Re: Is the NHS Best Practice Tariff for Type 1 Diabetes Applicable in the Irish Context?

Abstract:
Sir,

We refer to the IMJ article “Is the NHS Best Practice Tariff for Type 1 Diabetes Applicable in the Irish Context?” 1, we commend the focus of this article, in highlighting the importance of tight metabolic control in the paediatric population, despite the intrinsic challenges childhood and adolescence present in this regard. We too, have recently completed an audit of our service for the year 2013 and have found it to be a worthwhile exercise. The recently published report on the Irish Childhood Diabetes National Register confirms Ireland as a high incidence area of Type 1 Diabetes, with the incidence rate for Ireland lying in the top quartile for Europe. Indeed the incidence of Type 1 Diabetes in the Irish paediatric population has increased substantially from 16.3 to 27.5 per 100,000 per year between 1997 and 2008. The Diabetes Control and Complications Trial and follow up studies indicate that, 5-7 years of poor glycaemic control, even during adolescence can result in an increased risk of micro- and macro-vascular complications in the subsequent decade. Hence reiterating the importance of intensive control in this population.

There are currently 140 patients with Type 1 Diabetes attending the Paediatric Diabetes Service at University Hospital Galway. Of these we identified 87 who satisfied the audit criteria, of having 12 months of complete data and having been diagnosed for >1 year. Mean age was 12 years with mean duration of diabetes being 5.82-2.95 years. Mean number of outpatient appointments attended was 2.90-1.16, while the mean number of patient-service interactions, including nurse-led appointments and telephone support was 8.82 (range 1-63). The majority were on a Multiple Daily Injection Regimen (85%), with 12 patients on Continuous Subcutaneous Insulin Infusion pumps (13.8%) and 1 patient receiving Twice-Daily injections of pre-mixed insulin. We compared glycaemic control in our cohort with the results of the recent NHS National Diabetes Paediatric Audit 2010-2011, with 6.9% of our cohort achieving the ISPAD recommended optimal HbA1c target of <58mmol/mol, compared to 15.8% of UK patients. While 60.9% of our patients had a HbA1c >58 and <80mmol/mol, and 32.1% had HbA1c >80mmol/mol, compared with 55.5% and 28.7% of UK patients respectively.

These results were obtained with a paediatric diabetes team composed of a <0.25 working time equivalent (WTE) consultant paediatrician with a special interest in paediatric endocrinology, a 0.5 WTE diabetes nurse specialist and a 0.1 WTE dietitian. Despite extreme diligence and commitment from our team, glycaemic control in our cohort remains suboptimal. We, also, find that inadequate resources in particular staffing levels are a barrier to more intensive diabetes management at this centre. It is well documented that increased multidisciplinary team resources correlate with improved glycaemic control1. We therefore must conclude, that in the current context of limited national resources, we find the conclusions of CP Hawkes and NP Murphy to be most pragmatic4. While it would undoubtedly be associated with increased requirements for patients to travel, regionalising care for children with type 1 diabetes must be considered.

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References