Children and Young People's National Diabetes Network

Delivery Plan to 2030

Foreword

by

Dr Fiona Campbell OBE, MD, FRCPCH - Clinical Lead

Introduction

I am pleased to introduce the Children and Young People's National Diabetes Network (CYPNDN) Delivery Plan. This plan sets out the strategic direction and operational framework for improving diabetes care and outcomes for children and young people across England and Wales to 2030. Building on the achievements of the 2020–2025 Delivery Plan, the CYPNDN is committed to ensuring that every child and young person with diabetes receives high-quality, equitable and joined-up care, regardless of where they live.

The Delivery Plan is intended to guide networks, services and partner organisations in aligning improvement activity, strengthening accountability and focusing collective effort on the priorities that will make the greatest difference for children, young people and families.

Background and Rationale

Since its establishment in 2010, CYPNDN has played a pivotal role in reducing variation in paediatric diabetes care, improving clinical outcomes and increasing access to diabetes technology. The network brings together healthcare professionals, families and partners, including NHS England, NHS Wales, the Royal College of Paediatrics, DigiBete, Diabetes UK, Breakthrough T1D and others, to drive system-wide improvement through collaboration, shared learning and data-led approaches.

Despite this progress, significant challenges remain. The prevalence of diabetes among children and young people has increased by 16% since 2018/19, according to national audit data. Outcomes continue to lag those in some European countries, and persistent variation remains between diabetes centres, linked to geography, socio-economic status and ethnicity. Services are also facing substantial workforce pressures. Stronger integration with education and social care, alongside closer collaboration with young adult diabetes services, will improve transition and other priority areas.

Vision and Mission

Our vision is for all children and young people with diabetes to achieve the best possible health outcomes and quality of life, supported by consistent, equitable care. Our mission is to strengthen diabetes services through national leadership, collaboration and continuous improvement, ensuring that the voices of children, young people and families shape service design and delivery.

Strategic Approach

This Delivery Plan is structured around eight dedicated workstreams. It builds on previous progress while introducing new programmes of work to address emerging priorities. Each workstream addresses specific challenges, with a focus on reducing unwarranted variation and embeds equity across all activities. Cross-cutting themes include tackling inequalities and strengthening the voices of patients and families.

The Delivery Plan draws on robust data from the National Paediatric Diabetes Audit (NPDA) and the National Diabetes Audit (NDA), alongside recommendations from the national quality improvement programme Getting It Right First Time (GIRFT) and NICE Guidance relating to children and young people's diabetes care. All our work will be underpinned by the NHS Diabetes Digibete App to support diabetes self-management and structured education and its healthcare and use of digital resources.

The eight workstreams are:

- Schools and Social Care.
- Optimising Diabetes Care and Treatment.
- DKA Prevention.
- Early-Stage Type 1 Diabetes.
- Type 2 Diabetes.
- Teenage and Young Adult Care.
- Workforce and Speciality Leadership.
- Type 1 Diabetes and Disordered Eating.

Partnership and Governance

A robust network structure, multi-disciplinary specialty groups and strong engagement with families, young people and voluntary sector partners will support delivery. The plan aligns with national strategies in England and Wales and supports coordinated action across health, education and social care.

Looking Ahead

Through this Delivery Plan, CYPNDN aims to:

- Reduce variation in care and outcomes.
- Continue to address health inequalities.
- Strengthen workforce capacity and capability.
- Improve the transition of older teenagers to young adult services.
- Encourage good working relationships between partners in education and social care.
- Ensure meaningful involvement of children, young people and families in all that we do.

We hope that you find this Delivery Plan helpful to guide your future planning for children and young people's diabetes care. The work of the CYPNDN has been invaluable to date and I would like to wholeheartedly thank each and every person who has supported our endeavour to date and will do so in the future.

Dr Fiona Campbell OBE, MD, FRCPCH

Clinical Lead
National Children and Young People's Diabetes Network

23rd July 2026

About Us

The Children and Young People's Diabetes Network (CYPNDN) brings together professionals, families and partners to reduce variation, improve outcomes, and ensure every child and young person with diabetes receives high-quality, joined-up care.

Our Vision

Children and young people with diabetes achieve the best possible health outcomes and quality of life, supported by consistent, equitable care wherever they live.

Our Mission

To strengthen diabetes services for children and young people through collaboration, shared learning, data-driven improvement and national leadership.

Working in Partnership

With NHS England, NHS Wales, regional networks, Royal College of Paediatrics, DigiBete, Diabetes UK, Breakthrough T1D and research organisations, to deliver coordinated, system-wide improvement.

Working with Families & Young People

We ensure the voices of children, young people and families shape services, care pathways and future priorities.

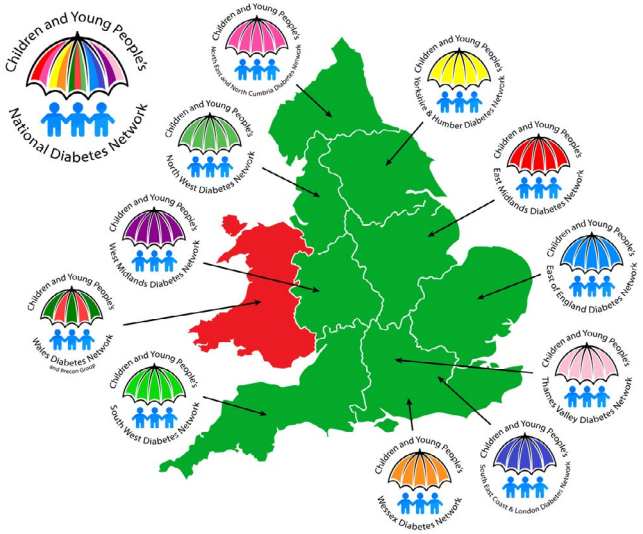
Children & Young People's National Diabetes Network: Progress and Impact

"CYPNDN exists to connect, support, and strengthen diabetes services so that every child and young person receives high-quality, equitable care, now and in the future."

