Paediatric Diabetes Best Practice Tariff Criteria

In 2012-13 we will introduce a mandatory Best Practice Tariff (BPT) for paediatric diabetes. The BPT is to provide an annual payment for the treatment of every child and young person under the age of 19 with diabetes. The level of the tariff has been pitched at providing adequate funding for all patients, and a model of funding which enables access to consistent high quality care – regardless of where it is delivered.

Implementation, tariff structure and prices

In 2011-12 a new TFC, 263, was introduced for paediatric[1] diabetic medicine. This had a mandatory first outpatient tariff of £358 and a follow-up outpatient attendance tariff of £121. To incentivise best practice, the follow-up tariff was set to attract a non-mandatory additional payment of £148 per follow-up clinic consultation provided specific criteria (as referenced in the Payment by Results (PbR) Guidance for 2011-12) were met.

The new best practice tariff covers outpatient care as detailed in the criteria listed below, from the date of discharge from hospital after the initial diagnosis of diabetes is made, until the young person is transferred to adult services at the age of 19. It does not include the cost of insulin pumps, insulin pump consumables, or any inpatient care. Insulin and blood glucose testing strips prescribed as an emergency by the Specialist Team will be covered by the tariff. Routine prescriptions for insulin, blood glucose testing and ketone monitoring are issued in primary care and so are not part of the tariff

From April 2012, paediatric diabetes services will attract a BPT payment of £3189 per patient per year, for every child or young person under the age of 19 attending a paediatric diabetes clinic, provided certain strict criteria are met.

It is recognised that, initially, not all diabetes services will be able to qualify for the BPT as they may not be able to fulfil all the listed criteria. There will be a staged approach to the implementation of the BPT in the form of a transition year (2012-13) to give the opportunity for all diabetes services to improve. The care provided during this improvement phase will be reimbursed on a pre-BPT basis with a mandatory first outpatient attendance tariff and a follow-up outpatient attendance tariff.

Following the transition year, it is intended that the BPT will be fully implemented in 2013-14. It is very important that local general managers and commissioners are made aware of this so that appropriate arrangements can be made to ensure that local paediatric diabetes services are able to meet the criteria by 2013.

The BPT will be awarded provided the following criteria are met:

- On diagnosis, a young person with the diagnosis of diabetes is to be discussed with a senior member of paediatric diabetes team within 24 hours of presentation. A senior member is defined as a doctor or paediatric specialist nurse with 'appropriate training' in paediatric diabetes. Guidance as to what constitutes 'appropriately trained' is available from the British Society for Endocrinology and Diabetes, or the Royal College of Nursing.

- All new patients must be seen by a member of the specialist paediatric diabetes team on the next working day.

- Each provider unit can provide evidence that each patient has received a structured education programme, tailored to the child or young person's and their family's needs, both at the time of initial diagnosis and ongoing updates throughout the child or young person's attendance at the paediatric diabetes clinic.

- Each patient is offered a minimum of four clinic appointments per year with a multi-disciplinary team (MDT), i.e. a paediatric diabetes specialist nurse, dietician and doctor. The doctor should be a consultant or associate specialist/speciality doctor with training in paediatric diabetes or a specialist registrar training in paediatric diabetes, under the supervision of an appropriately trained consultant (see above). The dietician should be a paediatric dietician with training in diabetes (or equivalent appropriate experience).

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[1] Paediatric includes all children and young people up to their 19th birthday.

- Each patient is offered additional contacts by the diabetes specialist team for check ups, telephone contacts, school visits, e-mails, trouble shooting, advice, support etc. Eight contacts per year are recommended as a minimum.

- Each patient is offered at least one additional appointment per year with a paediatric dietician with training in diabetes (or equivalent appropriate experience).

- Each patient is offered a minimum of four haemoglobin HbA1C measurements per year. All results should be available and recorded at each MDT clinic appointment.

- All eligible patients should be offered annual screening as recommended by current NICE guidance[2]. Retinopathy screening should be performed by regional screening services in line with the national retinopathy screening programme, which is not covered by the paediatric diabetes best practice tariff and is funded separately. Where retinopathy is identified, timely and appropriate referral to ophthalmology should be provided by the regional screening programme.

- Each patient should have an annual assessment by their MDT as to whether input to their care by a clinical psychology input is needed, and access to psychological support as appropriate.

- Each provider must participate in the annual Paediatric National Diabetes Audit.

- Each provider must actively participate in the local Paediatric Diabetes Network. A minimum of 60% attendance at regional network meetings needs to be demonstrated.

- Each provider unit must provide patients and their families with 24 hour access to advice on diabetes management. This should also include 24 hour advice to fellow health professionals on the management of patients with diabetes admitted acutely, with a clear escalation policy as to when further advice on managing diabetes emergencies should be sought.

- Each provider unit must have a clear policy for transition to adult services.

- Each unit will have an Operational Policy, which should include within it a structured 'high HbA1C' policy, a clearly defined DNA/was not brought policy taking into account local safeguarding children board (LSB) policies and evidence of patient feedback on the service.

Commissioners will monitor compliance with these criteria via locally negotiated contracts, which may include local records of clinic attendances, local education programme etc. It is expected that patient and public involvement (PPI) is used as part of this feedback and monitoring process. It is expected that compliance with all criteria will need to be demonstrated for at least 90% of patients attending the clinic.

Commissioners may wish to consult the Child and Maternity Health Observatory website (via the YHPHO website: www.yhpho.org.uk.), or the National Paediatric Diabetes Audit to obtain information regarding paediatric admission rates after the BPT is fully operational.

If a patient is referred elsewhere for a second opinion, shared care or full transfer of care, subsequent division of funding will need to be agreed between the referring and receiving centres using a service level agreement (SLA). The precise division of funding will need to be negotiated on a local level.

These criteria are underpinned by:

> DH guidance: *Making every young person with diabetes matter*[3];
> NICE guidance: *CG15: Diagnosis and management of type 1 diabetes in children, young people and adults*[4] and *TA151 Diabetes – insulin pump therapy*; and
> NHS Diabetes guidance: *Commissioning services for children and young people with diabetes*[5].

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[2] CG15 Diagnosis and management of type 1 diabetes in children, young people and adults (July 2004), available at www.nice.org.uk/CG15 and TA151 Diabetes - insulin pump therapy (July 2008), available at www.nice.org.uk/TA151
[3] www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073674
[4] www.nice.org.uk/CG15
[5] www.diabetes.nhs.uk/commissioning_resource/