcomes for the patients.
- Aim to have all units meeting the same HbA1c standards.
- Better links with adult services through CCG clinical networks.

We aim to incorporate these suggestions from the network in future work streams. One of the other suggestions was that people were keen to have a sharing event and this will hopefully be planned over the coming year.

Past and present funding

The permanent network coordinator started in September 2013 and is hosted by Birmingham Children's Hospital. Sponsorship from industry is becoming more of an issue for our network meetings. For the financial year 2015/16 the costs of the network meetings will also be allocated to the financial agreement and shared equally across all trusts. The network coordinator will carry on trying to source funding for the network meetings. The details of the MOU and payment required from each Trust are shown in [Appendix 2](#).

Regional and National links

Communication

Because of the size of the region the main communication methods are not face to face apart from at meetings and sub-group (task and finish) meetings. Good use of phone calls, teleconference, and emails is made for sharing information and answering specific

questions. Each month, a newsletter is sent to all members of the network plus other interested parties.

The main achievement of the national network over 2014/15 has been to establish a new national website. The network coordinator was a project lead for the website. The website contains information for healthcare professionals/families and other stakeholders, national information about guidelines, news, events and education for Healthcare Professionals (There are also regional network pages that are specific to that region containing all the documents/meetings/resources etc. This is a huge achievement for the national network as all documents/resources/information is now in one place enabling access to documents 24/7. Nationally, the CYPNCo's and the Chairs of all regional meetings continue to meet together to discuss the National Agenda for improving Paediatric Diabetes Care.

The West and East Midlands regional networks meet annually with a joint education meeting. Links to other regional groups such as the developing Strategic Clinical Networks have also been made. The West Midlands Paediatric Diabetes Network also has links with the Medicines for Children Research Network (MCRN) and Diabetes Research Network (DRN).

Improving outcomes of care

The focus of all the work of the network is to improve the quality of care for children and young people with diabetes. This has been achieved in many ways including:

- Ensuring that all Trusts are working to ISPAD/BSPED/ACDC policies and guidelines with the introduction of network agreed guidelines for 2014 in relation to the recent network Peer Review visit.
- Ensuring Trusts are updated on new cutting edge practice including research and technology.
- Supporting units to share their good practice.
- Supporting units and clinicians to share concerns about challenging cases.
- Bringing in nationally recognised speakers for network meetings.
- Updating on national research and advances in knowledge.
- Ensuring investment in Trust's through the achievement of Best Practice Tariff.

Best practice tariff

Achievement so far

All Trusts are fully aware of the requirements of Best Practice Tariff (BPT) for paediatric diabetes and the standards within it. Within the network the position of individual Trusts is monitored regularly with respect to BPT achievement to date. This progress was reported on in the benchmarking report that was circulated to all trusts in March 2015. When the Benchmarking survey was started in March 2013 there were only 50% of the trusts receiving payment for the BPT and only 27% were achieving the BPT standards, By June 2014 this had risen to 13 out of the 15 trusts achieving the standards and being paid for BPT. The remaining two units have subsequently achieved getting BPT.

Support offered

All Trusts have been offered significant support from the network in relation to BPT. This has been within network meetings and also advice on a Trust by Trust basis with support from the network chair. The network coordinator is also establishing relationships with business/service managers to continue this support in order to meet the standards both now and in the future.

Data and Information

Data and Information has been used effectively by the network on many levels. Each unit submitted to the NPDA for the last 5 years. Although there have been problems with the speed of feedback from the RCPCH in terms of returning data to units the topic has been kept high on the network's agenda. The network will be concentrating more on the action plans of each unit following the publication of the NDPA report. The PREMS audit was a particular concern in terms of delay as the report of the 2013/14 PREMs which only became available in March 2015. The findings of this report are due to be discussed in the June 2015 meeting. The network coordinators nationally are also working with the RCPCH who have a new project team in place to ensure that future submissions for both the NPDA and PREMs are of a high standard and will be working more closely together to support units in regions that are struggling. The RCPCH has retracted their analysis of the NPDA data for the period of 2013/14 and it is currently being looked at again to improve accuracy of results. Therefore we are unable to provide accurate data and charts until this has been rectified.

Data from the Regional Peer review has been utilised to provide further support to units and data from the West Midlands Network benchmarking exercises for BPT has also given the whole Network an up to date picture of progress in Trusts to improve Diabetes care. This enables team to compare their progress with other units and together with the Regional Peer Review is a tool to engage service managers.

While there is still a long way to go, the Patient Reported Experience Measures have shown that users on the whole approve of what we do and the way we do it, and have given us valuable further guidance on the improvements we could make.

Data collection and Database systems

Ensuring that MDTs are supported to collect relevant patient data has been a key piece of work for the network. Several units have shared updates on the database systems that they use. For some Trusts this has been their own bespoke model and for others it has been one that is nationally available such as Twinkle or Diamond. All Trusts have been successful at submission of the NPDA since 2011.

Audit analysis

Audits have been initiated locally. Some local audits have historically been presented at the network meetings and as have the results of the BPT Benchmarking exercise. A regional of complications of management of DKA is currently being completed. Several centres have presented the results of their audits at national meetings such as BSPED.

Education and Research

Education and research forms part of the agenda for each Network meeting (e.g. four days per year). People have presented interesting case studies and pieces of research that they are involved in. In the past due to there not being a network coordinator in post the education part of the agenda was not as effective as it could have been. Since the network coordinator has been in post, she has implemented an education schedule for the network, where each trust takes it in turns to be in charge of providing the education. The network coordinator helps with the logistics of the meeting, but it is up to the individual trust to source topics and speakers to deliver this session. This has been in place since March 2015 and has been working very well, with varied topics for each meeting. The focus of the joint East and West meeting each year in December is education and this is delivered usually over a three hour period.

Support for new research has been facilitated through the network via sharing of information and reports on research outcomes. It is also a standard item on our agenda meetings so new projects and updates on existing projects are supplied at each network meeting. However one of the aims of the network is to be involved in more research and to support units in achieving this.

The network aims to provide opportunities for all members of the MDT to be updated locally on best practice and cutting edge research and also for people to share their own good work. Other courses and education events, including those run by academic institutions and industry, have been advertised and promoted through the network both via the meetings and also the monthly newsletter, and more recently via the national website that has a whole section dedicated to education for healthcare professionals.

The Regional register

The network, whilst keen to have a regional register, has deliberated how this should be funded. Discussions have been held with Newcastle following a presentation at the regional network meeting in March 2014. The issue of funding remains a sticking point with member trusts and resolution doesn't appear to be imminent. The chair is seeking to identify national support in driving this forward locally through BPT criteria.

Service development

Work programme

The work programme developed by the steering group has provided a focus for the network and is used for two main purposes:

- To inform and shape the agendas for the network meetings.
- To prioritise the work through task and finish groups.

Network projects

24 hour medical care

One of the key challenges is in provision of Diabetes advice to fellow consultants on call out of hours. There have been a number of discussions at the network business meeting regarding this, and this was highlighted by trusts in the self-assessment exercise. A Network workshop to address this issue in BPT was held in the March 2014 Network meeting. Discussions ensued for the rest of 2014, and we are now having meetings with service managers to discuss twenty four hour advice for clinicians, having liaised with Warwickshire Haematology network, who have a 24 hour out of hours on call established. Work is on-going regarding the logistics to providing this service as an opt-in service for the trusts across the West Midlands region.

24 hour direct patient advice

Twenty four hour advice to patients varies across the Region in terms of who provides the service. Many services the direct advice to patients is via the middle grade on call via the wards. There are guidelines, and training in place in units adopting this strategy to ensure that appropriate advice is given. Recently at the National Diabetes Network meeting in December 2014, the Families with Diabetes National Network (FWDNN) gave a presentation on the out of hour's services and what parents nationally want. This was also presented at the West Midlands Network meeting in March so all members could hear about this. Work is continuing with finding out more information about what parents actually want and need from the service. The network coordinator is working with the parent representatives to gain views

from parents and carers across the region to see how to progress further with this. Once the views have been sought then progress can be made.

Psychology

All trusts have seen an improvement in the levels of psychology support within their teams. We as a network will be looking at how to help trusts achieve the standard required to ensure payment of BPT. Need to highlight the remaining challenges – they require trusts to find solutions together, or internally linking up with other services requiring psychology input and the shortage of trained psychologists- think that is what came out of the workshop

Schools project

We have set up a schools working group, which have developed resources to run diabetes awareness study days for school staff across the West Midlands region. We held the first study day in January 2015 where over 50 schools and 86 representatives from across the region. There is another study day in June and July 2015 and plans to run another one in September 2015. These events have been run by PDSN's and dietitian's from across the network and have been very successful in giving basic awareness of diabetes to school staff. Based on this work, we have also submitted a bid to the QiC awards, and written abstracts for BSPED and IDF. We aim to roll this programme out to other networks and hopefully set up a national rolling programme over 2015. This means that any member of a school would be able to attend any event in the country at a date suitable to them.

Benchmarking report

As part of the Benchmarking process completed by all trusts in the West Midlands in May 2013 and which was repeated in June 2014, all trusts were asked to identify what they would like to see the Network achieve over the next five years. The following objectives were suggested:

- All member units achieving BPT.
- Network owned shared common management guidelines across the region
- Network owned standardised policies across the region
- Shared patient information, education programs and materials across region
- Regional /shared out of hours advice service.
- Region wide audit and audit database.
- Coordinated action from recommendations that come out of the Peer Review.
- Paediatric Diabetes Register/database
- More work with commissioners and administrators in units,
- Projects such as school and transition
- Commissioners to understand paediatric diabetes requirements and payments of best practice tariff,
- Health needs assessment within the network.
- Equity of support for each diabetes unit, e.g. support in compiling business cases, direct interaction/negotiation with senior management if BPT not achieved.
- Published data on achievement of BPT from each unit
- Improvement of median HbA1c in all units

A lot of the above objectives have been met, we now have shared network approved guidelines, we are sharing resources and materials and education programmes across the region, this has been aided by the introduction of the new national website. We have begun work on looking at regional out of hour's advice services for both clinicians and parents and carers. We have coordinated the national peer review programme and received very encouraging reports for both the networks and individual trusts. We have developed a

schools working group and developed resources for a diabetes awareness day. We have set up a working group to look at transition.

Transition care

The network has had transition care as an area of focus over the last few years. There are national plans to develop transition care and as a network we are awaiting to see the work done nationally to then incorporate it into the network. However in the meantime we have set up a transition working group to look at transition regionally and to see what areas we can help units with. We are also planning to run a transition study day for all paediatric MDT's, Adult MDT's and trainees across the West Midlands region, this is planned for February 2016 and will consist of lectures and workshops from renowned speakers nationally for transition

Peer Review

We have successfully supported four trusts in the region with the national peer review programme. We have been monitoring these reports and action plans and have also worked with individual trusts on how best to address the concerns highlighted in the report. We are pleased to announce that all of the serious concerns and the majority of the concerns for all trusts have been rectified. The network is supporting those trusts with outstanding issues. We also partook in the regional peer review programme for the network; this was the first time the network has been involved with the network review. The report was very encouraging and the network achieved 83% in their compliance with measures, this is fantastic and matches half of the other networks nationally to this achievement. We have written a report based on the findings of the network peer review report and included the findings from all trusts within the region and their achievements made since this. This report was circulated to all member trusts, chief executives of member trusts, the national clinical lead for paediatric diabetes and other relevant stakeholders.

We were commended on the following things as areas of good practice.

- Clear inclusive and strategic leadership from the lead clinician and network coordinator.
- Regular network meetings with good engagement and attendance from all localities.
- Network meetings include business, education and research as standing items.
- Best practice tariff has been achieved across the majority of the Network.
- Exemplary support mechanisms for user involvement.
- 100% of localities have returned action plans to the Network in relation to the NPDA.
- Coordination of the national networks website.

