Being a child and being diagnosed with type 1 diabetes means having to make huge adjustments to everyday life, and diagnosis sends shockwaves through the entire family. The diagnosis is the first step on a lifelong path. It is followed by many issues including coping with medication at school and managing any change to routine.

Diabetes is a serious condition that needs the very best quality of care from day one. It is vital that parents know what good-quality care is so they know what their child should receive. That’s why we’ve launched our guide, Type 1 Essentials for Children and Young People.

Good care includes having regular checks, access to the right treatments, care from a specialist team and getting appropriate, skilled care if admitted to hospital. It’s crucial that families are supported, encouraged to have a say in care received, and equipped with the knowledge and skills they need. Schools should be on board to support children with diabetes, the transition between child and adult services should be a smooth one and no child with diabetes should miss out on life’s opportunities because of this condition (see page 20 for the 10 key elements).

Although these may seem reasonable expectations, we know that no health authority is delivering what we would class as good care. In fact, the provision of care processes is significantly poorer for children with diabetes than for adults.

The National Diabetes Paediatric Audit (NPDA) figures do show small year-on-year improvements since its introduction eight years ago, but the overall picture in England and Wales is one of less than adequate care.

Only about one in 17 (6%) of infants, children and young people receive all eight recommended care processes. The latest NPDA revealed only 16% reach the HbA1c target of under 7.5% recommended by the National Institute for Health and Clinical Excellence, with a third of all infants, children and young people having unacceptable HbA1c levels of over 9.5%. There has also been a significant increase in levels of diabetic ketoacidosis since 2005. The stark fact is that we are one of the worst-performing countries in Europe in terms of blood glucose levels for children with diabetes.

Shouldn’t we be providing the best services at this stage? Shouldn’t we be empowering youngsters with type 1 diabetes and their families to manage care well enough to help avoid complications later in life?

Giving children good care could prevent the most serious complications of diabetes developing in young adults and provide foundations for good, lifelong diabetes management. Ultimately, this could reduce complications, costs and premature death.

We won’t stop campaigning until permanent improvements are made to care and services for children and young people, and until their expected health outcomes are as bright as the futures they deserve.

You can download the guide at www.diabetes.org.uk. Talk about it with colleagues, share it with patients and help us make sure that children and young people with type 1 diabetes get 10 out of 10 care. NT

Barbara Young is chief executive, Diabetes UK

As a child I spent car journeys in the back with my sister breathing in the thick fug from my parents smoking away in the front. I am not sure if my asthma was caused by it – but I can’t imagine it helped.

Two weeks ago the public health minister called for smoking in cars with children to be banned. I think it’s a good idea but it looks unlikely to go on the statute book any time soon. In the meantime, nurses can help parents to realise the harm that can be caused by second-hand smoke. It can be a difficult conversation to start with the assumption that it will not be well received and may damage the nurse/patient relationship.

The REFRESH initiative has produced a guide on how to tackle the subject. Turn to page 28 to find out more. I would have been grateful if someone had raised the issue with my parents.

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