Established in

2010

The Children & Young People's National Diabetes Network (CYPNDN) was created to address significant variation in paediatric diabetes care across England and Wales. At the time, outcomes lagged European benchmarks, and national leadership was needed to improve consistency and quality.



Impact

- **Improved clinical outcomes**, including better HbA1c levels.
- **Increased access to diabetes technology** across services.
- **Reduction in some health inequalities**.
- Over the past five years, the **national median HbA1c** has moved closer to the **NICE target of 48mmol/mol.**

Key Achievements

- **Regional CYP Diabetes Networks expanded** to strengthen local and regional support.
- **National Paediatric Diabetes Audit (NPDA)** data used to drive continuous improvement.
- **Best Practice Tariff and national quality programmes** introduced to standardise care.
- **ICB-level GIRFT reviews** integrated to support children, young people, and young adults.

Ongoing Challenges

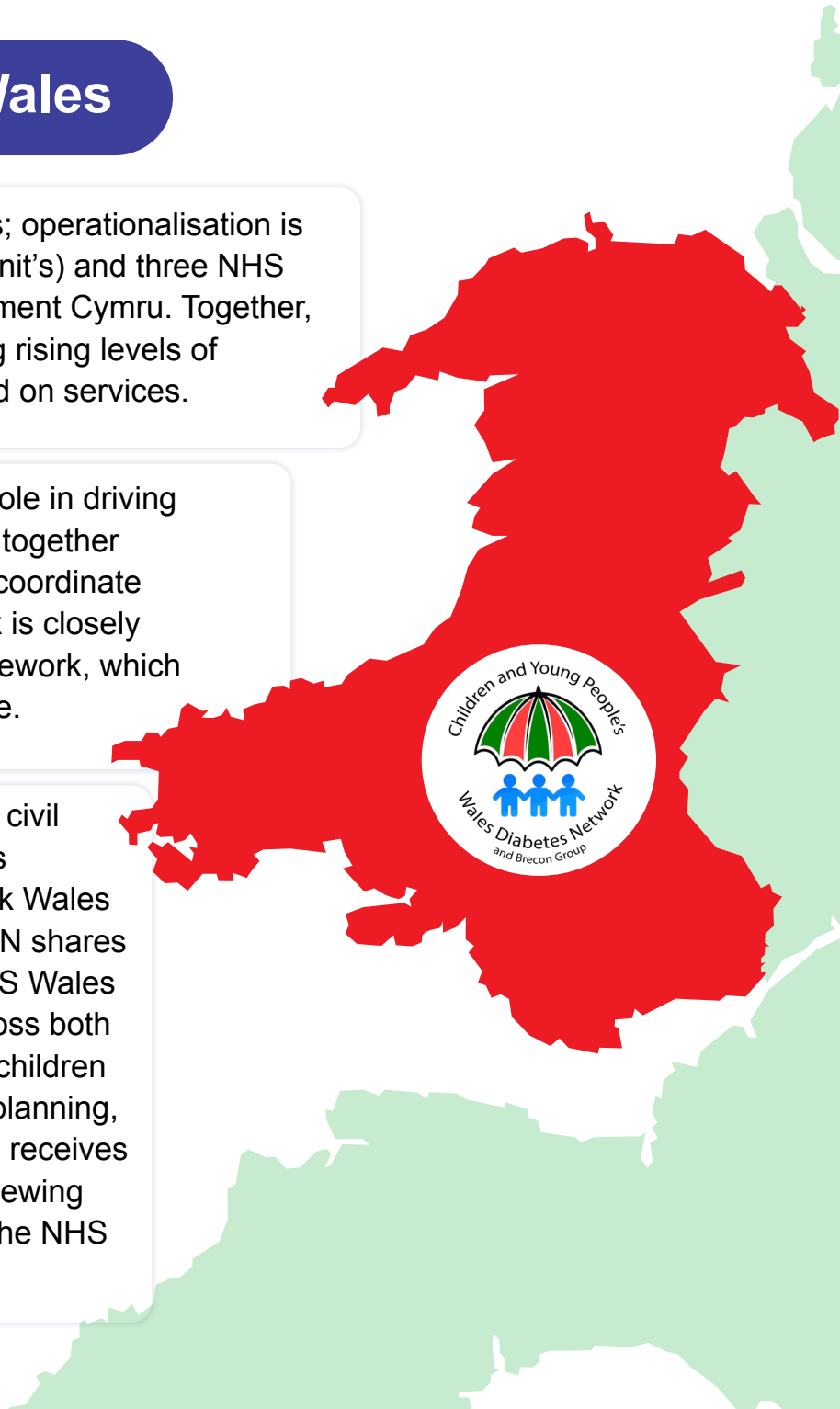
- Outcomes lag some European countries.
- **Variation persists** across geography and socio-economic groups.
- Workforce pressures and service integration remain priorities.
- Transition to adult care and holistic support (psychological, education, social care) require further attention.

The Landscape in Wales

The system in Wales is strategically led from Welsh government via NHS Wales; operationalisation is delivered through seven Health Boards (6 of which have Paediatric Diabetes Unit's) and three NHS Trusts, supported by national bodies such as Public Health Wales and Improvement Cymru. Together, they work to address the country's significant public health challenges, including rising levels of chronic conditions, widening socio-economic disparities, and increasing demand on services.