We have set up a DKA audit to look at the management of complications with DKA and we hope to present this audit later in 2015.

Plans for the future

There are plans to discuss the network work programme during 2015 and to bring more ideas about what people wish to work on as a network over the coming years. This will focus the network on its aims and objectives and by ensuring that we work more effectively with the national network and other regional networks we can reduce the amount of duplication of work and resources that we currently encompass. There are plans to improve the national network structure and ensure that work is evenly divided across regional networks, this will increase the focus of all regional networks.

We continue to streamline processes, by the effective use of Task and Finish groups that have been established which has been proven to show this to be an effective mechanism for producing good outputs. These groups are chaired by the Network coordinator and will be made up of a small number of volunteers including parent and carer representation. Using the support of the network coordinator, outputs and outcomes will be achievable without the need for huge inputs of clinical time. The use of technology such as sharing draft documents by email and also teleconference facilities to discuss issues, will allow the work to move forward apace whilst still ensuring full engagement from clinicians.

Role of the units

What they have achieved

Each unit has worked hard to put into place what is needed to achieve BPT. The amount of input that this has required has varied significantly from some areas that required no input as they were already achieving this standard of care, to others who have seen their paediatric diabetes team's resources significantly increase.

What they are planning

The teams have all developed their local work programmes for the year 2014/15 and beyond and all are working to these work programmes. The network is also offering support for units to achieve this. We also monitor these action plans via the trusts submission of their annual reports as well as submission to the NPDA and PREMs. Much of this work is aimed at increasing the skill and education of the teams and also looking at how teams further support patients and their parents and carers to get better control of their diabetes.

Guidelines

Primary

Currently there are no network primary care guidelines however we have successfully recruited a primary care representative since last year. We are looking at the various primary care referral guidelines that have been developed by other networks and hope to have this completed by June 2015.

Secondary

The use of BSPED/ISPAD and ACDC guidelines for local adaptation has been agreed within the network meetings, we now have network approved guidelines for the network and these are based on either national/international guidelines or bespoke ones written by the network for the region.

Patient numbers for each trust

Below is a breakdown of patients per trust and shows how many new diagnoses there were and the numbers of patients on pump therapy. Mid-Staffordshire has been shown separately from North Staffordshire due to the merger only occurring in November 2014

Trust	Patient numbers	No of new patients	No of patients transferred/left service	No of patients on MDI/other regimens	No of patients on pumps
Birmingham Children's	354	33	45	269	85
Burton	136	16	13	122	14
Dudley	150	21	13	120	30
George Eliot	106	6	12	91	15

Heart of England	480			372	108
Hereford Wye Valley	61	6	4	23	38
Mid-Staffordshire	112	4	32	80	32
The Royal Wolverhampton	208	26	8	110	90
Sandwell and West Birmingham	185	33	16	152	52
Shrewsbury and Telford	259	31	30	191	68
South Warwickshire	90	6		42	47
Walsall Healthcare	127	10	2	74	51
Worcestershire Acute	285	23		186	103
University Hospitals Coventry and Warwickshire	200	28	30	150	50
University Hospital of North Midlands	208	32	36	167	41

Key Achievements for each member trust of the network

Birmingham Children's Hospital

- **Best Practice Tariff funding** - This has continued since first awarded to the Trust in October 2012, and staffing improvements have facilitated meeting the requirements for this tariff.
- **West Midlands Regional Peer Review** - The update on progress of the work plan following Regional Peer review with the West Midlands Quality Review service and the West Midland Regional Paediatric Diabetes Network in January 2013 was provided to WMPDN in 2014. Areas highlighted as further considerations were reviewed and progress is listed below
 - Clinic space is sufficient for three monthly MDT reviews for all children, allowing for DNA's and rescheduling.
 - Progress has been made on downloading meters and pumps in clinic though there remain issues to be resolved with Diasend due to poor wireless signal in the clinical research facility where clinics are held.
 - Home downloading of meters is discussed in the new patient education programme and is also taught and embedded in pump school
 - Diabetes specialist nurses are expected to each deliver one day per year each to cover wards during winter pressures, and when unable have been trained to support the delivery of flu jabs to Trust staff
 - The web based Twinkle system uses a standard formatting, which is transferred to Winscribe, introduced in the trust for clinical letters from June 2014.
 - Ward Link Nurse group initiated although in medical areas only with on-going work towards gaining evidence to be initiated Trust wide

- Retinal screening status is routinely checked at annual review and double-checked on the regional retinal screening database, if necessary, patients reminded and arrangements for another appointment made, at Birmingham Children's Hospital if necessary.
- There has been a reduction in the number of home visits, and more contacts are made on the diabetes unit now that more space for patient reviews is available. There is clear focus, of both the new patient and continuing education programmes, on self-management.
- TWINKLE' has been replaced with the web-based HICOM service. All members of Diabetes unit staff have access to this system. Doctors began to use the system from April 2014 onwards, and the nursing dietetic, social worker youth and family support worker from November 2014. There are plans for psychology to use the system in 2015.
- **National Peer Review 18th September 2014** - This was a highly successful national peer review. The measures were separated into Hospital measures and MDT (multi-disciplinary team) measures. The trust achieved 85% of Trust wide measures and > 95% on MDT measures. Regarding Trust measures 30 of 124 (24%) Trusts with published reports at the time of writing had met more than 80% of Trust measures. Only 6 of the 124 of published services undergoing the national peer review for paediatric diabetes (4.8%) met more than 90% of the MDT measures. The trust were commended on:
 - Leadership of the Lead Consultant and Lead Nurse
 - The high standard of Patient information
 - The PEDSQL Psychology assessment tool is routinely embedded in annual screening.
 - The continuity of care in keyworker postcode allocation.
 - The robust and sustainable arrangements around PDSN 24hr on call.
 - The focus on patient education with intensive start up and on-going review and rapid response.
 - Continuity with insulin pump therapy even during hospital admissions.
 - That all patients are considered for the eligibility of entry into clinical trials.
 - Retinopathy assessment feedback being regularly incorporated into the patient case notes
- Areas for the Trust and MDT to address are:
 - Record keeping of training of ward staff outside the MDT, and to consider incorporation of the safe use of insulin module into trust wide nursing and medical training.
 - To review the psychology input to the Diabetes service as concerns were raised that children and young people can be seen by a range of BCH psychologists rather than the two dedicated diabetes psychologists
- **Structured Education** - The DHCU age banded Structured Education programme "Diabetes You and Me; Live Life to the Max" programme completed its first year in September 2014, and continues to offer parallel but separate age banded education sessions for CYP and parents/ carers after school on Wednesday afternoons. Whole day age appropriate sessions were also offered to parents of under 7's, parents of the over 7's, and parents of adolescents in 2014. During the school holidays 3 age banded education and fun days were offered to children (to allow for any families who found attending the after school sessions difficult). These sessions were also poorly attended, despite written invites and flyers. We anticipate that as these sessions are new, and children and families have not been used to attending for regular education updates this has an impact on the attendance. As the new patients are now used to getting a comprehensive education programme we anticipate they will engage more readily with education in subsequent years. We are also exploring

strategies of linking education sessions for the adolescents to other group social activities such as "bowling evening" or "pizza night"

- The New Patient education package, launched in October 2014 together with the New Patient Guideline has been generally well attended and received.
- Changing schools study days for children moving from year 6 (junior school) to year 7 (High school) were updated, well attended and again received excellent feedback.
- Successful Easter and Christmas parties were held for pre-schoolers including educational diabetes related games.
- **Insulin Pump therapy** - The insulin pump pathway was developed and implemented to facilitate CYP and families making informed choices for pump therapy and to facilitate the team in their assessment of CYP and carers competencies to enable them to benefit from this intensive treatment. DHCU continues to advocate patient choice and offers the 4 available insulin pumps. Pump school was introduced in June 2013 for patients selecting treatment with the Medtronic insulin pump. This enables group starts and ensures the team can utilise resources efficiently. Following success of the Medtronic pump school a pump school programme was developed with Roche. This also involves school staff attending a session at the end of the first week of pump school. To date attendance by school staff has been 100%.
- By the end of 2014 there were 85 children in the service on insulin pumps (25.2%). Eighteen CYP commenced CSII during 2014 at pump school and a further 6 children outside of pump school (1 as part of the SCIP trial, 2 children with CF and 3 newly diagnosed).
- A total of seven pump schools ran in 2014. Pump schools for Animas and Omnipod ran for the first time (two Medtronic schools, two accu-check, two Omnipod and one animas) for 2015 the focus will be on training more junior nurse in the team to facilitate delivery of pump school.
- There are eight planned pump schools (type to be held dependent on CYP demand) for 2015.
- **Other Achievements**
 - Our dedicated Diabetes social worker continues to enable families' social issues to be addressed parallel to education about Diabetes and meeting their nursing and medical needs. There has been increasing numbers of families where working agreements to progress and supervise care has been of benefit.
 - The family support worker has attended triple P training to enable teaching of the strategies to parents of children under our care.
 - DHC activity camp was successfully awarded charitable funding awarded in January to subsidise costs to families. The Camp ran from the 26-28th July 2013 and was attended by 35 CYP.
 - Continuation of Girls group run by Youth worker, plans to start up a boys group
 - Completion of transition pathway, led by Dr Ruth Krone and introduction of accompanying documentation of the transition process using "ready, set, go" in line with Trust policy
 - Introduction of CGMS trial for young children on Medtronic pumps with severe or recurrent hypoglycaemia, with hypo unawareness. A business case is in progress for CGMS funding (Dr Krone)
 - Development of pump study day for those whose pump start pre dated pump school.
 - The department working collaboratively with Dr Parelukkar in ophthalmology is now able to offer retinal screening to those under 12 years who meet the ISPAD criteria for retinal screening, whose needs are not met by the national screening programme.

- Developing a structured approach to combined diet and nursing annual reviews offering home visits in defined postcode areas on specific dates to reduce staff travelling time between appointments and offering appointments on the unit to those unavailable for the home visits. This is aimed at improving attendance at the nurse and diet annual reviews by reducing the total number of separate appointments for families.
- Staff Nominations 2014 – DHC Team in Unsung heroes Category and DHC administrator Star of the Month, twice.

Burton Hospitals

- **Psychology Service** - After being able to demonstrate that the initial Psychology input was insufficient for the caseloads needs; additional hours were obtained enabling an increase in Psychologist sessions from 1 a week to 4 a week. This has allowed the Psychologist to be able to get to see more of the CYP and also be able to give more time to those requiring on-going care.
- **Research projects: National Research Projects.** The Team are continuing to recruit to the ADDRESS 2 Study, Detemir Study and JUMP and have met or exceeded our recruitment numbers for these.
 - ADDRESS 2 Study - 16 new patients (Paeds & adults)
 - Detemir Study - 1 patient
 - Jump Study - 4 patients

It has been acknowledged that Queen's hospital has recruited the maximum numbers in West Midlands for the ADDRESS 2 study.

