Paediatric Diabetes Best Practice Tariff Criteria

The mandatory Best Practice Tariff (BPT) for paediatric diabetes was introduced in 2012-13. 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 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 best practice tariff now 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 also includes inpatient admissions for management of diabetes for these young people (since 2014-15). Providers will no longer be reimbursed separately for these admissions. They will continue to be reimbursed for admissions for these young people that are not related to diabetes. It does not include the cost of insulin pumps or insulin pump consumables. Patient education associated with the use of insulin pumps is, however, included in the BPT whether provided in outpatients or as a day case. 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.

Paediatric diabetes services will attract a fixed BPT payment 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. For 2014/15 the value is £2988.

The annual value and criteria for the BPT is decided by NHS England and Monitor. The current value and criteria, as outlined below, are available from Monitor.

Best practice tariff criteria
a) 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;

b) All new patients must be seen by a member of the specialist paediatric diabetes team on the next working day;

c) 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;

d) 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, dietitian and doctor. The doctor must 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 dietitian must be a paediatric dietitian with training in diabetes (or equivalent appropriate experience);

e) Each patient is offered additional contact by the diabetes specialist team for check ups, telephone contacts, school visits, troubleshooting, advice, support etc. Eight contacts per year are recommended as a minimum;

f) Each patient is offered at least one additional appointment per year with a paediatric dietitian with training in diabetes (or equivalent appropriate experience);

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

h) All eligible patients must be offered annual screening as recommended by current NICE guidance.34 Retinopathy screening must be performed by regional screening services in line with the national retinopathy screening programme, which is not covered by the paediatric diabetes BPT and is funded separately. Where retinopathy is identified, timely and appropriate referral to ophthalmology must be provided by the regional screening programme;

i) Each patient must have an annual assessment by their MDT as to whether input to their care by a clinical psychologist is needed, and access to psychological support, which should be integral to the team, as appropriate;

j) Each provider must participate in the annual Paediatric National Diabetes Audit;

k) Each provider must actively participate in the local Paediatric Diabetes Network. A contribution to the funding of the network administrator will be required. A minimum of 60% attendance at regional network meetings needs to be demonstrated. They should also participate in peer review;

l) Each provider unit must provide patients and their families with 24 hour access to advice and support. This should also include 24 hour expert 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. A provider of expert advice must be fully trained and experienced in managing paediatric diabetes emergencies;

m) Each provider unit must have a clear policy for transition to adult services; and
n) Each unit will have an operational policy, which must include 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.

**Tariff payment**

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.

Where commissioners are satisfied that the standards have been achieved, the BPT must be paid for all the young people attending the clinic.

If a provider admits a young person who is not registered with them, they must invoice the provider with whom the young person is registered. If the young person is not registered with a provider, the admitting provider must invoice the relevant commissioner.

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 National Paediatric Diabetes Audit to obtain information regarding paediatric admission rates after the BPT.

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.