Within this landscape, the National Diabetes Strategic Network plays a central role in driving improvement, consistency, and innovation in diabetes care. The network brings together clinicians, service leaders, people living with diabetes, and national partners to coordinate pathways, share best practice, and monitor performance across Wales. Its work is closely aligned with national quality statements and the NHS Wales Performance Framework, which emphasise prevention, early detection, and equitable access to high-quality care.

The National Diabetes Strategic Network reports through to Welsh Government civil servants. The governance framework is currently being reviewed by NHS Wales Performance and Improvement. As part of this the CYP Wales Diabetes Network Wales position within the wider framework is also under review. Currently, the CYPWDN shares reports with the National Diabetes Strategic Network and is aligned with the NHS Wales national plan. Together, these structures help ensure that diabetes services across both paediatric and adult pathways are continually evaluated and strengthened. For children and young people, this means a growing focus on early intervention, transition planning, and reducing unwarranted variation, ensuring that every young person in Wales receives timely, coordinated, and person-centred support. The CYPWDN is currently reviewing our internal terms of reference and organisational structure prior to dovetailing the NHS Wales and National CYP Diabetes Delivery plan to ensure alignment.



Status Report: CYP Diabetes in England and Wales

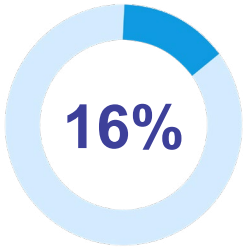
Diabetes in Numbers

33,433

There were 33,433 children and young people with Type 1 Diabetes being managed within PDU's in England and Wales in the 2024/25 National Paediatric Diabetes Audit.

58.0
mmol/mol

National median HbA1c fell from 60.0 mmol/mol to 58.0 mmol/mol between 2023/24 and 2024/25.

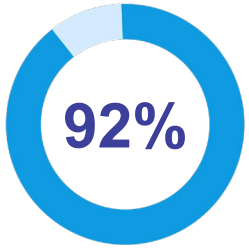


Incidence and Prevalence

While the incidence of paediatric diabetes in 2023/24 has returned to near pre-COVID-19 levels, the overall prevalence of children and young people (CYP) with diabetes managed in Paediatric Diabetes Units (PDUs) across England and Wales has increased by **16% since 2018/19**.

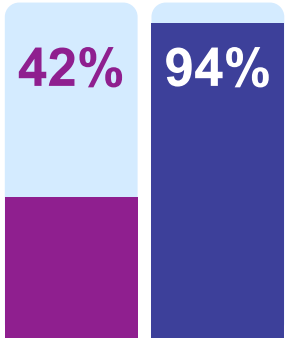
Clinical Outcomes

Despite reductions in HbA1c and increased uptake of diabetes technologies, improvements in national rates of microvascular and macrovascular complications have been limited.



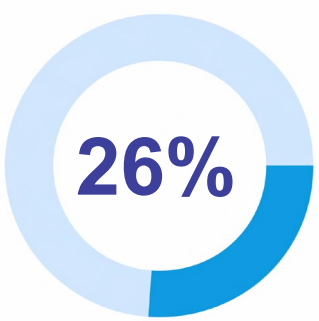
Care Processes

Completion rates for Type 1 diabetes health checks remain high nationally, with **92% of expected checks delivered**. However, significant variation persists between PDUs, ranging from **75% to 100%**.



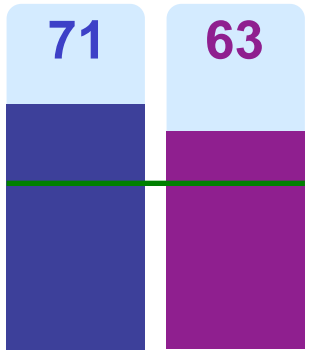
Weight Management:

94% of CYP with **Type 2 diabetes** have a BMI in the overweight or obese range, compared to 42% of those with **Type 1 diabetes.**



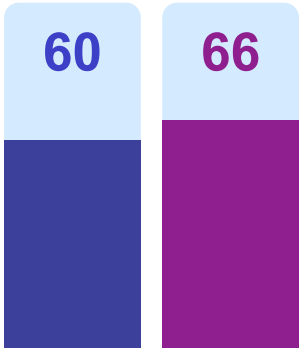
Hospital Admissions and DKA

Post-diagnosis hospital admission rates remain a challenge, and the incidence of diabetic ketoacidosis (DKA) at diagnosis of Type 1 diabetes remains at **26%**.



HbA1c Ethnicity:

Ethnicity: Mean HbA1c for Black CYP with Type 1 diabetes increased to **71.0 mmol/mol** (from 70.0 mmol/mol in 2022/23), compared to **63.0 mmol/mol** for White CYP.



HbA1c Deprivation:

The HbA1c gap between the most and least deprived quintiles remains unchanged at **66.0 mmol/mol** vs. **60.0 mmol/mol**.

Performance Monitoring:

The NPDA quarterly dashboard remains a critical tool for benchmarking and quality improvement, with the national median HbA1c at **56 mmol/mol (Q4 2024/25).**

Technology Access:

Uptake of rtCGM, insulin pumps, and Hybrid Closed Loop systems is lower among ethnic minority groups and those in deprived areas.

Technology Adoption:

Technology Adoption: Use of diabetes-related technologies, including insulin pumps and continuous glucose monitoring, continues to rise. Advanced technologies such as Hybrid Closed Loop systems are associated with **lower HbA1c levels.**

Core Foundations for Future Development

Since its launch in England in 2010 and expansion to Wales in 2015, the Children and Young People's National Diabetes Network (CYPNDN), working closely with families, has been shaping, standardising, and improving diabetes care for children and young people nationwide. The following programmes and guidance represent key resources that underpin this work and support consistent, evidence-based practice across England and Wales.