- **In House Research Projects** - The Team are undertaking an in-house research study - '**Cook & Count**'. This project is looking at whether practical cooking sessions involving counting carbohydrates of the recipes will improve blood glucose control and subsequent HbA1c's. This project was fully approved by the Trusts Ethics Committee and was funded via DMEG (Diabetes Management Education Group) a Diabetes specialist sub group of the British Dietetic Association. The results will be included in next year's annual report.
- **Annual Review Clinics** - The Annual Review Clinics have been further developed and are now more structured and include an educational review. A Dietetic annual review has also been introduced and as part of the annual review all CYP have an assessment of their wellbeing undertaken by using the PIED and HAD's questionnaires (psychology screening questionnaires) at the Annual Review Clinic
- **Enhanced Links with our Commissioners** - Dr J Crosse, a local GP with an interest in Paediatric Diabetes Care was nominated by the CCG to represent them at the Teams monthly MDT's and also at the 3 monthly Locality Meeting which includes colleagues from the Adult Diabetes Service.
- **PREM Survey 2013/14** - Queens Hospital Paediatric Diabetes Team achieved above average in comparison to the West Midlands and England and Wales for positive feedback on our services in the PREM survey. The Team continually work towards improvement in all areas.
- **Reductions in high HbA1c's** - The Team continues to work hard within the Trust Guidelines for 'Managing High HbA1c.' and is focussing on achieving more HbA1c's in the acceptable range of < 7%. This current year's data looks promising but is not fully accessible as yet.
 - NPDA data from 2013/2014 showed improvements throughout HbA1c Levels here at Queens:-

- **Mean of 70mmol/mol (8.6%)**
- **15.4% have an HbA1c of < 58 mmol/mol (7.5%)**
- **19% with an HbA1C of > 80 mmol/mol (9.5%).**

- **Patients Hand Held Records** - The team is in the process of rolling out the new 'Handheld Patient Records'. All newly diagnosed patients are receiving theirs at diagnosis and established patients are swapping over at their next clinic appointments.
- **Ward Staff Training** - Staff study days are held once every 3 months – this day is for senior students as well as all grades of ward staff. It has both Nurse and Dietician input and covers all devices, (pens/meters/pumps), insulin's, DKA and nursing care and carbohydrate counting etc. Once the Study Day has been completed all attendees are required to undertake and return a written competency within a month of the study day.
- **Best Practice Tariff (BPT)** - The Team are proud to say that BPT was achieved in 2013/14 and they have continued to achieve this by meeting the necessary criteria and standards set in the Best Practice Tariff.
- **Patients Structured Education**
 - Structured education continues to be offered from the Team to the CYP and their parents/carers from diagnosis throughout transition to the Adult Service by the nurses and dietician in both separate and joint sessions.
 - Due to losing PDLN on maternity leave last year the Young BERTIE course and development of the younger BERTIE course were affected.
 - Along with the above education/training is also provided to staff in Nurseries/Playgroups, Schools/Colleges, Clubs and associations and hospital based staff.
- **HbA1c Tests** - The Team now have 2 Portable HbA1c machines within the Trust, one based in the Paediatric outpatient department and one within the transitional/adult clinic in the Diabetes Centre.
- **Burton & District Children and Families Support Group** - The Team continues to promote the successful and active Family Support Group, they assist them with the events it holds each year. Last year the group held numerous events, both social and educational, including;
 - 'Meet the Team' social events
 - Educational sessions re specific issues related to diabetes care
 - Coffee Evenings
 - Fund raising Events, raffles and tombola's
 - A day out at Whitemore Lakes Activity Centre
 - The Christmas Party
 - A day trip to Blackpool
 - The annual (very successful!) trip to the Pantomime.
- **TWINKLE Database** - The Team now use the new Twinkle.net database and extract the data for NPDA and are extending their skills to be able to extract helpful and supportive data for BPT.
- **Trust Diabetes Guidelines** - All the Paediatric diabetes guidelines are reviewed and updated every 3 years as per Trust policy. The Dietetic Department have produced a new Guideline for the 'Newly diagnosed child/young person and family with Type 1 Diabetes'.
- **Ward Education** - The Team have developed a tool kit for 'Caring for the child/young person with Diabetes'. This is located in a specific 'Diabetes Drawer' on the Paediatric ward and provides staff with access to all written information on the care required by a 'Newly Diagnosed Patient' along with the necessary devices/equipment

i.e. - Insulin pens, meters, pen needles and a sharp's boxes etc. It also contains all staff education material as a reference.

- **Job Plans** - The Job Plan for the Paediatric Consultant for the current year has been submitted for final approval.
- **Social Care** -There are strong links with Social Care through the Trusts Safeguarding Lead. There is a robust DNA policy which includes referral to Social Care after persistent DNA's.
- **Podiatry** - The Team has access to the adult podiatry service within the hospital as required.
- **Patient Information leaflets** - All patient Information Leaflets are on the Trusts Intranet and are updated as per Trust Policy.
- **Reduction in DKA admissions** - There were several DKA admissions over the year 2013/2014 and on analysis it is fully expected that the 2014/2015 data when published will show a marked reduction in DKA admissions.
- **Appointment Lengths** - All Clinic appointments have now been changed to a 30 minute slots as per Peer Review target.

Dudley Group

- Achieved Best Practise Tariff for financial year 2014 -15
- Took part in National Peer review with overall good report and no immediate concerns reported.
- We have introduced further structured education including:
 - ❖ A Secondary School Starter Events
 - ❖ Doctors teaching
 - ❖ Ward training.
 - ❖ Group Carbohydrate counting education
 - ❖ Group insulin pump education from novice to advanced.
- The team have also revised the structured education list at diagnosis, introduced carbohydrate counting menus on the wards and education in relation to this, including a ward information package which can be found on all paediatric nursing stations containing all up to date guidelines, protocols and paperwork.
- Devised a structured curriculum for pump school.
- Secured funding for a new point of care HbA1c testing machine, which is operational from May 2014.
- The team have 4 MDT meetings per year to discuss patients.
- Developed a safe guarding multidisciplinary meeting 6 monthly whereby all children who have a Common Assessment Framework (CAF) in place, are on a child in need plan, child protection plan or are a looked after child are discussed in the presence of the lead Doctor/Nurse for the trust for Safeguarding, the Paediatric Matron, and Safeguarding Lead for the Trust (Deputy director of nursing). Discussions at these meetings are recorded and minutes and any actions necessary are produced.
- We offer group carbohydrate counting education sessions to all patients, parents/carers affected by diabetes.
- The team is now able to offer more than one type of insulin pump enabling patients to have a choice as deemed necessary by peer review requirements.
- Offer diagnostic CGMS when deemed necessary.
- Now offer joint Nurse and Dietetic Led Clinics twice a month.
- Input data onto TWINKLE database.
- Full dataset submission to the NPDA for 2013/14.
- Full participation in Patient and Parent Reported Experience Measure survey for the service

- Involved in research projects ADDRESS 2, TRIAL NET & JUMP and inform all patients of this.
- All relevant guidelines in place: New DNA policy for Paediatrics, Diabetic Emergency Management of Children and Young People with Diabetes (not in DKA), Diabetes Management for a newly diagnosed child and have updated the guidelines for the management of paediatric patients in diabetic ketoacidosis.
- Ward information folder has been developed containing guidelines, carbohydrate counted ward menus, correction charts, medication to take home checklist, contact numbers and names of the diabetes team.
- Revised our school pack information and now have a list of training packages for schools that include blood glucose testing, ketones testing, and insulin administration for school personnel.
- Reductions in clinic average HbA1c's- Data Taken from NPDA 2012-13 mean HbA1c was 72 mmol/mol and most recent data received for 2013-14 NPDA shows mean HbA1c is now 69mmol/mol.
- Involvement in the NHS Choices Survey and give patients the NHS Choices cards.
- Patient diagnosis leaflets have been revised and offered in different formats; also these leaflets have been adopted by another NHS Trust.
- Started to deliver ward staff training and working towards making paediatric diabetes part of the mandatory induction programme for all Paediatric staff.
- Organised a primary to secondary school transition day that was very well attended.
- In line with BPT and to improve the quality of service received by newly diagnosed patients, an on-call rota is now in place. The on-call rota enables expert advice to be given to health care professionals within 24 hours of a child or young person being newly diagnosed with Type 1 diabetes.

George Eliot

- Recruitment of the third PDSN
- Twinkle database
- Meeting BPT
- Minor Reduction in HbA1C

Heart of England

- Working towards BPT.
- National Peer Review
- Provision of a complex service over 5 hospital sites
- Continued development of a structured education programme for newly diagnosed children as well as structured group education for school transition from Primary to Secondary schools.
- Providing 6 structured Group Education sessions as part of our Insulin Pump Academy
- Introduced and approved psychological questionnaire at Annual Review and an increase in access to psychology services.
- Recruitment of Administrative support for the team. Sharron Atkins joined in August 2015.
- Several fun activities held, Christmas parties, picnic in Hatton Park, Tobogganing and adrenalin tubing event held across the Trust and Activity camps.
- Carbohydrate counting sessions held in Supermarkets, accessible to all patients from all 5 hospital sites.
- Introduction of quarterly newsletters to all children and young people with both Type 1 and Type 2 diabetes.

- There have been an increased number of children commencing insulin pump therapy: 30% across the Trust.
- Across the Trust 4 different insulin pumps are offered.
- Transition service development continues – formal handover of transition clinics with adult colleagues.
- DENDRITE (specific paediatric diabetes database introduced to capture activity) continually updated
- Submission to the NPDA - Yes
- Involvement in research projects – Cascade, JUMP
- Dr Swati Karandikar became Vice Chair of the CYPWMDN.
- Alison Peasgood, Raphaella McEwan and Paitra Sparkes members of the Schools Working Party and involved in the roll out of Regional schools training days.
- Raphaella McEwan and Dr Rweyemamu are members of the newly formed Transition working group of CYPWMDN
- There have been improvements in retinal screening and obtaining the results. These can be tracked and inputted onto DENDRITE. There is also an onsite screener at Heartlands.
- Provide annual ward staff training as part of an Emergency Care Study Day, which is Mandatory.
- Provide carbohydrate counting and dietary education sessions for nursing staff on the ward and as part of SHO training – sessions for both run twice annually
- Elaine Keegan and Alison Peasgood successfully completed their Non-Medical prescribing course.

Hereford Wye Valley

- Continued achievement of the Best Practice Tariff (BPT) criteria and payment for the BPT.
- We have continued to provide social events with a learning element – exercise and diabetes management.
- Completed a comprehensive Transitional Care Policy with special pathways to child and adult safeguarding and the management of high HbA1c.
- Set up an nhs.net email account and an electronic manual for primary care for GPs to access non-urgent advice from diabetes specialists in both paediatric and adult diabetes services.
- We have restructured our transition clinics, and have a funded DSN with transition interest in post since April'14.
- We have ensured the acquisition of Diasend, which has been in use since September'14.
- Second consultant with diabetes interest in post since September 2014.
- Excellent national peer review visit report, following visit in September 2014.
 - The report identified that the WVT CYP Diabetes MDT met 28/31 measures (90.3%), and was in the top 10% of unit's country wide.
 - The unit met 5/7 of the hospital measures for CYPD services.
 - A number of good practice/ significant achievements highlighted, which include the detailed 'hospital to home' patient information booklet, and the support of the MDT to the family during diagnosis and admission to hospital.
- Newsletters to families.

Mid-Staffordshire

- The service was paid the best practice tariff (BPT) by the clinical commissioning group (CCG) for 2014-15. There was better communication between the teams in primary and secondary care.
- There has been year-on-year improvement in mean HbA1c with 16.7% achieving HbA1c of <7.5% (58mmol/mol) compared with 15.7% in 2013-14 and 13% in 2012-13. There has also been a reduction in number of children with poor control i.e. HbA1c >9.5% (80mmol/mol). In 2013/14 there were 26.5% compared with 32% in 2012/13.
- We had structured education sessions on 'more about food' for teenagers.
- We use a comprehensive outcome sheet for annual review in clinic. This has led to an improvement in the screening process with identification of children needing review.
- HbA1c testing equipment's were available in clinic and regularly calibrated. This helps to inform changes to their diabetic management.
- We had an activity weekend and fun day including pantomime in January 2015 which was much appreciated by children and their parents.
- We had education session for teachers, school cook and catering team, transition session for teenagers going to higher school and insulin pump update.
- More children are now on insulin pump and prior to starting each individual had carbohydrate counting education session with the dietitian. There are five training sessions for eligible children before starting on pump and they are offered three choices to choose from.
- We use Twinkle database to submit data to the National Paediatric Diabetes Audit (NPDA) on an annual basis.
- We are involved in local and international diabetic research studies.
- Guideline on management of diabetes ketoacidosis was updated. It was made available in paediatric assessment unit.
- Information on managing newly-diagnosed children with diabetes was supplied to parents on the ward and school visits were made and information pack was also made available.
- We had excellent podiatric and social service link.
- We had regular doctors and ward staff training.

