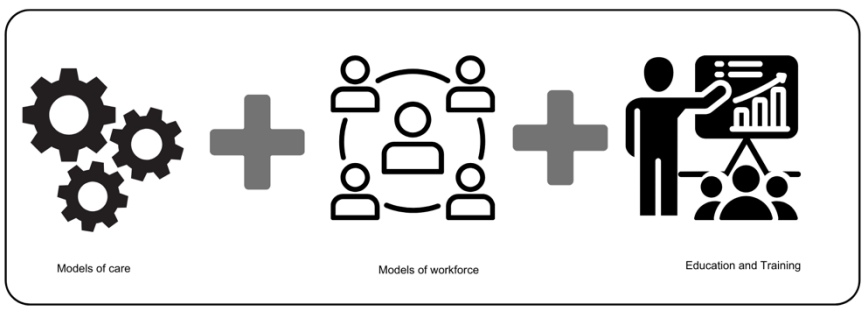
# WORKFORCE STANDARDS FOR CHILDREN AND YOUNG PEOPLE'S DIABETES SERVICES

# INTRODUCTION

The National Children and Young People's Diabetes Network developed 4 aims to support further improvements in Paediatric Diabetes care in 2020. These minimum staffing standards have been developed for Monday - Friday 5-day diabetes services as part of the Aim 3 remit to produce nationally defined staffing ratios for diabetes services.

Delivering services that can improve health outcomes requires workforce planning and the development of a sustainable workforce to ensure the appropriate level of staff are available to deliver safe, high quality care to patients and service users which meets the key criteria of the Diabetes Improvement Programme in England, Core20PLUS5 and the requirements of the Health Boards in Wales.

The core elements of a sustainable workforce are models of care, models of workforce and education and training. These elements are addressed in the NHS Long Term Workforce Plan which should be considered alongside these staffing standards.



## Background

A literature search using NHS Knowledge and Library Hub, PubMed and Embase elicited few current recommendations for staffing of MDT diabetes services with a small number of related papers relevant for consideration. A 2012 review of use of AHP staffing ratios concluded that there was scant evidence compared to nursing and medicine[1], however staffing ratios were felt to be a useful tool for service planning. The focus of published papers is predominantly inpatient care, evidence for staffing ratios in paediatric diabetes was limited to the work of the SWEET consortium [2] and ISPAD consensus guidelines[3]. Data from the 2019 NPDA workforce survey[4] showed no association between staffing numbers expressed as WTE per 1000 patients and HbA1c outcomes in clinics, this echoed the findings of a 2014 survey of diabetes services across the UK [5]. What has been demonstrated is that how a team functions impacts on outcomes [6].

The knowledge, skill, and competence of those delivering roles within paediatric diabetes care must be considered alongside staffing numbers. In 2015 Diabetes UK [7] published a position statement on high quality care for CYP with Type 1 Diabetes in the UK calling on commissioners to ensure that paediatric diabetes teams have a full complement of competent paediatric diabetes healthcare professionals. However, in 2018 Kime et al [8] concluded that there is a lack of high quality, standardised training for HCPs working in diabetes across Europe. Currently in the UK there is a lack of standardised postgraduate paediatric diabetes training for HCPs to access, with only one postgraduate paediatric diabetes training module available from Birmingham City University. Where competence and skills information exist, links have been provided in the later sections of this document.

There is one recommendation on clinic size within ISPAD guidelines, suggesting that a minimum clinic size should be 150 patients, to allow staff to gain sufficient experience to provide care to CYP with diabetes with sufficient staffing resources to provide cover for leave. The latest available NPDA report [9] show clinic sizes range between 50 and 600 patients in an individual unit. There are currently 172 Paediatric Diabetes Units across England and Wales. The mean clinic size (NPDA 2021-22) is 195 patients with a range of 52 to 582 patients in a single unit [10]. From the 2021/22 audit report there are 35 units with more than 250 patients, and 61 units with fewer than 150 patients and 19 units with fewer

than 100 patients. Hackl and colleagues [11] in 2021 demonstrated that centre size was associated with outcomes in Germany, with larger centres showing an improvement in HbA1c compared to smaller centres. Clinics were defined as medium sized with 50-100 patients and extra large with >200 patients. Based on these definitions' centres in England and Wales would all be classed a medium sized or above. This study did not look at the staffing/workforce capacity of clinics.