1 10 year Health Plan 'Fit for the Future'

The NHS Long Term Plan sets out a vision for redesigning health services for children and young people, with a strong emphasis on improving care for those with long-term conditions, including diabetes. Central to this vision are three strategic shifts in healthcare delivery:

- From hospital to community.
- From analogue to digital.
- From sickness to prevention.

These principles will underpin future planning and delivery of paediatric diabetes services.

2 NHS Core20PLUS5

NHS Core20PLUS5 is NHS England's national framework for reducing health inequalities, identifying priority populations and five clinical areas for accelerated improvement.

Within the Children and Young People's Core20PLUS5 programme, diabetes is a 'PLUS5' priority. Focusing on equitable access to diabetes technology and delivery of key care processes for children and young people with Type 2 diabetes.

3 National Paediatric Diabetes Audit

The National Paediatric Diabetes Audit (NPDA), delivered by the Royal College of Paediatrics and Child Health, provides comprehensive benchmarking data for all Paediatric Diabetes Units (PDUs) across England and Wales.

With 100% participation and quarterly reporting of key metrics introduced in 2024, the PDA supports service improvement, outcome monitoring, and the sharing of best practice.

Core Foundations for Future Development

4 Best Practice Tariff

In England, the Best Practice Tariff (BPT) provides an annual incentive payment for the care of children and young people under 19 with diabetes, rewarding services that meet defined quality standards.

However, accurate identification and allocation of BPT funding remains challenging for many teams.

5 Right Care Tool Kit

Published in 2024 by NHS England's National Children and Young Adults Programme, the Right Care Toolkit provides a structured framework to support Integrated Care Systems (ICSs) in planning and delivering high-quality diabetes care for children and young adults aged 0-25 years.

6 Getting It Right First Time (GIRFT)

Getting It Right First Time (GIRFT) is a national NHS England programme that improves care through detailed service reviews.

For the first time, GIRFT has reviewed children and young adult diabetes services, identifying unwarranted variation across and within ICSs and producing actionable recommendations for improvement.

7 CYPNDN Delivery Plan

The CYPNDN Delivery Plan 2020-2025 focused on four priorities: standardised care, access to technology, workforce development, and the voice of parents, children, and young people.

Using the established CYP Diabetes Network, the plan brought together professionals, support staff, and families to collaboratively address these challenges.

Strategy

Our Strategic Role

CYPNDN supports diabetes services and system partners by:

- Reducing unwarranted variation across Paediatric Diabetes Units (PDUs) and Integrated Care Boards (ICBs) through ongoing evaluation and benchmarking.
- Using national data, including the National Paediatric Diabetes Audit (NPDA) and quarterly dashboards, to drive continuous quality improvement.
- Supporting PDUs to engage with national programmes and deliver high-quality care using structured improvement methodologies.
- Promoting consistent standards of care, including universal adoption of the Best Practice Tariff Service Specification.
- Sharing best practice and supporting standardisation across local, regional, and national networks.
- Providing expert insight into national priorities, service gaps, and future implementation needs.
- Supporting system partners, including ICBs, to deliver improvements aligned with GIRFT recommendations.

The Challenge We Are Addressing

Despite significant progress, challenges remain. These include:

- Persistent variation in outcomes linked to geography and deprivation.
- Workforce capacity and sustainability pressures.
- Inequitable access to psychological, education, and social care support.
- Fragmented pathways, particularly during transition to adult services.

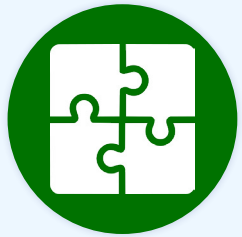
Addressing these challenges requires coordinated action across healthcare, education, social care, and community services.

Our Future Direction

Looking ahead, CYPNDN will continue to play a strategic leadership role by:

Securing sustainable models of support and commissioning.

Supporting the workforce to deliver evolving diabetes technologies and models of care.



Strengthening integration across health, education, and social care systems.

Improving transition and young adult pathways, reducing loss to follow-up.

Promoting early detection and proactive management of diabetes in children and young people.

Influencing policy, research, and service design to shape future national priorities.

Delivering Excellence

1

Maintain a Robust Service Infrastructure

Ensuring systems and processes remain resilient to support effective care design and delivery.

2

Deliver Comprehensive Care Pathways

Continuing to support prevention, early diagnosis, effective disease management, and optimisation of treatment across all stages of care.

3

Focus Through Dedicated Workstreams

Aligning efforts with the NHS Long Term Plan priorities and addressing ongoing themes of standardising care, reducing inequalities, and minimising variation.