The Royal Wolverhampton

- Appointment of a Family Support worker who works jointly within the team and in the City Council Youth team. This has given our CYP the unique opportunity of being able to easily access locally available care.
- Appointment of a psychologist on a contractual basis with a view of recruiting into substantive post
- Reduction in % of patients with HbA1c > 9.5%(80mmol/mol) from 40% (2010) to 31% in 2013-14
- Initiation of a Family support group by a parent aided by family support worker
- Collaborative working with local teachers to refine structured education
- NPDA submission made easier by way of utilising local Diabeta 3 database
- Active participation in research studies
- Expansion of pump/sensor service, regular audits of our practice

Sandwell and West Birmingham

- Both Sandwell and City Clinics achieved HBA1c in the 2013/2014 NPDA audit that was better than Regional and National average. The Sandwell clinic achieved the best average HBA1c in the Region. This has been the case for the last 3 years. Our local audit for 2014/2015 shows further improvement in mean HBA1c and % of children achieving HBA1c of less than 58mmol/mol. See below:
 - Sandwell 39.81% of children had an average HbA1c of <58mmol/mol
 - City 27.42 % of children had an average HbA1c of <58mmol/mol
- The PREM report for the Service was positive as both sites improved on previous years report on all the items. The Sandwell service was rated 9.3 out of 10 by parents (National and Regional average of 9) and the children rated the Sandwell service 9 out of 10 (National and Regional average of 8.8).
- We started formal PUMP schools and now have >30% of the clinic on Insulin pumps.
- We held 9 Structured Education sessions cross site. Feedback remains positive. Attendance is variable though.
- Psychology – There is now parity as the service provided by Dr Ash Reynolds now covers both City and Sandwell diabetic patients.
- We had a successful Christmas Party; the adolescents were taken canoeing and other outdoor activity whilst the younger children went to 'GO KIDZ GO' an indoor activity centre. The team raised a good amount bag packing in Tesco. 1 fund raising activity.
- We acquired Twinkle database and this will aid submission to the NPDA.

Shrewsbury and Telford

- BPT – Achievement of BPT for 2014-2015 for the second year
- PDSNs have worked hard in 2014-15 with the new changes in diabetes management advice for schools to ensure all patients have an individual care plan and schools have had increased diabetes awareness training.
- Local Young Health champions with diabetes supported by the PDSN's have been commended for their production of a U tube video about management of diabetes in schools
- Structured education – continued an individualised approach to structured education with everyone receiving an individual structure package at annual review usually a home visit by the named PDSN dependent on needs
Also group sessions were offered for patients transitioning to secondary school, pump updates and carbohydrate counting.
Annual review clinics – improvements in organisation so patients are identified prior to clinics and investigations such as bloods and urines pre- planned
- Further successful annual diabetes residential weekend at Boretton Park PGL centre organised by Shrewsbury Kids with Insulin Dependent Diabetes support group attended by 30 patients and 6 members of the team
- Continuing to Increased numbers on pumps now more than 25% of the clinic on pumps.
- The embedding of the role of the young person DSN within the team appears to have Improve engagement with the 16yrs+ I utilising technology such as texting, more Downloading of meters in hospital clinics and the setting up of college clinics
- Successful recruitment greater than target for Address2 research
- New technology- tablet computers introduced for PDSN team for remote working to avoid duplication of work and continue to establish TWINKLE as more of a patient record.

- Improvements in Ward link nurse role post reconfiguration with dedicated time and roles and responsibilities –now have 3 key nurses for organisation, education and training.

South Warwickshire

- Achievement and payment of the Best Practice Tariff (BPT)
- Due to the achievement of BPT we have been able to get a business case approved for a 0.3 wte psychologist and we recruited to this position in January 2015. This will lead to an improvement in our psychology provision.
- Our dietician has set up an additional clinic so that we can offer all our young people the additional annual dietetic appointment as recommended.
- We have made improvements in the process of carrying out annual reviews and the percentage of young people achieving this in a timely manner has increased.
- We trialed a psychology group session that was a peer review programme that lasted for 6 weeks and received good feedback on this programme.
- We acquired equipment for point of care testing of HbA1c in February 2014. This has improved clinics as the result is now available for the appointment.
- We have seen an increase in nursing staff with Amy Morgan our PDSN starting in November 2013.
- We established a transition clinic in September 2013 and at the end of 2014, following a team review, plan to carry out a patient survey aimed at getting feedback for improving the service.
- We acquired a database (DIAMOND) for our diabetes patients.
- We completed a full data set submission for the National Paediatric Diabetes Audit (NPDA).
- We have been involved in recruiting young people to a research project – “Diabetes Care in UK Universities- Barriers to good transitional Diabetes Care in UK Universities”
- We have seen a reduction in our mean HbA1c and the percentage of patients with a high HbA1c.
- We have succeeded in being able to access the results of retinal screening for our young people.

Walsall

- Implemented changes in the way service works to comply with Best Practice Tariff (BPT) for diabetes. Activity levels in this financial year were in full compliance with the BPT criteria.
- Structured education program
- We have new diabetic intensive education program in operation We have organized following workshops/refresher sessions for existing diabetics
- Carb counting workshops x 13 over the past year plus individual sessions as required
- Education workshops x 12 workshops
- Transition to senior school workshops x 3 sessions
- Camp x 1 – attended by 20 children and young people
- Activity sessions- started in October 2014 x 4 sessions held so far, attended by between 2-10 CYP at each session
- **Psychology**
 - We have been using PI-ED questionnaire for screening children and young people in need of psychological input
 - Active psychological input remains through CAMHS via referral

- We have monthly meeting with CAMHS Consultant to discuss cases that have not been referred to CAMHS
- Annual review is conducted in regular MDT clinics. We offered an annual review to all patients in this year. We have been using a streamlined method of completion of annual review process including blood and urine tests.
- We have been trained in foot examination by our podiatrist. We have started giving out Diabetes UK foot care leaflet during annual reviews.
- **Staffing**
 - Now we have 2.0 WTE paediatric diabetes specialist nurse
 - We now have 0.2 WTE Dietitian. Her maternity leave was covered by employing locums in this year.
- Insulin pump therapy group starts, 14 patients were commenced on CSII therapy in 2013-14 and a further 13 patient in 2014-15.
- In February 2015 we have successfully started a monthly joint transition clinic with adult services. We are working on a business case to extend that service at the moment.
- To improve in-patient management of DKA, we have updated the pathway and introduced a 'DKA Box'. This box is kept in A&E and paediatric assessment unit and contains copies of paperwork as well as all the information/materials needed for starting DKA treatment. The medical and nursing staff were provided training in using this box.
- We have successfully implemented Twinkle database and are using it as a live system for data entry and sharing, clinic letters generation and auditing purposes.
- 2013-14 was the last year when we manually submitted data to NPDA. This year, we shall use Twinkle system to auto-generate a report for NPDA. We hope this will improve data accuracy and completeness.
- Following new/revised guidelines have been implemented in this year
 - DKA guidelines
 - Diabetics undergoing surgery guidelines
 - Telephonic advice guidelines
- We have started using Diabetes UK school resource pack. PDSN's are contributing to the WM network schools study days and are working with WMPDN's to help develop the school education pack. We shall be hosting a schools' study day in September 2015.
- PDSN's help present the Walsall schools medical needs training days for all medical conditions, this is aimed at all school teachers and support workers and is held on a 2 monthly basis.
- NPDA from 2013-14 shows that our mean HbA1c results and proportion of patients achieving HbA1c of <58mmol/mol is better than average of the network. The preliminary analysis for 2014-15 data shows further improvements in mean and median HbA1c and rise in proportion of children & young people with HbA1c below 58mmol/mol.
- PREM survey scores that our patients regard our team highly and would strongly recommend our team to their friends/relatives diagnosed with similar illness.

Worcester

- Achieving the BPT
- Reduction in HbA1c across the whole county over the last two years
- Regular reviewing of guidelines and patient information leaflets
- Positive PREM (Patient Reported Evaluation Measures) report – very good evaluation of service by patients and families two years running

- Establishment of pump start courses for groups of 4 patients at a time
- Other structured education sessions – with continuation of some CASCADE sessions for 10-14 year olds, annual pump update education session.
- Improvements in care processes (e.g. lipid profiles) and documentation (e.g. retinopathy reports) at time of annual review.
- Dietetic education sessions for children with diabetes and coeliac disease
- Steady increase in number of patients being treated with insulin pump therapy – with a small number also being helped by continuous glucose monitoring through their pumps.
- Successful submissions to the National Paediatric Diabetes Audit for several years.
- Another successful involvement in a national research project (relating to structured education in young people with T1DM – led by the University of Ulster)
- Improvements in transition to adult services

University Hospitals Coventry and Warwickshire

- We have changed our clinic template to offer 30min appointments for patients, in keeping with DQUINS measures.
- Transition- Our well established transition service at Coventry is now introduced to patients with a transition information leaflet.
- HbA1c testing equipment- We have a new POCT device following malfunction of the previous one.
- Structured education – We have run two targeted carbohydrate counting education sessions for patients with high HbA1C, we have held a structured education session in August 2014 for young people starting secondary school and have organised a parenting seminar for our parents in partnership with Positive Parenting Programme
- Our diabetes specialist nurses have developed a PowerPoint presentation to deliver educations for schools, thereby ensuring consistency of information being delivered
- Our dietitian has now started doing home visits for newly diagnosed patients and other selected patients.
- New patient information leaflets have been developed on transition clinic, high HbA1C and virtual clinics. A patient information leaflet on illness management for those on pumps is being developed.
- Laptops are now available to allow downloads at home visits
- Psychology – Following a period of lack of continuity we now have a new psychologist.
- A quarterly ward link nurse newsletter is written and circulated to update ward staff on new developments and reinforce messages.
- We have provided ad hoc training sessions for new members of nursing staff that have started on our paediatric wards in the last year
- Best Practice Tariff – We have received the best practice tariff over the last financial year.
- DIAMOND database was upgraded in July 2014 to facilitate data submission with NPDA
- Submission to the NPDA is facilitated by our data manager with improvement in data quality
- PDSNs now have remote access to DIAMOND database to allow real time documentation of patient contacts
- Annual review – Our recent NPDA report shows an improving trend in the delivery of diabetes related care processes.
- PREM scores for 2013-14 – patient feedback was very positive both in terms of ratings and free text comments

- Our database of patient HbA1Cs shows a reduction in the number of patients with HbA1C above 80mmol/mol- we are hopeful that this will be reflected in our next NPDA report
- We are recruiting patients for ADDRESS 2, and are recognised as one of the higher recruiting paediatric units in the UK

University Hospital of North Staffordshire

- Sustained improvement in HbA1c
- PREM scores in line with network average
- Achieving Best Practice tariff
- Currently provide age appropriate structured education for groups in various locations and sessions at various times of the day to suit the patient/carer needs and requirements. We are developing single structured education to be provided at point of contact.
- Parent and Family Link provide fun sessions and activities for various age groups. We support Family weekends/ days with Diabetes UK.
- HBA1c performed in clinic and also in the community in Nurse Led clinics, home, schools.
- Psychology group sessions appending.
- Carbohydrate counting sessions are provided in the community for appropriate age banding by Dietician with PDSN support
- Transition / Transfer is conducted monthly with joint clinics with Adult Diabetologist and Adult DSN with Paediatric Consultant and PDSN in Secondary care.
- Currently provide CSII from 1 company. Plan to offer a choice of 2 pumps in July
- Dietetic clinics at annual review.
- Submit to the NPDA and involved in various research projects, i.e. Trialnet, Address2.
- Have developed new School Pack information including using the Diabetes UK booklet and new Care plans.
- Developed a Fact pack of information from Diagnosis to transition.
- Weekly telephone contact with patients on high HbA1c intervention list
- Provide a monthly booked Nurse-led clinic in the community for patients with high HBA1c.
- Nominated for SSOTP Outstanding Team of the Year award Front facing/clinical by 2 families and came Runner-up.
- Liaise with Staffordshire Eye Screening department twice a year to obtain information.
- Provide Training for: pre and post graduate students. Ward staff, GP's school Nurses.
- Provide on-call service 8am- 8pm 7 days a week except bank holidays
- Psychology time increased from 0.2 wte to 0.5 wte in April 2014.
- All children and young people (aged 8-16 years old) are given the opportunity to complete a psychological screening questionnaire (PI-ED) at annual review and are followed up by the Clinical Psychologist.
- Children, young people and parents are also referred directly to the Paediatric Psychologist when psychological needs identified.
- The development of group sessions for children and young people has been discussed
- Ability to provide home/school visits to newly diagnosed patients and those who need further support with carbohydrate counting etc.

