

Know your PBRs – it maybe your only funding stream



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April 2011 saw the transitional arrangements of the NHS reforms with changes in PCTs and funding streams in the NHS. Many paediatric diabetes services still sit within acute paediatric services and will therefore have to pay their way within this current financial climate. Commissioners, whether PCT- or practice-based, will need to understand service delivery and will have to monitor compliance of the Payment by Results (PBR) tariffs via local agreements.

From April this year, a non-mandatory tariff was put in place for paediatric diabetes services (Department of Health [DH], 2011). This tariff is to incentivise best practice with a mandatory first outpatient attendance tariff of £358 and a follow-up outpatient tariff of £121. There will also be an additional payment of £148 per clinic visit providing several criteria are met. The criteria that have been proposed by the DH were developed using NICE (2004) clinical guidelines and previous DH (2007a; 2007b) reports.

The initial draft document (DH, 2011) recommends that a young person with diabetes should be seen by a senior member of the paediatric diabetes team within 24 hours of diagnosis. This would be ideal, but many paediatric teams are run part-time. Thus, this has now been modified to be discussed within 24 hours and seen on the next working day, which seems more realistic. However, it is highly unlikely that staff will be paid on-call, and this service will rely on the good nature of staff.

The recommendation that the young person with diabetes should have a minimum of four clinic appointments per year with the multidisciplinary team and the inclusion of the definition of the team, within the document (DH, 2011), will be welcomed by those who have struggled to obtain designated paediatric dietetic time, specifically for paediatric diabetes. Teams that may have problems with clinic capacity, owing to the number of children and young people being diagnosed, may be able to

put forward a case for more clinic time or more staff as the tariff facilitates service evaluation and gap analysis. The stipulation for HbA_{1c} level results to be made available in clinic with at least four readings per year could require some teams to purchase point-of-care equipment, which may be difficult as business cases may have to be made for the purchase of such equipment. However, many of these requirements are not unobtainable and we should all be striving to achieve these minimum standards of care.

The tariff also suggests eight, 15-minute contacts by other team members (e.g. check-ups, telephone contacts and school visits) per year. As we healthcare professionals are aware, there are a number of our patients who take up the majority of our time and the key will be capturing all this information within hospital systems and ensuring other patients receive equal support.

The emotional wellbeing of children and young people has been formally recognised by the requirement for annual psychological assessment and access to psychological support as appropriate. It is unclear how this should be measured, and by whom, and further guidance would be welcomed by many teams.

In this month's supplement, O'Brien et al consider the effects of mothers' dieting patterns on disordered eating behaviours in young adolescent females. We are all acutely aware that young people with diabetes can have atypical eating disorders. Diabetes UK have coined the phrase "diabulimia" (see <http://bit.ly/kFxazH>) to try to explain to young people the effects of deliberately missing insulin doses to lose weight. However, with poorer metabolic control in this group, it is important to try to understand the trigger factors for such behaviour to enable appropriate psychological support to be provided. The interesting findings reported in this article on what may be a difficult subject to discuss point to more family-based interventions being the way forward. ■