4

Drive Quality Improvement Through Data

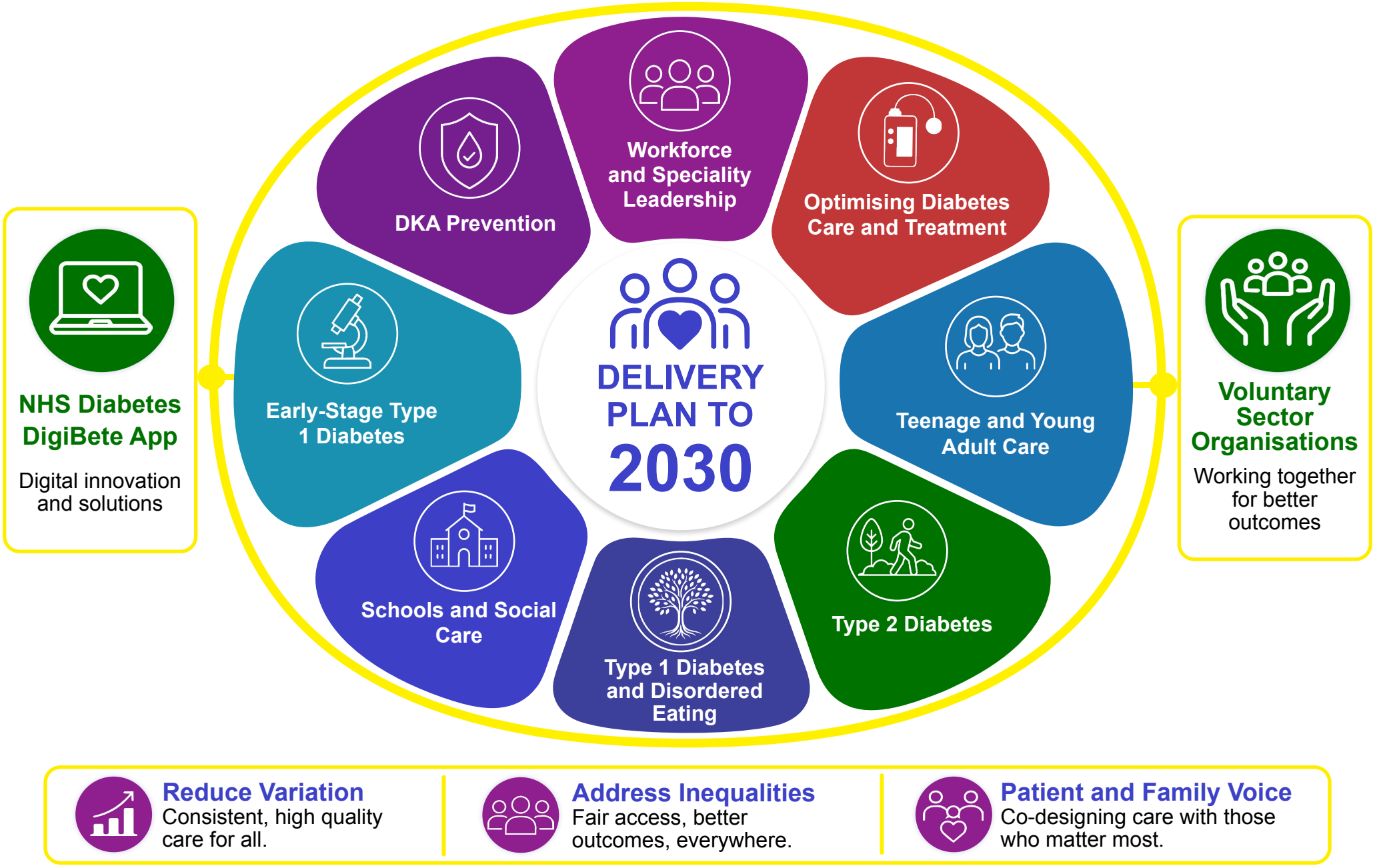
Using robust analysis of national and local data to inform decision-making. Key sources include quarterly, annual, and spotlight National Paediatric Diabetes Audits, Patient Reported Experience Measures (PREM), and local performance metrics.

5

Adapt Strategy Based on Evidence

Leveraging insights from audits and recommendations from the Children and Young Adult GIRFT programme to identify gaps, monitor progress, and refine our approach.

Delivery Framework



Reduce Variation
Consistent, high quality care for all.

Address Inequalities
Fair access, better outcomes, everywhere.

Patient and Family Voice
Co-designing care with those who matter most.

Operationalising the Vision, Mission, and Strategy

The Children and Young People's Diabetes Networks will deliver against eight dedicated workstreams. These workstreams will be led by Network Managers in collaboration with clinical leaders and supported by multi-disciplinary teams. Endorsement pathways will be embedded across all workstreams to ensure every stakeholder has a clear role in shaping and owning the final outputs.

The 8 Workstreams

Schools and Social Care

Optimising Diabetes Care and Treatment

DKA Prevention

Early-Stage Type 1 Diabetes

Type 2 Diabetes

Teenage and Young Adults

Workforce and Speciality Leadership

Type 1 Diabetes and Disordered Eating

Cross-Cutting Themes

Addressing Inequalities

Reducing Variation

Embedding the cross-cutting themes of addressing inequalities and reducing variation will ensure that equity in access to care, technology, and support is central to all our activities. This approach guarantees that the needs of underserved communities are proactively considered in every decision and that standardisation of care is at the core of every initiative.

Our Delivery Model

Robust Network Structure

Delivery of each workstream will be underpinned by a robust network structure, incorporating multi-disciplinary specialty groups and the voices of patients and families. Engagement with wider stakeholders-including voluntary sector organisations and strategic collaboration with partners such as DigiBete will ensure alignment, innovation, and sustainability.

Workstreams

The following sections provide a detailed breakdown of each workstream and the actions required to deliver the Network's vision and strategy. Each workstream section outlines the proposed approach, system enablers, key deliverables and measures of success.

Select a workstream below to navigate directly to the relevant section.

DKA Prevention

Optimising Diabetes Care and Treatment

Early-Stage Type 1 Diabetes

Schools and Social Care

Teenage and Young Adults

Type 1 Diabetes and Disordered Eating

Type 2 Diabetes

Workforce and Speciality Leadership

DKA Prevention

Our Priorities

- Support regional networks to routinely review and monitor DKA data, using insights to inform local quality improvement initiatives.
- Partner with the NPDA to review and maintain the completeness and accuracy of DKA reporting across services.