- Liaising with school meals/ catering providers at residential centres to provide carbohydrate counted menus.
- Engaging the majority of patients in a dietetic annual review by offering it at the same time as their medical annual review.
- Successful 'Moving to High School' education session.
- Developing and reviewing the on-going carbohydrate counting sessions for pump patients to better meet their needs

Key challenges for each member trust of the network

Birmingham Children's Hospital

- Reduction of the number of patients with an HbA1c >75mmol/mol
- Increasing the number of patients with an HbA1c <58mmol/mol
- Engaging young peoples and parents in continuing diabetes education
- Whilst link nurses are in place for wards commonly caring for children with Diabetes (Medical HDU, PAU, Ward 2 and Ward 7) the integration and extension of a structured Link Nurse programme to improve care of children with diabetes on those wards who care for children with Diabetes far less frequently is in progress. The logging of staff training outside the department will also prove a continuing challenge.
- Ensuring continued embedding of the 2 designated diabetes psychologists and rapid access to psychology in the advent of the service changes in CAMHS, will require close liaison between the lead clinician, and psychologist and service managers.

Burton Hospitals

- **Staffing issues** - During the period 2014/2015 one of the Nurses was on Maternity leave and has since returned on reduced hours. The Team is currently looking at the best way to utilise these hours for the benefit of both the caseload and the service. Currently the PDSN to patient ratio is below the recommendation of 1 WTE to 70 CYP.
- **Psychology Service** - As stated previously despite an increase in Psychology hours at the start of the year the team has found there has been, and continues to be, an increased need for referral in this area. This is a national trend with more CYP requiring support of Psychology Services and referral to CAMHS.
- **PREM Survey** - As previously stated – the survey demonstrated that the Paediatric Diabetes Service at Queens scored higher in several areas in comparison to both the 'West Midlands' and 'England and Wales' in total. However it is recognised that the survey identified that improvements are required especially in the following areas:
 - Technologies, i.e. Continual Subcutaneous Insulin Infusions, new meters, and CGMS etc.
 - Dietetic Service

To try to rectify this, despite previous poor attendance, the Team will continue to provide sessions that include changes in management and associated new technologies) along with extra dietetic sessions. More information will be included in the newsletters for those not wanting to access these sessions.

- **Clinic Capacity** - At all Consultant Led Clinics CYP are offered the opportunity to see the Diabetes Nurses, Dietitian and if available the Psychologist as well as the Doctor. Unfortunately on some occasions room availability for all these services can be limited. Capacity for the Transitional Clinic is also limited again due to physical availability of space and also service commitments of the Adult Diabetologist.

- **Education services** - Since the changes in education policy surrounding 'Long Term Health Conditions' Schools have been more demanding on the Paediatric Diabetes Service despite the Network now running training days that the Team participates in the delivery. Unfortunately these are not always well attended - only one of the Schools from our locality attended the last study day. The Team continue to encourage all local schools to send a staff member for their own benefit as well as that of the CYP with diabetes
- **Carbohydrate Counting of School Meals** - Last year's changes in the provision of free school meals, (for children in their first 2 years in school) gave rise to a huge increase in the demand for the Dietician to 'Carb Count' School Meals, this has proved to be very time consuming. Dietetics are trying hard to establish effective contacts with catering companies to assist in this area.
- **Reduce number of DNA's/Cancellations** - The Trust implemented a TEXT reminder service for all clinic appointments in the last 12 months which has significantly reduced DNA rates but has increased the cancellation rate! PDSN's also do a team reminder to patients. The largest area of DNA/Cancellations lies in the older age groups as can be seen below.

Dudley

- Staffing issues -at the present time there is only one Consultant for the service.
- Administrative support and Twinkle administrator for the paediatric nurses and dietitian needs to be appointed to.
- There is no integrated member of the team from psychology, however two sessions of psychology time per month is currently being commissioned following the analysis of what the paediatric service case load requires as a minimum.

George Eliot

- Administrative Support
- Psychology support
- New dietitian appointment
- Twinkle and local pathology systems interface

Heart of England

- Staff shortages/ Recruitment into vacancies:
 - Recruitment into 0.5 WTE psychology
 - Recruitment of 2.1 WTE dietitians
 - Insufficient PDSN : Patient ratio
 - Insufficient admin support.
 - Challenge of consultant cover for clinics due to patient load increasing.
- Issues with clinic capacity – due to insufficient dietitian's and PDSNs.
- Issues with job plans:
 - Lack of management time in the lead nurse role.
 - Difficulties with getting more PDSNs.
 - Remuneration for out of hours.
 - Out of hours support services.
 - Winter pressures on wards.
- Podiatry links tenuous.
- Challenge to reduce the number of patients with an HbA1c >75mmol/mol.
- Transferring and replication of data onto new database.
- Transition challenges:
 - Patients agreeing to transfer

- Partial booking for transition patients at GHH
- No transition clinic at Tamworth.
- Patients booked onto wrong clinics.
- Pump funding for transition patients due to different funding for adults and paediatrics.
- Non- attendance of adult diabetologist in Solihull Transition clinic
- Education service challenges:
 - Schools issues – not allowing children to do blood glucose tests/treat hypo's in class; unable to attend school trips; inadequate medical rooms to administer insulin etc.
- Structured education challenges:
 - Venues
 - Resources
 - Money
- Reduce number of DNAs.
- Language barriers:
 - Diverse patients with related language barriers
 - Problems attaining interpreters especially for Somalian, Urdu, Romanian and Bangladeshi

Hereford Wye Valley

- We have had a number of adolescents with poor glycaemic control, needing intensive MDT support, some with complex social issues.
- Demography of caseload is tilting toward greater proportion of adolescent patients (nearly 50% of total caseload) causing difficulties with transitional clinic capacity.
- We have struggled with getting feedback on issues from Social Services.
- The rural nature of our area means that families are unwilling to engage with activities/group education and domiciliary visits are time consuming.
- We have struggled to get patients engaged and attend the structured education sessions we have put on and again this is due to the rurality of our location.
- Lack of a proper admin support/local network coordinator.
- Reduction of the number of patients with an HbA1c >75mmol/mol.
- Office space for nursing team and psychologist.

Mid-Staffordshire

- The major challenge is the transitioning process with the merger with RSUH in November 2014. All patients in our patch will now be cared for at RSUH in acute emergency and all will be required to attend the clinic in Stafford.
- There is an issue with provision of diabetes advice to fellow consultant's on-call out of hours. There have been a number of discussions at the network business meeting regarding this issue. A network workshop was held in the March 2014 meeting and a decision made to explore network wide on call arrangements for clinical advice was made.
- There is a high rate of non-attendance at clinic in Cannock and transition clinic in Stafford. Parents are contacted before the clinic and telephone calls are made few days before their attendance.

The Royal Wolverhampton

- Inadequate nursing staffing and retention of staff
- Establishing 24hr on call rota
- High DNA rate

- High deprivation in catchment area , families needing more nursing, psych input

Sandwell and West Birmingham

- The main challenges remain dietetic staffing. Need to recruit to additional 0.65WTE Dietitian to ensure we can meet all aspects of BPT.

Shrewsbury and Telford

- Reconfiguration of paediatric services particularly inpatient services has been challenging for the ward staff in particular with a new working environment but post reconfiguration improving inpatient diabetes care and ward staff knowledge has been accepted by management as a priority.
- Staffing issues resignation of 1 WTE PDSN in September 2014,difficulties recruiting further staff –post now filled
- Gaps in Psychology because of lack of dedicated resource and maternity leave – Service provided by community trust commissioned separately from BPT .As of April 2015 only now have 12 hours /week of dedicated time.
- PREM information from 2013/14 showed an improvement compared to 2012/13 but significant areas where there was a need for on-going improvements such as access to the diabetes team and patients perceptions of the service compared to national and west midlands results.
- Issues with clinic capacity have come to light over the year with clinics frequently being overbooked and running late
- Issues with job plans previously lack of dedicated consultant time for ward reviews and meetings in job plans –now included in all job plans
- Issues with Twinkle database and how data is pulled for NPDA in particular.
- Reduce number of DNA's
- Our structured education programme is mainly individualised and done at a home visit due to poor uptake and attendance of group education events we have further challenges on how to improve engagement with group education.
- Issues with usability and reliability of near patient testing HbA1c machines

South Warwickshire

- The increased demands of providing a quality service meant there was a need for more nursing time. After review we were able to get an additional day of nursing time approved.
- We had experienced issues with clinic capacity. The clinical lead helped with a temporary solution of doing an additional clinic. This issue will be properly addressed with the appointment of the 2nd Diabetes consultant.
- We have also experienced issues with lack of administrative support. There have been difficulties recruiting to the post despite a business case being approved.
- We have worked on continuing to reduce the number of patients with an HbA1c >80mmol/mol and increase the number of patients with an HbA1c <59mmol/mol.
- We have experienced issues with the transferring of data onto our new database, due to lack of administrative support and technical issues with the database. This has meant that submission of data for the NPDA has had to be done manually rather than electronically which has been time consuming.
- The DNA rate in our transition clinic is higher than desired and as a team we are looking at ways to reduce this.

Walsall

- Maintain activity levels to ensure compliance with BPT
- Reduction in mean HbA1c
- Improvement in DNA rates in our clinics.
- Secure enough resources to continue to provide adequate transition service
- Improve access to psychology services

Worcester

- Deficit in Consultant Hours (being addressed by the appointment of an additional consultant, who will start working in the county in June 2015)
- Improving out of hours advice, which will probably require an additional PDSN appointment (especially when combined with the need to do more education)
- Psychology, PDSN & Dietetic challenges under service heading below
- Addressing the one apparent 'deficit' in the Patient Recorded Evaluation Measures (PREM) of last year – to give young people with diabetes more opportunities to meet others with the same condition. We already organise an activity weekend (at the 'Pioneer Centre' in Cleobury Mortimer) each year – but will this year organise an event for teenagers. We organise an annual barbeque for families – but will try to offer more!
- We need to keep the clinics at WRH under review – because there is very little flexibility (to alter appointments, etc.)
- Many of the patients with problems have social problems, rather than pure psychological problems. If we cannot improve links with local social services, we may need to employ a social worker through the acute trust to help with this.
- We will continue to try and improve links with the local retinopathy screening service – to make sure that we have access to all reports relating to our patients.
- Despite an improvement in the median HbA1c levels in all clinics over the last two years, and an improvement in the percentage of patients with a HbA1c < 58 mmol/mol this year, we still need to reduce the number of patients with very high HbA1c levels (perhaps especially on the WRH site).

