

# Paediatric diabetes teams struggle to secure due funding



*Anna Morton*

Many paediatric diabetes units in England are struggling to secure the extra funding made available in April by a new Best Practice Tariff, despite meeting its mandatory standards. The “Best Practice Tariff for Paediatric Diabetes” sets out 13 areas of care that must be met for teams to qualify for greater financing. From April 2013, services not meeting the tariff standards will be unable to claim any funding from local commissioners to provide their children and young people diabetes service.

It has been available for trusts to claim from April 2012. Each unit will receive £3189 per annum per child registered with the diabetes team up until their 19<sup>th</sup> birthday (plus an adjustment for market forces factor). This represents a significant increase in funding for the service to this particularly vulnerable group.

For nurses, this funding will ensure more and better care for children and young people with diabetes through the additional resources it should create. This will mean more specialist care to alleviate the burgeoning workload on ward nurses and, in theory, more opportunities for specialists. However, many paediatric diabetes teams are reporting back to us that commissioning groups are looking for loopholes not to have to pay the tariff, while others claim they do not have the necessary funding available.

My clinical colleague Dr Fiona Campbell, Paediatric Network Clinical Lead and Consultant Paediatrician at Leeds, believes providers are either unaware the standards are mandatory, are finding reasons – just or unjust – not to pay, or believe it unlikely units will face closure or merger if the benchmarks are not met by next year. This is extremely disappointing considering units are working hard to achieve the criteria under the current budget constraints.

By definition, those units who cannot provide evidence to show they have met Best Practice

Tariff standards will not be delivering sufficient quality care to their patients. As a result, local commissioners will need to consider making alternative provider arrangements for those patients. This will necessitate negotiations with a provider organisation that can provide evidence that they are delivering diabetes care to the tariff standards. This move will be with the tariff at its full value, representing a significant financial loss. For example, moving a clinic of 160 registered children would result in the transfer of £510 240 in funding to the receiving trust.

Against this background, I wrote a letter in September to paediatric diabetes service providers asking for an update on the new tariff. I formally asked for an update on how trusts were proceeding in gaining the tariff and urged service providers to contact our regional paediatric network coordinator and network clinical leads for assistance.

At NHS Diabetes, we provide the essential link between diabetes strategy and frontline improvements for patients. Through our integrated work programmes, we provide national leadership and direction, as well as support to local organisations working to champion excellent diabetes care.

Through our remit, we will continue to work with commissioners to ensure standards are met by April 2013 and that those paediatric teams working at the required standards receive the funding they are due. Finally, I would like to take this opportunity to call for all nurses involved in the support and care of children and young people with diabetes to join the NHS Diabetes paediatric diabetes network to ensure sharing of good practice, up-to-date guidance and education tools.

For more information about the Best Practice Tariff and how to join the paediatric diabetes network, email Marie Cummins at [marie.cummins@diabetes.nhs.uk](mailto:marie.cummins@diabetes.nhs.uk). ■

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