Key Actions

- Early DKA diagnosis guidance.
- National GP education package.
- School-focused DKA awareness materials.
- GP feedback letters.
- Review of contributing factors in known patients and DKA admissions.

DKA Prevention

Enablers and System Support

- Use NPDA data to target support in areas with high DKA rates.
- Embed GP education into ICS training and CPD.
- Create a national audit loop to track DKA trends and intervention impact.

Measures of Success

- Reduced national and regional DKA rates at diagnosis.
- Increased early GP referrals to paediatric diabetes services.
- Improved GP knowledge and confidence.
- Greater school awareness and stronger safeguarding for unwell pupils.
- Strong public health campaign reach and engagement.
- Families reporting better symptom awareness before diagnosis.
- Fewer repeat DKA admissions in children and young people with T1D.

Optimising Diabetes Care and Treatment

Our Priorities

- Promote diabetes technology by enabling patients to start Hybrid Closed Loop (HCL) systems within two weeks of diagnosis and providing ongoing support to maximise outcomes.
- Develop a national Time in Target Range consensus statement and patient guidance.
- Ensure patients from ethnic minority backgrounds, and those facing economic or social exclusion, receive tailored support.
- Standardise education for children, young people and families to support safe self-management, shared decision-making and informed choice.
- Support implementation of nationally agreed competencies and training for healthcare professionals in diabetes technology.
- Monitor emerging technologies, address adoption challenges, and support multidisciplinary teams in their effective use.
- Advocate for sufficient workforce capacity and innovative technology-focused roles.
- Share best practice to support successful transition to adult services for young people using diabetes technology.
- Work with diabetes teams to support families to understand the value of their NHS login as a single sign-in for accessing their health records, services, and resources, including diabetes-related support.

Key Actions

- Ensure first year of care pathways include early implementation of diabetes technologies.
- Keep translated educational resources up to date and provide opportunities for healthcare professionals to understand cultural competencies and poverty proofing ethos and values.
- Ensure all MDTs are using nationally approved structured diabetes technology education within their clinics.
- Support ongoing professional HCP development focused on optimising technology use in clinical practice via national network education days, by co-ordinating and disseminating HCP technology education programmes and training resources to healthcare professionals.
- Regularly review and use data (NPDA, PREM, Spotlight and local audits) to inform quality improvement across the networks.
- Digital care pathway development with DigiBete, encouraging families to complete their Structured Education in line with NICE guidance.

Optimising Diabetes Care and Treatment

Enablers and System Support

- Ensure all teams comply with NHS Supply Chain procurement processes for diabetes technology and maintain awareness of new and updated technologies available through the framework.
- Encourage networks and ICBs to communicate to resolve challenges and issues relating to the diabetes technology infrastructure.
- Ensure NPDA and other available data sources are used to inform quality improvement in the optimisation of diabetes technology.
- Work collaboratively with adult diabetes services and the ICB to ensure continued access to diabetes technologies throughout a patient's life course, supporting a seamless transition from paediatric to adult care.

Measures of Success

- Increased and equitable uptake of HCL systems across all regions including by patients from ethnic minority backgrounds and those facing economic or social exclusion (via NPDA).
- Improved time-in-target range and reduced HbA1c levels in CYP using technology (via NPDA).
- Fewer hospital admissions due to hypoglycaemia or DKA among tech users (via NPDA).
- Positive CYP and family feedback on confidence, ease of use and quality of life (via PREM).
- Demonstrated reduction in variation in device access and outcomes across ICBs (via NPDA).

Early-Stage Type 1 Diabetes

Our Priorities

- Develop the CYP National Early-Stage Type 1 Diabetes (EST1D) Network including EST1D peer support forums within the CYP National Diabetes Network structure.
- Host national online education study days.
- When funding available, support planning and organisation of CYP Early-Stage T1 annual summit.
- Deliver targeted education for families at high genetic or autoimmune risk.
- Provide digital tools and culturally appropriate resources to support self-management.
- Support teams to offer psychological and behavioural support for at-risk children and young people and their families including pre-screening support.

Key Actions

- Embed national pathways within Local Care Systems to the Children and Young People's National Diabetes Network.
- Work with partners to understand and disseminate the health economic impact of screening and early identification.
- Co-design care packages and educational resources with CYP and families to reflect lived experience and reduce stigma.
- Planning and organising of national training events.
- Whilst in place, offer strategic coordination support to the BSPED Pre-T1D Special Interest Group, Steering Group, BPSED Clinical Champions and regional nurses – embedding activity in the CYP National EST1D Network to ensure sustainable delivery.
- Support the early T1D research infrastructure.

Early-Stage Type 1 Diabetes

Enablers and System Support

- Support early detection shift from research to clinical practice, work with the NPDA to ensure that benchmarking for early detection is available.
- Embed early Type 1 diabetes pathways within paediatric diabetes services across ICSs, integrating all screening channels with structured follow-up and management within available funding frameworks and aligned with clinical guidelines, ensuring seamless transition into established T1D pathways.
- Provide guidance and training to strengthen local MDT practice.
- Ensure equitable access to early screening and follow up through national oversight and workforce planning.
- Increase GP awareness of early T1D and ongoing early-detection research
- Ensure patients identified with EST1D have access to early type 1 Diabetes MDT care.

Measures of Success

NPDA will show:

- Increased identification of at-risk children through systematic screening.
- Equitable access to services across all regions and population groups.
- Effective and stable transition into established clinical pathways for symptomatic T1D.