University Hospitals Coventry and Warwickshire

- Issues with clinic capacity- there having been difficulties with accommodating 1-2 monthly appointments for patients who may need this in the transition clinic, issues around patient bookings in the transition clinic are being addressed.
- There are difficulties in finding adequate clinic rooms for the much expanded MDT resulting in blocking of patient flow through clinic and patients having to come back another day for a separate appointment- this issue has been raised with the service manager.
- Staffing issues- There is a need to rethink how we use the administrative support we have due to the frequent and increasing demand for data. Our administrators job plan is being reviewed in light of the demonstrated increased workload
- Dietetic presence in clinics especially at Rugby has sometimes been lacking due to some unforeseen circumstances- contingency plan for the future being discussed.
- Psychology time is limited to 7hrs a week, this includes admin time. A need for greater support is recognised and is being discussed
- New legislation has led to an increased demand from schools for staff training. Encouraging them to attend Schools Awareness Days and steering them away from expecting PDSN to go into school to provide this has been a challenge.

- Developing a rolling programme of training for ward staff- adverse event reports are now being completed when patients have been mismanaged on wards to demonstrate need for on-going staff training. Learning points from investigation of adverse events are discussed at QUIPs meetings and disseminated to junior doctors through our WhatsApp group.
- Identifying time, space and support with resources to provide structured education has been a challenge. Encouraging patient attendance at education sessions has also been a challenge.
- Responding to all the demands from the diabetes network for data, surveys, audits and reports has certainly been a challenge.
- Reduction of the number of patients with an HbA1c >75mmol/mol- We have trialled monthly high HbA1C clinics and are now trialling telephone clinics. We are developing posters to reinforce target blood sugars and HbA1Cs.
- Increasing the number of patients with an HbA1c <58mmol/mol- this number had dropped at the time of last NPDA report. Measures have been taken to address this as noted above.
- PREMS data shows that patients would like us to facilitate more peer support- a parents support group already exists, enquiries are being made into a youth group that patients could be signposted to.

University Hospital of North Staffordshire

- No major staffing issues.
- No major issues with clinic capacity.
- No Social workers involved but refer to services if necessary.
- Podiatry Links poor- to address with Podiatry Team Leader.
- To improve general HBA1c.
- Awaiting Twinkle to transfer data.
- To reduce DNA rate by contacting Patients/parents via texting.
- Engaging young people in structured education
- To adapt structured education for appropriate age groups.
- Integrating services with County Hospital and ensuring equity of services across both sites

2014 – 2015 Individual member trusts objectives

Birmingham Children's Hospital

- Extension of TWINKLE in the day to day departmental activity of psychologists.
- Introduction of Boy's group
- Explore systems for logging training of ward staff in diabetes and extending to the use of online modules such as safe use of insulin.
- Extension of Link Nurse Group and support.
- Introduction of BPT dashboard reviews to enable better targeting of children and young people with HbA1c < 80 mmol who fall below the radar of the high HbA1c guideline, and require more contact.
- Recruit to the Nurse Consultant post
- Complete departmental guidelines for steroid induced diabetes.
- Complete initial audit of new patient education HbA1c outcomes.
- Review psychology integration in the diabetes service.
- Evaluate efficacy and outcomes of the psychology assessment questionnaires.
- Evaluate initial operation of the social worker and family support worker roles.

- Explore feasibility for using CGMS as an education tool for those with the highest HbA1c
- Explore feasibility of alternative telecommunications for target clinics.
- Explore feasibility of online education for CYP and families.
- Ensure succession planning with the planned retirements of one CNS, one dietitian and the department lead administrator.

Burton Hospitals

- **Psychology group sessions-** There are currently on-going discussions re the provision of psychology group sessions for CYP.
- **IT Issues**
 - To ensure all PCs that require downloads for pumps/meters have them properly installed.
 - To have the results from the portable HbA1c to be automatically entered into patient's electronic record to the Hospital Information System rather than being manually entered.
 - To work with IT to get live access to our HISS when in the community.
- **The TEAM**
 - To utilise TWINKLE to its full capacity and to employ a part time Data Clerk to assist with TWINKLE data inputting and report extraction.
 - To look at staffing needs and utilise funding available to enhance the patients pathway further by increasing the size of the team with the possible recruitment of a Band 4 member of Staff as either an Assistant Practitioner or Youth Worker.
- **Insulin Pump Therapy (Continuous Subcutaneous Insulin Infusion CSII)**
 - Due to maternity leave within the Team it was not feasible to do as many pump starts in the last 12 months as was initially planned.
 - Some of the older pump patients have now moved on to the Adult Service.
 - In the coming year the Team aims to start more CYP on CSII to achieve the suggested percentage of the caseload.
 - Currently the Team offers a choice of only 2 different Insulin Pumps to the CYP. This year the Team hopes to move towards having a greater choice of Pumps for the CYP as recommended by the Peer Review.
 - The current format of 'Pump School' will be improved with a better framework being developed with the intention of having more successful pump starts.
- **HbA1c** - To continue to work further on decreasing the HbA1c levels of all our patients.
- **Transition Service.**
 - Due to the number of YP who will soon be entering the transition phase - the size/format of the Transitional Clinic requires attention as currently there are time restraints.
 - A Transitional Pump Clinic needs to be developed in order for the YP to meet members of the adult team prior to moving to the Adult Service as do their non-pumping peers. Again there are time/venue restraints.
 - Although the Team has been running Joint Transition Clinics with the Adult Diabetologist for many years further joint work with the adult DSN's is planned to increase engagement with the YP in transition.
 - The current Young BERTIE Structured Education course is due for redesign.
 - The Adult DSN is due to start a Nurse Led Clinic just for YP under 25 years of age.
- **School Pack information**

- The information packs for teachers and educational staff is to be redesigned ensuring all the changes from the education policy are met.
- Networks School Training days will continue to be promoted in all schools.
- **New Diagnosis information** - The Team is currently updating the 'Newly Diagnosed Information pack' in order to be clearer and more helpful to our CYP and their parents/carers.
- **Information Sessions for CYP AND parents** - In line with the results of the PREM – the team will be looking at different ways to meet the caseloads needs in relation to information re technologies etc. Strategies need to be formulated to investigate more successful methods of delivering information to CYP.
- **Retinal screening/results** - To work with the community to get access to the register for CYP's retinopathy screening results.
- **Reduce number of DNA's/Cancellations**
 - Strategies need to be designed to reduce the amount of late cancellation of appointments leaving empty clinic slots.

Dudley

- Appointment of an additional Paediatric Consultant with an interest in Diabetes.
- Increase in Psychological support in the team.
- To embed point of care testing system.
- Improve nursing and medical staff knowledge and skills relating to paediatric diabetes.
- Optimising hypoglycaemia training within the ward environment.
- Continue to achieve the Best Practice Tariff

George Eliot

- Target High HbA1C
- Recruit a dietitian
- Structure Transition care

Heart of England

- Recruitment of Staff :
 - 2 WTE PDSNs
 - 1 WTE HCA (fixed 1 year contract completed)
 - Adult Diabetologist for Solihull
- Achieve BPT mandatory standards and receive payment from 2 CCGs.
- Work towards action plan following National peer review report.
- Liaise with Burton Hospitals to receive BPT payment for South Staffordshire patients.
- Reduce Hba1c mean and median.
- Streamline Transitional services throughout all sites of the Trust.
- Develop and Implement structured education for non-pump patients.
- Increase opportunities for ward staff training and ward link nurses.
- Increase availability of clinic rooms for Heartlands and Good Hope Hospital.
- Improve office accommodation for PDSNs on both hospital sites.

Hereford Wye Valley

- To improve our ward staff training with the introduction of a structured curriculum.
- To facilitate a session for SENCOs and teaching staff in our area to discuss issues that they may experience in delivering care for children with diabetes in their schools.
- Increase our social events for patients and increase our patient involvement.

- To work with Worcestershire paediatric diabetes teams in delivering a programme of diabetes education to nurseries, schools and colleges across the two counties.
- To develop CGM/flash glucose monitoring in the service with an aim to win funding from CCG.
- To develop an interactive and educational environment for diabetes clinics for the paediatric and transitional populations.
- Dedicated local coordinator for the team.

Mid-Staffordshire

- Further reduction in number of CYPD with high HbA1c (>9% (75mmol/mol)).
- Ensure a coordinated approach to the diagnosis, treatment and on-going care for all children and young people diagnosed with diabetes to meet BPT.
- Provide comprehensive information to patients, carers and their relative.
- Follow national and Children and Young People Diabetes Network (CYPDN) guidelines.
- Involve children and their families in the organisation of the service.
- The involvement in local, national and international research studies.

The Royal Wolverhampton

- Achieve full complement of staff
- Further reduction in % of patients with HBA1c > 80 mmol/mol
- Introduce measures to reduce DNA rates in clinics
- Telephone/Drop in clinics
- More involvement in research

Sandwell and West Birmingham

- Further improvement in all outcome measures
- Improvement in Transition services
- Reducing clinic waiting times.

Shrewsbury and Telford

- Improve clinic capacity waiting times and patient perceptions of clinics –further resource and other ways of Improve patient flow e.g. by upgrading Hba1c machines
- Improve HBA1c results and % of patients achieving targets
- Improve access to psychology services by increase in amount of time commissioned so preventative work can be done with patients rather than just reacting to situations
- Improve results in general for PREMs and NPDA
- Work with our patient group such as local health champions to gain more patient engagement possibly utilise some of the suggestions of the just Duct group from Scotland.
- Particularly improve engagement with 16 plus age group who make up > 80-% of the patients with high HbA1Cs
- Achieve BPT standards and improve quality of care and outcomes for our patients

South Warwickshire

- Expand the consultant medical support for the service.
- Establish the psychologist and administrative person into our team.
- Improve the on-going training for ward staff education

- Establish activities for children.
- Continue to improve structured education provided to our patients.
- Increase and improve the ways we communicate with young people and their families.
- Improve the percentage of patients achieving a target HbA1c of less than 59 mmol/mol and reduce the percentage of patients with an HbA1c over 80mmol/mol.
- Review the effectiveness of the transition service.

Walsall

- Prepare and submit business case for transition service.
- Aim to achieve improved mean HbA1c and increased %age of patients achieving HbA1c below 58mmol/mol.
- Further develop new and existing diabetic patient's education plan.
- Improve medical/nursing staff training specially in using insulin pump therapy.

Worcester

- We are having detailed discussions about improving 'out of hours' advice to local families. We have already improved the guidelines on 'sick day rules' for use by families and ward staff – but will try to extend the phone advice service from the diabetes team over the next year or two. Combined with directives to improve structured education that may only prove possible with the appointment of an additional PDSN.
- We hope that we will continue to improve the median HbA1c level in all of the clinics in the county – in the way that we have now done for two years running.

University Hospitals Coventry and Warwickshire

- We would like to be able to offer patients a choice of pumps rather than one pump only as we currently do. We recognise that this will have implications for staff training and computer software.
- We aim to develop and deliver a rolling programme of Ward staff training/updates in keeping with DQUINS measures and with view to improving inpatient care for children with diabetes.
- We aim to establish a regular audit of BPT compliance.
- We want to improve outcomes for our patients and see an increase in the number of patients with HbA1C <58mmol/mol.
- We aim to continue to improve on the number of patients receiving all care processes - foot examination training is being organised as yet another step towards this.
- We aim to work towards developing a more formal continuing structured education programme that we can offer to patients.

