

# Paediatric Diabetes Best Practice Tariff Criteria – for paediatric diabetes units in England A brief guide Updated November 2017 V2

This brief guide sets out for clinicians the current situation with respect to funding by NHS England for paediatric diabetes care and applies to paediatric diabetes services in **England only**. Since 2012-13<sup>1</sup> a mandated Best Practice Tariff (BPT) has applied to paediatric diabetes. The tariff payment is set at a level to enable access by patients to consistent, high quality management of their diabetes regardless of where it is delivered.

## Implementation, tariff structure and prices

The BPT is an annual payment that covers outpatient care from the date of discharge from hospital after the initial diagnosis until the patient is transferred to adult services at the age of 19. It is a national price for paediatric diabetes units in England that is designed to incentivise high quality and cost-effective care. The aim is to reduce unexplained variation in clinical quality and to encourage best practice. The price differential between best practice and usual care is calculated to ensure that the expected costs of undertaking best practice are reflected and to create an incentive for providers to shift from usual care to best practice.

To receive the BPT payment ([currently set at £2,927 per patient year of care](#)) Trusts must demonstrate that they have met strict, defined criteria set by NHS England. These criteria are updated every two years and reflect NICE guidance, professional standards and accepted evidence.

Units that fail to meet the criteria will not receive the BPT but instead be subject to the Payment by Results tariff [TFC 263, paediatric diabetic medicine](#), which currently has a mandatory first MDT outpatient tariff of £343 (£194 single professional) and a follow-up outpatient attendance tariff of £178/£170.

Whilst BPT applies to a range of specialist services across the NHS, the design and selection of the criteria to be met varies significantly to reflect the contributing factors and those deemed to be both possible to achieve and which can be demonstrated to result in improvement.

The current tariff criteria for paediatric diabetes were consulted upon from July to September 2016 for implementation from April 2017, and were little changed from the previous set. The next [round of consultation](#) will take place in July 2018 for implementation in April 2019.

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<sup>1</sup> Full implementation in 2013-4

## Criteria to be achieved

The BPT criteria for 2017-9 are set out in [published guidance](#) by NHS Improvement.

Local Commissioners Groups in England are expected to monitor compliance with the criteria through terms in local negotiated contracts in order to approve release to the Trust of the full tariff sum. The approach to this verification process varies with some CCGs requiring detailed evidence of compliance and others taking a more pragmatic view within the overall commissioning contact negotiations.

Diabetes services have been aware of these published criteria since 2012, and almost all services are now claiming Best Practice Tariff. Increasingly there is an expectation from NHS Improvement that compliance with the criteria is clearly evidenced by every Trust to demonstrate reduced variation in care and improved outcomes for children and young people. Those Trusts that cannot demonstrate compliance to their CCG contracts team risk losing the full tariff and reverting to receiving the reduced Payment by Results tariff until all the criteria are met.

## Action required

It is therefore very important that Paediatric Diabetes Units can demonstrate compliance with the criteria below. Where this cannot be evidenced it is important that local general managers and contract teams are made aware urgently of the risk to ongoing funding and the actions needed to comply.

Criteria 2017-9	
a.	On diagnosis, a young person's diabetes is to be discussed with a senior member of the 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. Information on what constitutes 'appropriately trained' is available from the <a href="#">British Society for Paediatric Endocrinology and Diabetes</a> <sup>2</sup> or the <a href="#">Royal College of Nursing</a> . <sup>3</sup>
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 their needs and their family's needs, both at initial diagnosis and at ongoing updates throughout their attendance at the paediatric diabetes clinic.

<sup>2</sup> <http://www.bsped.org.uk/about/index.aspx>

<sup>3</sup> <https://www.rcn.org.uk/library/subject-guides/children-and-young-people-childrens-endocrine>

d.	Each patient is offered a minimum of four clinic appointments per year with a multidisciplinary team (MDT), defined as including a paediatric diabetes specialist nurse, dietitian and doctor. At every visit, the patient must be seen by the doctor <sup>4</sup> , who must be a consultant or associate specialist/specialty 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 <a href="#">current NICE guidance</a> . <sup>5</sup> 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 be annually assessed by their MDT for whether they need care from a clinical psychologist and access to psychological support, which the MDT itself should be able to provide.
j.	Each provider must participate in the annual National Paediatric Diabetes Audit.
k.	Each provider must actively participate in the local paediatric diabetes network. They must contribute to funding the network administrator, and show they attended at least 60% of regional network meetings. They should also participate in peer review.
l.	Each provider unit must give patients and their families 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 on 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.
n.	Each unit will have an operational policy, which must include a structured 'high HbA1C' policy, a clearly defined 'did not attend/was not brought' policy, taking into account local safeguarding children board policies, and evidence of patient feedback on the service.

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<sup>4</sup> The requirement to see a doctor at every visit was an addition for the 2015-16 iteration of the BPT, but this was not widely consulted upon. In all other aspects there was a 'roll over' of Paediatric Diabetes BPT from the 2013/14 edition.

<sup>5</sup> <https://www.nice.org.uk/guidance/conditions-and-diseases/diabetes-and-other-endocrinal--nutritional-and-metabolic-conditions/diabetes>