PROMS will show:

- Greater family confidence in managing early-stages of diabetes.
- Positive feedback from CYP and families on the support provided by MDTs.

A competency framework will:

- Improve HCP confidence in supporting, monitoring and managing people identified with early-stages of diabetes.

Schools and Social Care

Our Priorities

- Deliver targeted information and training to boost knowledge and confidence.
- Strengthen cross-sector collaboration through local engagement mechanisms.

Schools:

- Ensure CYP with diabetes can access all aspects of education and schools are equipped to support CYP effectively.

Social Care:

- Embed clear escalation pathways and graded vulnerability indicators for CYP with diabetes.

Key Actions

- Enhance education and awareness across healthcare, education, and social care professionals through accessible national training resources and practical guidance.

Schools:

- Provide an e-learning training package for schools.
- Establish clear escalation pathways.

Social Care:

- Implement a nationally consistent approach to safeguarding children and young people with diabetes.
- Strengthen identification to risk by supporting regional adoption of graded vulnerability indicators.
- Expand support for key additional groups, including teenagers and young people transitioning to adulthood, and children and young people in foster or kinship care.

Schools and Social Care

Enablers and System Support

- Provide opportunities within networks to share case learning and where appropriate escalate to integrated children's services boards.
- Embed diabetes-specific training into mandatory induction and CPD for schools and social care staff. Include diabetes in multi-agency assessments (e.g., EHCPs, CIN plans).

Schools:

- Reference National Statutory Guidance and relevant professional guidance.
- Support teams to deliver effective training to education settings, responding to national guidance and improving the offer in response to feedback.

Social Care:

- Align with national safeguarding frameworks and local Multi Agency Support Panel.

Measures of Success

- Fewer diabetes-related safeguarding incidents from missed signs.
- Stronger multi-agency communication and faster escalation of concerns.
- Positive feedback from CYP and families on feeling safe and supported.

Social Care:

- Consistent use of graded vulnerability indicators across regions.

Schools:

- Increased uptake of DigiBete online Schools training across all regions.

Teenage and Young Adults

Our Priorities

- Co-design services with teenagers and young adults to ensure flexible, accessible care.
- Implement a national transition pathway with clear, standardised expectations across paediatric and adult services, aligned to the NHSE service specification.
- Embed psychological support, youth work, peer support, and mentoring within TYA care models.
- Provide targeted education resources on technology, lifestyle, and self management.
- Equip staff with training in adolescent development and effective engagement approaches.

Key Actions

- Adopt and implement transition standards and guidance following NHSE publication.
- Develop TYA-friendly design and digital care resources covering education, employment, and life skills.
- Strengthen workforce training in adolescent health.
- Investigate transition outcomes and enhance data monitoring to support benchmarking and shared learning.
- Support CYP to navigate life transitions - including higher education, apprenticeships, employment - and expand access to peer support and lived-experience input.
- Deliver an annual education study day.

Teenage and Young Adults

Enablers and System Support

- Embed CYP diabetes within wider long-term condition strategies.
- Use NPDA and AYA audit data to monitor outcomes and drive improvement.
- Establish cross-boundary agreements to support young people moving between geographical areas.
- Strengthen workforce planning for 16–25 services.
- Improve data quality for 19– 25-year-olds to support commissioning and service design.

Measures of Success

- Reduced drop-out and loss-to-follow-up after transition.
- Improved NPDA/AYA outcomes (HbA1c, DKA rates, technology uptake.)
- Positive CYP and family feedback on services.
- Greater access to psychology, youth work, and peer support, reflected in PREM data.
- Increased workforce confidence in adolescent engagement.
- Equitable TYA services across all regions.

Type 1 Diabetes and Disordered Eating

Our Priorities

- Launch national guidance for identification of eating distress and embed within services.
- Provide practical clinical and therapeutic management advice for MDTs.
- Deliver education and training, promoting MEED guidance for families and professionals.

Key Actions

- Provide guidance and resources to support early identification of eating difficulties.
- Establish data on the prevalence of eating difficulties and eating disorders.
- Offer clinical and therapeutic management guidance for MDTs.
- Deliver education, resources, and training sessions.
- Embed support for food-, body image- and insulin-related distress within diabetes teams.
- Embed awareness and prevention of eating disorders, disordered eating and diabetes distress within education for children and young people, their families, and the wider multidisciplinary team.

Type 1 Diabetes and Disordered Eating

Enablers and System Support

- Advocate for NHSE commissioning of an under-18s service that enables innovative models of care.

Measures of Success

- Increased identification and recording of eating difficulties in CYP with T1D.
- Reduced hospital admissions linked to T1DE complications.
- Greater clinician confidence in managing T1DE.
- Positive feedback from CYP and families on feeling understood and supported.
- National integration of MEED-aligned guidance within paediatric diabetes services.

Type 2 Diabetes

Our Priorities

- Equip MDTs with education, resources, and peer support to deliver holistic, comprehensive, evidence-informed care.
- Promote equitable access to the latest treatments and technologies including CGM and new medications. Support teams to incorporate new treatments into practice.
- Ensure CYP have the tools and resources needed for effective self-management.
- Strengthen cultural competency across the workforce.
- Align national guidance with evolving treatments and emerging evidence.
- Amplify CYP and family voice in service design and improvement.
- Increase awareness of EOT2D risk factors and referral pathways across Primary, Community, and Secondary Care.
- Contribute to obesity prevention initiatives.