University Hospital of North Staffordshire

- Integration of services at 2 sites
- Improve IT including individual Laptops and access to Twinkle remotely to help patient care

- To improve Patient's experience, Diabetes management to self-empower, HBA1c to National guidelines and reduction in hospital admissions.
- On-going evaluation of Structured Education.
- Increase hours to full time for the Family support worker.
- Look at possibility of educator role
- Working with the Paediatric Psychology Service in Stafford to further develop the diabetes paediatric psychology service across the county.
- Increase routine psychological screening and assessment for children (younger than 8 years old) and young people (older than 16 years old).
- Working closely with colleagues in the south of the county following amalgamation with Mid-Staffs, to develop an equitable dietetic service across the whole county.
- Looking at the dietetic service offered to patients with coeliac disease, obtaining patient's views on current service and what they would like to be offered going forward.
- Developing an education checklist with rest of team to ensure that all patients are offered consistent structured education especially in view of the fact that many patients do not want to access group sessions.
- Investigate the feasibility of offering a LOCAL residential, activity weekend for young people with diabetes.
- We will be joined by County Staff of:
 - 1 consultant
 - 1 PDSN
 - Dietitian
 - 0.4wte Psychologist

Appendix 1 - Job Outline for the role of Chair of West Midlands Paediatric Diabetes Network

Aim

To chair the West Midlands Paediatric Diabetes Network effectively ensuring that the network works well with good stakeholder engagement and develops a work programme that helps to improve the diabetes care in the West Midlands region for children and young people with diabetes.

Objectives

- To effectively chair network meetings (4 times a year). Providing strategic and clinical leadership to the network.
- To work with the network coordinator to ensure that there is an effective work programme for the network and that this is delivered across the region.
- To ensure that the work programme meets Department of Health requirements e.g. Best Practice Tariff and is in tune with national guidance such as recommendations from NHS Diabetes.
- To work with the network coordinator to support all units across the region to achieve all of Best Practice Tariff standards including 100% NPDA submission and effective monitoring of attendance at the network to demonstrate attendance at 60% of meetings.
- To work with the network coordinator to ensure that meetings are booked, with industry support, minuted and that the agendas are relevant to the work programme and stakeholders.
- To work with the network coordinator to ensure that there is good stakeholder engagement and communication including involving parents and carers, industry and charities such as DUK and JDRF.
- To work with the network coordinator to ensure that there is regular proactive communication including a monthly newsletter sent to an up to date list of contacts.
- To work to support the network coordinator in responding to reactive communications such as requests for information. This will include supporting units who request help such as providing advice, sharing good practice, undertaking a visit or writing letters.
- To work with the network coordinator to ensure that the work programme is delivered by being involved in or chairing task and finish groups (small sub groups of the wider network that are undertaking specific pieces of work).
- To lead on work such as consolidating views on regional audit priorities and the role for a registry in the West Midlands, examining data and liaising with research leads.
- To attend national meetings such as regional SHA meetings, twice yearly National Diabetes network meetings and topic related meetings held by the Department of Health or NHS Diabetes.

Supporting Evidence

We will be looking for specific examples to evidence the criteria detailed below.

Factors	Description	Essential	Desirable
Knowledge, Training and Experience	Knowledge of current diabetes issues including being in clinical practice in the West Midlands region.	√	
	Understanding of aims of current healthcare policy in diabetes and appreciate the impact of this on the network.	√	

	An appreciation of the relationship between the Department of Health, the Strategic Health Authority and individual provider and commissioning organisations.		√
Communication Skills	Able to effectively chair meetings.	√	
	Able to negotiate with senior stakeholders on difficult issues, presenting complex and sensitive information to large and influential groups.	√	
	Able to represent the West Midlands Paediatric Diabetes Network at national and regional meetings.	√	
Analytical	Ability to analyse complex facts and situations and develop a range of options.	√	
	Takes decisions on difficult and contentious issues where there may be a number of courses of action.	√	
Planning Skills	Demonstrate capability to plan over short, medium and long-term timeframes and adjust plans and resource requirements accordingly.	√	
Management Skills	Able to direct activities of network coordinator.	√	
Autonomy Freedom to Act	Experience of identifying and interpreting National policy.	√	
	Experience of interpreting best practice to make successful changes to a system.		√
Physical Skills	Have sufficient time (estimated to be about a session per month) to undertake the work of the network and represent the network at regional and national meetings.	√	
Equality and Diversity	Have an understanding of and commitment to equality of opportunity in terms of day-to-day working practices and also in relation to management systems for diabetes.	√	
	Evidence of equality and diversity training.	√	
Financial and Physical Resources	Support the network coordinator to manage a non-pay budget and work with industry to ensure that meetings are supported.		√
Other	Demonstrate a strong desire to improve performance across the West Midlands region for children and young people with diabetes.	√	

Appendix 2 - Memorandum of Understanding

Memorandum of Understanding Between West Midlands Paediatric Diabetes Network and XXXX NHS Trust

Introduction:

This memorandum sets out the framework for a working relationship between the West Midlands¹ Paediatric Diabetes Network (hosted by Birmingham Children's Hospital NHS Foundation Trust, Steelhouse Lane, Birmingham, B4 6NH) and XXX NHS Trust. It sets out the principles on which both parties work together in the course of their day to day working relationship.

Responsibilities:

1. The West Midlands Paediatric Diabetes Network is responsible for ensuring that they:

- Organise and facilitate a minimum of 4 West Midland paediatric diabetes network meetings per year. Minutes for these will be provided to all members within 3 weeks of the meeting.
- Chair, supervise and support any network projects through task and finish groups.
- Communicate regularly with all units, answer queries and offer support by phone, email or in person as appropriate.
- Support units in their discussions with commissioners regarding the implementation of the Best Practice Paediatric Diabetes Tariff.
- Organise and support parent representation in network meetings.
- Organise and support industry representation in network meetings.
- Support units in participating in the regional paediatric diabetes register and National Paediatric Diabetes Audit (NPDA).
- Liaise with local commissioners to raise awareness of funding issues pertinent to paediatric diabetes services.
- Arrange education days on topics relevant to paediatric diabetes for diabetes teams and any other healthcare professionals involved in the care of young people with diabetes (e.g. Hospital ward staff).
- Support units and the network in the completion of peer review process and share learning from it.
- Continuously facilitate and increase engagement with stakeholders and raise awareness of paediatric diabetes healthcare and service issues.
- Link into the diabetes national agenda and represent the region at relevant stakeholders meetings and ensure that national objectives are met.
- Arrange (via the network executive) for all funding pertaining to the West Midlands Paediatric Diabetes Network to be held and managed in a trust fund at the host Trust (BCH) and to ensure that this money is used solely for the business and purposes of the East and West Midlands Paediatric Diabetes Network.
- Invoice all participating units in the network via BCH for their annual network contribution.
-

¹ The Paediatric Diabetes Network is made up of representatives from all paediatric diabetes units across the West Midlands and is the forum where all network business and work plans are set and discussed.

2. XXXX NHS Trust is responsible for ensuring that they:

- Make an annual financial contribution (2014/15 - £2,179.29) towards the running costs of the network (this figure to be reviewed on an annual basis).
- Send a Trust representative² to 60% of all network steering group meetings.
- Send apologies for all steering group meetings that they cannot attend.
- Support the aims and objectives of the Network and those set out nationally and incorporated into the networks annual plan of work.
- Actively participate in the network's working groups.
- Actively participate in the national self-assessment and peer review process.
- Should network post need to be made redundant to share associated costs.
- Maintain their own local paediatric diabetes register and contribute their data to the Regional Paediatric Diabetes Register and submit data to the National Diabetes Audit.

Statement of Support:

We as the Clinical Leads and Business Managers for our local paediatric diabetes service, and on behalf of our paediatric diabetes team, agree to this memorandum and to work in partnership with the West Midlands Paediatric Diabetes Network towards enhancing diabetes care across the region and support the commissioners to improve the quality of care for all children and young people with diabetes.

Signatories to the memorandum of understanding:

² This needs to be a member of the diabetes team; however, business managers are also welcome to attend.

Appendix 3 - Team members

Trust	Name	Role
Birmingham Children's Hospital NHS Foundation Trust	Melanie Kershaw	Lead Consultant/Chair
	Tim Barrett	Consultant
	Ruth Krone	Consultant
	Renuka Dias	Consultant
	Vidya Narayanan	Speciality Doctor
	Lesley Drummond	Lead Nurse for Paediatric Diabetes
	Lorraine Shaw	Clinical Nurse Specialist
	Louise Collins	Clinical Nurse Specialist
	Kirsty Mobberley	PDSN
	Susan Gleeson	PDSN
	Lesley Swift	PDSN
	Rebecca Morgan	PDSN
	Donna Sands	PDSN
	Rebecca Skelding	UHB Transition Nurse
	Waseema Azam	Dietitian
	Hilary McCoubrey	Dietitian
	Hazel Riggall	Dietitian
	Julia Twynholm	Psychologist
	Claire Leonard	Psychologist
Mike Hodges	Diabetes Social Worker	
Sara Anderson	Family Support Worker	
Charlotte Firth	Youth Worker	
Lesley Porter	Admin Lead	
Julie Kirwan	Administration	
Lindsey Wilson	Administration	
Yvette Richens	Administration	
Lydia Salice	Service Manager	
Birmingham Black County and Solihull	Vandna Najaran	Local Service Specialist, Birmingham, Black Country and Solihull Local Area Team NHS England
Birmingham Community	Chris Rumney	Nurse Advisor, Medical Needs in Schools and Early Years' Service
Black Country Partnership NHS Foundation Trust	Ashley Reynolds	Psychologist
Burton Hospitals NHS Foundation Trust	Jacob Samuel	Lead Consultant
	Sobitha Devi	Speciality Doctor
	Hannah Mshelbwala	Speciality Doctor
	Jane Humphries	Lead PDSN
	Rachel Swindell	Paediatric Diabetes Liaison Nurse
	Adele Taylor	Dietitian
Jane Parker	Psychologist	

	Helen Ward	Administration
	Justine Cull	Service Manager
Diabetes UK	Peter Shorrick	Walsall/Nottingham Area
Dudley Group of Hospitals NHS Foundation Trust	Anand Mohite	Lead Consultant
	Hayley Weekes	Lead PDSN
	Joanne Elford	Paediatric Diabetes Liaison Nurse
	Nicola Vass	Paediatric Diabetes Liaison Nurse
	Sasha Dunn	Dietitian
	Dr Siddique	Adult Diabetologist
	Steve Phipps	Service Manager
George Eliot Hospital NHS Trust	Radhika Puttha	Lead Consultant
	Bharathi Pai	Consultant
	Christine Brown	PDSN
	Jeanette Diegnan	PDSN
	Claire Neail	PDSN
	Carole Sandhu	Dietitian
	Kathy Kelleher	Healthcare Assistant
	Sarah Piper	Service Manager
Heart of Birmingham Teaching CCG	Hazel Malcolm	Commissioners
Heart of England NHS Foundation Trust	Stephen Rose	Lead Consultant
	Swati Karandikar	Consultant
	Sanjay Rathi	Consultant
	Justina Rweyemamu	Consultant
	Paitra Sparkes	Lead Paediatric and Young Person Diabetes Specialist Nurse
	Elaine Keegan	PDSN
	Nicola Lancaster	PDSN
	Alison Peasgood	PDSN
	Rebecca Scrivens	PDSN
	Kerrie Williams	PDSN
	Ian Gamlen	Lead Dietitian
	Gillian Abernethy	Dietitian
	Raphaella McEwan	Dietitian
	Jodie Owen	Dietitian
	Adele Freeman	Psychologist
	Catherine Field	Psychologist
	Heather Jones	Psychologist
	Sharron Atkins	Administration
	Nicky Crew	Administration
	Sarah Rowley	Administration
Angela Cornwell	Administration	
Claire Leonard	Healthcare Assistant	
Lynne Bowyer	Service Manager	
Hereford Wye Valley NHS Trust	Shital Malik	Lead Consultant
	Hemantha Balehithlu	Consultant
	Mark Weston	Clinical Nurse Specialist
	Joanne Hall	PDSN

