

STANDARD OPERATING PROCEDURE PSYCHOLOGICAL SUPPORT FOR CHILDREN AND THEIR FAMILIES FOLLOWING A DIAGNOSIS OF DIABETES

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VALIDITY – All local SOPS should be accessed via the Trust intranet

CHANGE RECORD

Version	Date	Change details
1.0	June 2023	New SOP. Approved at Divisional Governance Meeting (22 June 2023).

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1. Introduction

The newly diagnosed diabetes pathway has been part of the long-term health conditions work in Hull and East Riding since approximately 2018. The long term health conditions pathway sits within the children's neurodevelopmental team and consists of 1.6 WTE Clinical Psychologists, with a Clinical Team Lead in addition. There has been a national increase in diabetes diagnoses over recent years and the service is looking to use its limited resource in an effective and efficient manner.

National guidance (NICE Quality Standard QS125; Paediatric diabetes psychology standards, 2021) states that it is good practice for young people and their families to be offered timely access to information and emotional support following diagnosis and ongoing psychological support if required. The local Paediatric department are hoping to support young people and their families by making them aware of the availability of Psychological support within the first 6 weeks post-diagnosis.

The service has two different service specifications (Hull and East Riding). The proposed model would be applicable to both service specifications and therefore offer parity of care across Hull and East Riding for those newly diagnosed with diabetes. It is proposed that a group model of initial support for those diagnosed with diabetes and their families may support the initial adjustment to diagnosis in a timely manner, whilst not precluding future individualised work if needed.

2. Scope

This standard operating procedure would apply to those referred to the long-term health conditions team from the Paediatricians or diabetes nurses in Hull or East Riding where the young person has a Hull or East Riding GP.

Families will be offered a service based on their chronological order on the waiting list. There may be some occasions where it is felt most appropriate to allow a short wait for an appropriate group to be available for the family or young person (for example the group may only have two members and would have greater benefit if a short wait allowed for 3 more to attend). If this was the case, this would be discussed with the family referred.

3. Definitions

HUTH (Hull University Teaching Hospitals). This references the Trust who run the Paediatric department

LTHC (Long Term Health Conditions Team- Humber)

4. Duties and Responsibilities

Operational Manager

To support and facilitate the implementation of the SOP, to link in with the divisional operational team regarding any waiting lists or referral differences.

Clinical Team Lead

To screen referrals, facilitate the process of allocation to a group and to support the clinicians to request and adapt to feedback from the groups.

Consultant Clinical Psychologist

To support the service development within LTHC, supervise clinicians and support clinical governance of the service offer. To work in conjunction with the clinical team lead, clinicians and operational lead to achieve this.

Clinicians

To participate in the MDT where cases are discussed for appropriateness for intervention. To develop content of groups alongside participants. To adhere to the SOP and request feedback from interventions, adapting the offer based on feedback.

Administration Staff

To support the allocation of people to groups by sending appropriate communication and contacting families via telephone if considered clinically appropriate.

5. Process

Referrals are received via contact point and screened by the Clinical Team Lead. If accepted, they are discussed in the MDT and appropriateness for a group intervention considered.

Criteria for Group Intervention

Young people and families will be offered a group intervention if they are referred following being newly diagnosed with diabetes. This is likely to be within the first 3 months following diagnosis but may be later. They will be offered group intervention in all cases, unless specifically referred for individual work, or where the referral details safeguarding or risk features which would make managing these concerns challenging in a group situation.

A primary school age, teenage and parent group will be offered. Groups tailored to more specific ages or presentations may be developed dependent on need.

If the child is under 8 years old, the parents will be offered the group and contacted to see if their child also requires a session. If so, a individual family session will be offered.

Group Content

All groups will include the following, adapted for the audience:

- Introduction and confidentiality
- Journey to diagnosis
- Psychoeducation around adjustment to the diagnosis including acknowledgement of loss and grief
- Opportunities to discuss what is working well and what is difficult, along with possible management strategies
- Information about what work is offered by the service and how to refer

Location of groups may be online or in person if a suitable building can be sourced. The team are hoping to use a range of buildings to allow for those referred to access something in their local area.

Outcome Measures

The groups session rating scale (GSRS) will be used to evaluate groups and the information gathered used by the team to inform continuous improvement.

Post Group

The group is offered as a one session intervention. The young person and family will be discharged following the group with advice around how to contact the service in the future unless a need for family/ individual work is highlighted. This could include but is not limited to the following:

- A safeguarding need is identified – If this occurs the workers from the group will offer follow up to support management of this issue, before offering either individual work or discharge from the service in line with all safeguarding procedures.
- A therapeutic need is identified – if this is highlighted via comments in the group or discussions with clinicians as the group is finishing, a one-off consultation will be offered or the family will be placed on the waiting list for intervention.

Record Keeping

Records of group attendance will be documented in line with Trust policy and will include information about the individual's participation within the group.

6. Consultation

This SOP will be put forward for consideration with the clinical network. It will be considered with the diabetes team who would be referring into this service. We have attempted to ask young people with lived experience of diabetes to be involved in looking at this as well. At the time of contact, the Humber Youth Action Group had no members with lived experience of diabetes. The HUTH diabetes team did not have a patient forum that we could access. We therefore approached young people and their families already open to the service to see if they would be willing to share their views.

7. Implementation and Monitoring

Groups will begin to be offered to those currently on the waiting list for consultation following diagnosis of diabetes. When the waiting list has reduced, all those referred to the service for work following a diagnosis will be offered group initially. Feedback will be sought from the group participants and reviewed after each 'cohort'.

8. Training and Support

The groups will have two staff members to facilitate. One of whom will always have an appropriate professional qualification in order to manage risk. The second staff member may also be qualified but may also be a Trainee Clinical Psychologist or Assistant Psychologist.

All staff access line management from the Clinical Team Lead and clinical supervision from an appropriate Clinical Psychologist within the Neurodevelopmental Team.