Key Actions

- Self-management resources for CYP with T2D and their families.
- HCP peer networks with clear Working Group oversight.
- Study days, education sessions, and online learning.
- Embed and refine the First Year of Care Pathway.
- Regularly update ACDC guidance as treatments evolve.
- Pathways for early identification, remission monitoring, transition, and complication management.
- Support beyond clinic through education, social support, and social prescribing.
- Promote relevant clinical trials.
- Ensure equitable access, recognising the needs of adolescents and those with learning disabilities or neurodevelopmental conditions.
- Coordinate with other Network workstreams on obesity prevention and response.

Type 2 Diabetes

Enablers and System Support

- Parity across units and Networks to drive consistent improvements in care and outcomes.
- Clear prominence within ICB/Health Board obesity and diabetes strategies, reflecting the specific needs of CYP with T2D.
- Access to CGM funding in line with NICE NG18 and NG28, with continuity through transition.
- Equitable access to treatment, care, and medication for all CYP.
- Enhanced NPDA data - including PREMs and T2-specific outcomes - to strengthen improvement at patient, unit, and national levels.

Measures of Success

- MDTs report greater confidence and competence in managing T2D, including ambiguity, comorbidities, and remission.
- First Year of Care Pathway adoption strengthens understanding of disease severity and drives a remission-focused approach.
- Structured education available across all ages and stages.
- CYP and families report positive relationships with MDTs and schools.
- Active MDT involvement in Network and stakeholder work on healthy environments and obesity.
- Improved access to, and use of, T2-specific data to drive service and national improvement.
- Data shows better outcomes and higher compliance with screening guidance.

Workforce and Speciality Leadership

Our Priorities

- Provide multidisciplinary insight and robust review across national workstreams to support holistic, high-quality care for CYP with diabetes.
- Collaborate with Professional Bodies and central NHS functions to advocate for CYP with diabetes and their families.
- Sustain and strengthen specialty-specific leadership and associated workstreams.
- Respond proactively to evolving NHS structures, offering clear guidance for MDTs and ICBs on workforce planning and delivery.
- Champion paediatric diabetes as a valued, rewarding, and sustainable career pathway.
- Signpost professional development opportunities and identify and address gaps in skills and capability across the workforce.

Key Actions

- Specialty Leadership Groups progress national and specialty priorities through targeted workstreams and quality-assure National Network or regional outputs for potential NCYPDN adoption.
- Engage in collaboration and consultation with Professional Bodies and central NHS/DHSC functions.
- Review and refine previous outputs to ensure alignment with current NHS frameworks, developing new guidance where gaps exist.
- Promote clear career pathways and opportunities from training and induction through to career end.

Workforce and Speciality Leadership

Enablers and System Support

- NPDA Workforce Spotlight and Minimal Staffing dataset.
- NHSE GIRFT CYA Diabetes Programme and NHS Wales initiatives.
- NHS 10-Year Plan, Workforce Plan, Model ICB and Regional Frameworks, and forthcoming supplementary guidance.
- Models for Team-to-ICB/Health Board reporting and escalation to support diabetes commissioning and workforce planning.

Measures of Success

- Sustained, visible specialty representation at regional and national levels.
- All NCYPDN workstreams and outputs include multidisciplinary membership or have access to specialty input when required.
- Networks benefit from evidence-based or consensus-driven good practice and quality-assured resources.
- Strong, consistent communication and collaboration between Specialty Leadership and Professional Bodies.
- Workforce Standards, Competency Frameworks, and related documents align with NHS strategic and operational guidance and are used by MDTs and ICBs in workforce planning.
- Members understand the NCYPDN's contribution to improved outcomes and support this trajectory from induction through to career end.
- Members have access to comprehensive, wide-ranging CPD opportunities.

Children & Young People's National Diabetes Network

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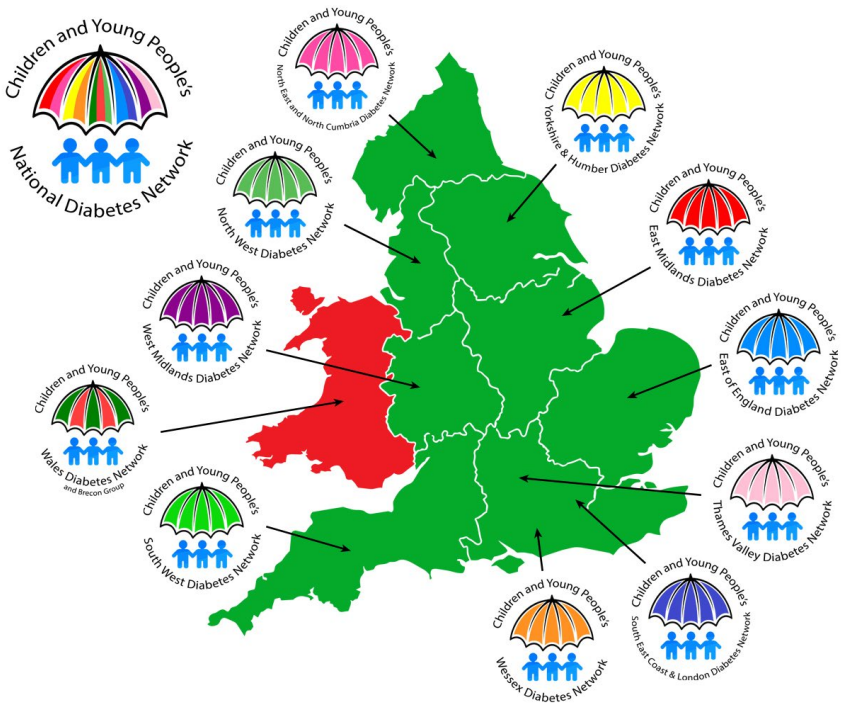

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