	Ainsley Rees	PDSN
	Sarah Harding	Dietitian
	Nien Gardner	Psychologist
	Vanessa Lewis	Service Manager
Midlands Psychology, Stafford	Clarissa Martin	Psychologist
Mid-Staffordshire NHS Foundation Trust	Olumuyiwa Oso	Lead Consultant
	Phil Coates	Consultant Adult Diabetologist
	Karen Whitehead	Lead PDSN
	Amanda Carson	PDSN
	Emma Biddulph	Clinical Play Specialist
	Alison Kendrew	Dietitian
	Lucy Preston	Dietitian
	Sophie Burgess	Psychologist
	Jennie Binns	Administration
NHS England	Kate Burley	Quality Improvement Programme Lead, West Midlands Strategic Clinical Networks
North Staffordshire Combined Healthcare NHS Trust	Tracey Fallows	Children and Young People's Diabetes Nurse
The Royal Wolverhampton Hospitals NHS Trust	Nisha Pargass	Lead Consultant
	Rajesh Jayaraman	Consultant
	Gregory Minnaar	Consultant
	Gill Salt	Lead PDSN
	Jackie Shaw	PDSN
	Jennie Brown	Dietitian
	Nishti Ismail	Dietitian
	Garfield Holmes	Family Support Worker
	Karen Walker	Psychologist
	Deborah Deakin	Administration
	Jodie Robinson	Administration
Sandwell and West Birmingham Hospitals NHS Trust	Chizo Agwu	Lead Consultant
	Meenakshi Bandhakavi	Consultant
	Lizbeth Hudson	Lead PDSN
	Gail Higgins	PDSN
	Amanda Whitehouse	PDSN
	Gill Ashton	Dietitian
	Lorna Rows	Dietitian
	Ashley Reynolds	Psychologist
	Julie Oliver	Administration
	Lesley Jordan	Administration
Shrewsbury and Telford Hospital NHS Trust	Kathryn McCrea	Lead Consultant
	Rajesh Chidananswamy	Consultant
	Patricia Gibson	Consultant
	Ramachendran Rajendran	Associate Specialist
	Lynn Mander	Dietitian
Shropshire Community Health NHS Trust	Amanda Stephenson	Lead PDSN
	Beth Hughes	PDSN
	Sean Pettet	PDSN

	Nicola Collins	PDSN
	Suzanne Digwood	PDSN
	Abby Marr	Psychologist
	Clair May	Psychologist
South Warwickshire NHS Foundation Trust	Gillian Lyder	Lead Consultant
	Denise Main	Lead PDSN
	Amy Morgan	PDSN
	Alison Bone	Dietitian
	Linda Holland	General Manager- Women's and Children's Services
Walsall Healthcare NHS Trust	Muhammad Shabab Javed	Lead Consultant
	Bhashir Muhammad	Consultant
	Deepak Mittal	Paediatric Associate Specialist
	Deborah McCausland	Lead PDSN
	Beckie Wood	PDSN.
	Elaine Turner	Dietitian
	Elaine Finazzo	Administration
	Helen Gough	Service Manager
Worcester Acute Hospitals NHS Trust	John Scanlon	Lead Consultant for Worcester and Kidderminster
	Naeem Ahmad	Lead Consultant for Redditch
	Chantal Solan	Associate Specialist
	Diane Cluley	Lead PDSN
	Esther Anstey	PDSN
	Jane Francis	PDSN
	Victoria Howard	PDSN
	Tracey Kirkwood	PDSN
	Dorota Amador Bueno	Dietitian
	Sue Summers	Dietitian
	Catherine Binney	Psychologist
	Tracey Jansen	Psychologist
	Janice Kerr	Service Manager
University Hospitals Coventry and Warwickshire NHS Trust	Ambika Karthikeyan	Lead Consultant
	Heather Stirling	Consultant
	Sailesh Sankar	Adult Consultant Diabetologist
	Andy Orzechowska	Lead PDSN
	Rebecca Goodwin	PDSN
	Tanya O'Meara	PDSN
	Rebecca Van Ristell	PDSN
	Kim Swinhoe	Adult DSN
	Amy Poole	HCA and Data Manager
	Susan Cooper	Dietitian
	Judy Hughes	Dietitian
	Sarah Jarvis	Dietitian
Teresa Madurai	Psychologist	

University Hospital of North Staffordshire NHS Trust	Parakkal Raffeeq	Lead Consultant
	Uma Kumbattae	Consultant
	Dr Varughese	Adult Diabetologist
	Tracy Fallows	PDSN
	Jo Hankey	PDSN
	Joanne Moul	PDSN
	Marion Breslin	Dietitian
	Caroline Hill	Dietitian
	Charlotte Tolgyesi	Psychologist
	Carole Davies	Family Support Worker
	Catherine Morris	Community Service Manager

Appendix 4: CYPWMDN Terms of Reference

TERMS OF REFERENCE Agreed October 2014

The CYPWMDN will work to achieve the agreed aims and objectives by engaging with the full range of stakeholders including: Clinicians, Diabetes Nurses, Dietitians and Psychologists, Diabetes Service managers of member Trusts, Commissioners, Services Users, Women's and Children's Strategic Clinical Networks, the Research and Academic community, LEAs, the Voluntary Sector and local Networks/stakeholder groups where these exist.

Aims

- To raise the quality of paediatric diabetes care across the region; improving outcomes and quality of life for children and young people affected by diabetes, and their parents and carers.

Objectives

Clinical Care

- Ensure that access to care for children and young people with Diabetes is equitable across the region.
- To identify gaps in service, barriers and challenges to service improvement and approaches to address these.
- To work proactively with primary care clinicians to ensure care and outcomes improve in all settings.
- To improve support for Young People in transition from Children's to Adult services.
- To work towards providing the best patient/parent education available.

Clinical Targets

- To see year on year reductions in HbA1c in services across the region.
- To achieve year on year improvements in reducing hypoglycaemic incidents, microalbuminuria and other complications.
- To work towards all units delivering National Diabetes Audit returns.

Guidelines

- To develop region-wide guidelines for aspects of care not covered in national guidelines.
- To explore approaches to the provision of out of hours care.
- To provide network wide primary care guidance for identification and referral for suspected diabetes in Children and Young People.
- To develop suitable assessment approaches to understand the current state of care and inform this development.
- To endorse network-wide adoption of national guidelines for paediatric diabetes care.

Networking

- To share information, highlighting, celebrating and promoting best practice and disseminating new approaches.
- To provide peer support, advice and good counsel.
- To facilitate parent/ carer engagement with the network.
- To regularly link with the national networks group and share learning.

- To provide information and guidance and work collaboratively with commissioners to support improvement in quality and funding of paediatric diabetes care across the West Midlands.
- In conjunction with the national paediatric diabetes network group, strategic clinical network, West Midlands Maternity and Children's strategic clinical network and NHS IQ to work towards a consistent high quality model of care for England sensitive to, and meeting, both regional and local needs.

Projects

- To support all units in achieving Best Practice Tariff.
- To work towards development of a Regional Diabetes register.
- To address inequalities in provision for children with diabetes in schools.
- To provide an annual report on the work of the network to Member trusts and key stakeholders to include address of inequalities in care and improvements in outcome.

Network Structure and Membership

The network chair post will be held for a term of 3 years, and be determined by election. This term may be extended with agreement from network members.

The Chair will have the support of a core steering group consisting of 6 clinician representatives from different areas of the region, 2 Paediatric Diabetes specialist Nurses, 2 Paediatric Diabetes Dietitians, 2 Psychologist and at least one Parent Representative and the Network coordinator. This group will assist in compiling the agenda, informing the network members, leadership and participation in Network project groups, taking notes and following up actions.

The Network board will comprise the chair, network coordinator and steering group as well as the CCG representative, Primary Care representation, Adult diabetologists representative, LEA representation, Parent carer representation as well as other stakeholders (NHSIQ, SCN, NHSE representation and Diabetes UK).

Network membership will include all Paediatric diabetes team members in all member trusts, the Network Board and Medical trainee representative.

All member trusts will pay an annual membership fee to cover the costs of running the network.

Member Trusts are expected to provide representation (any paediatric diabetes team member) at each business meeting.

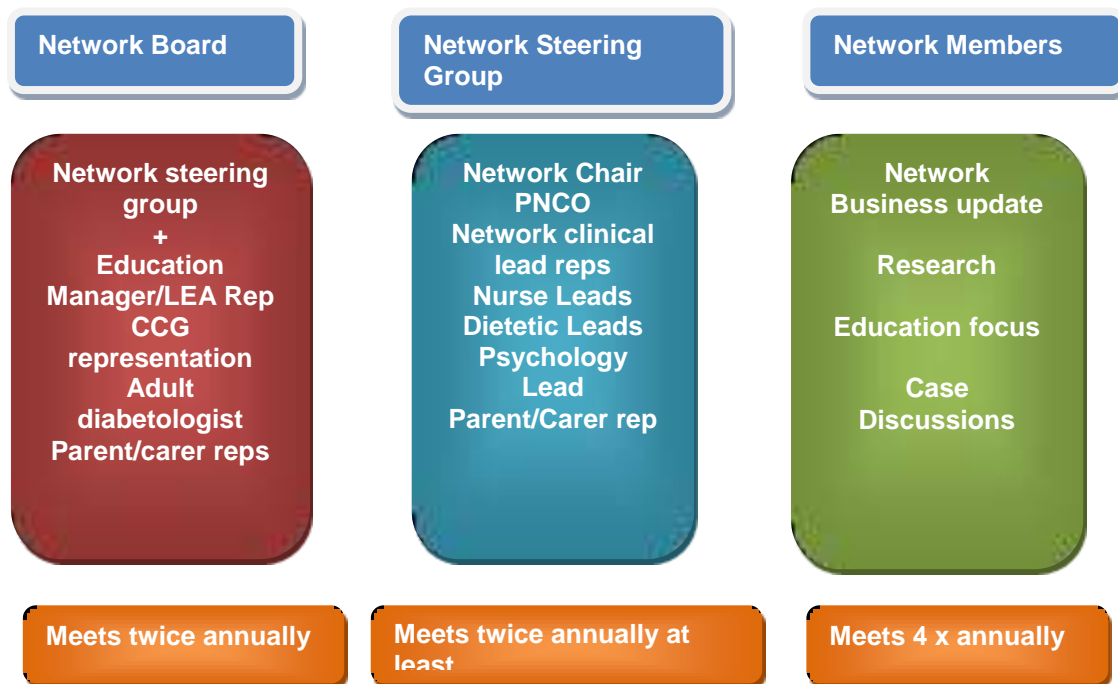
Meetings

Meetings will be held quarterly in to coincide with meetings of the Midlands Paediatric Endocrinology Group. Meetings will include the networks ongoing actions and business as well as selected expert speakers and opportunities to update each other, share news and network as appropriate to support members in their practice.

Support for venue and refreshment costs may be provided by sponsors as appropriate.

Meetings will be chaired by the network chair and minuted by the network coordinator. The structure and meeting frequency is set out below.

Network structure and meeting schedule



Accountability/Reporting:

The network will report to the National Paediatric Diabetes Network group, all member trusts, CCG clusters, NHSE and the strategic clinical network as appropriate. An annual report on the work of the network will be provided to Member trusts and key stakeholders to include address of inequalities in care and improvements in outcome.

Review

The network will review its role and terms of reference annually.