The Aim 3 group conducted a staffing survey which also provided information about the potential shortfall in staffing by 2025 due to retirement. Since this survey was undertaken further staffing pressures have emerged across the NHS because of the Covid 19 pandemic. Information was gathered from clinical leads, as well as professional leads from nursing, dietetics, and psychology to provide a snapshot of current staffing in 2020, gaps and potential loss of staff through retirement. Table 1 summarises the staffing situation in 2020 and the expected staffing requirements computed from number of children with diabetes in the 2018/2019 NPDA report with a 4% annual growth, the median staffing at the time of the survey and the expected number of retirements from the survey results.

| Staff Group | 2020 | Expected Requirement in 2025 | Estimated retirement | Additional staffing needs |
|---|---|---|---|---|
| Medical | 190 | 232 | 38 | 80-88 |
| Nursing | 385 | 468 | 48 | 131 |
| Dietetic | 160 | 195 | 20 | 55 |
| Psychology | 95 | 116 | 12 | 33 |

Table 1 Estimated numbers of Health Care Professionals for Paediatric Diabetes Services in 2025

Diabetes services in England and Wales have different funding arrangements. In England Paediatric Diabetes is currently locally commissioned against the Best Practice Tariff (BPT) specification. BPT was introduced in 2012 and has been fully in place since 2013-14. The 14 criteria that need to be demonstrated for full funding are set by NHS England. The aim of the paediatric diabetes BPT is to support clinical services to deliver consistent, high-quality care to children and young people with diabetes. As of October 2023, full funding was

£3,453 per patient receiving a full year of care, this figure has been used for comparison of staffing costs versus income.

In Wales Paediatric Diabetes services are funded and delivered by the seven local health Boards These local health boards are both commissioners and providers of the services in their areas. The role of the newly formed Diabetes National Strategic Network within NHS Wales executive is to inform, oversee and support the national plan and support local health boards to deliver their service improvements for diabetes.

## Current staffing

Data from the minimal staffing dataset 10 collected by the NPDA provides a limited snapshot of staffing as reported by clinical leads at the end of the audit year. This data is the most up to date information on current staffing levels. The median staffing levels and range for medical, nursing, dietetics, and psychology from the last 2 datasets are shown in Table 2. For each area of the MDT there were units reporting zero staffing in all professional groups. Across the 172 units reporting staffing in March 2023 there is a lack of administrative support with 60% of units reporting administrative provision below band 5 and 13% with no admin support at all. Specific support with data management was identified in 15 units. Three units reported dedicated social work time and 40 units had some youth or family worker or play specialist support.

| Year (Number of Units) | Medical | Nursing | Dietetics | Psychology |
|---|---|---|---|---|
| | PAs per 100 patients | WTE/100 patients | | |
| 2022 (115) | 2.9 (0 -11.8) | 1.6 (0 - 2.9) | 0.5 (0 - 2.1) | 0.2 (0 -0.8) |
| 2023 (172) | 2.7 (0 -10.4) | 1.5 (0 - 3.8) | 0.5 (0 - 1.9) | 0.2 (0-0.9) |

Table 3 Median staffing from NPDA minimal staffing dataset

Across England and Wales 94.3 % of CYP have Type 1 Diabetes, in many services there are fewer than five CYP with Type 2 Diabetes [9]. In England BPT requires diabetes units to provide patients and their families with 24-hour access to advice and support alongside 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. The requirement for out of hours support has been included in staffing calculations for a 5 day service. For 7-day services with a seamless pathway of care, there would be a requirement for additional staffing. The additional workforce will be dependent upon the range of services being delivered. Guidance on 7 day service standards is available from NHS England [12].

The recommendations in this document should provide a framework and minimum staffing for diabetes services to develop business cases to ensure appropriately resourced local services for the delivery of care to CYP with Diabetes, using the current Monday-Friday model of care. Where services have large numbers of CYP with Type 2 Diabetes for whom health outcomes are worse than those with Type 1 Diabetes, high ethnicity and deprivation, or geographical challenges, local service business planning should consider a workforce that meets the different needs of, and diabetes management required for the clinic patient cohort.

# Existing workforce recommendations

The core health care professional roles required for delivery of diabetes care have been identified as medical consultant, paediatric diabetes clinical nurse specialist, paediatric dietitian with specialist knowledge in diabetes, paediatric psychologists, and social workers, by the International Society for Pediatric and Adolescent Diabetes [12](ISPAD 2022). Additional roles that may support delivery of care include youth and family support workers, play specialists, health care assistants and the administrative support that is needed for operational delivery of care. Recommendations that have been used to inform the creation of these staffing standards are summarised below.

## NHS (National Health Service) Long term workforce plan

The long term plan published in June 2023 sets out the vision of future staffing in the NHS. The plan addresses training and retention of staff. The recommendations include increased use of apprenticeships for training the HCP (healthcare professional) workforce, increasing the scope and range of practice of AHPs (Allied Health Professionals), including independent prescribing and advanced practitioner roles.

Workforce planning and development within paediatric diabetes should consider the long term plan for NHS workforce applies within their locality.

## Medical

There are no national recommendations on medical staffing levels for diabetes. Workforce calculations have been made based on the number of clinical sessions and related time required to care for 100 patients. This calculation includes time for audit, research, clinical and service development.

## Nursing

The Royal College of Nursing (RCN) Paediatric and Adolescent Diabetes Special Interest Group published guidance (1993) on the role and qualifications necessary for nurses who care for children and young people with diabetes and their families [13]. The review showed an average caseload of 137 children per nurse (WTE (Whole Time Equivalent)), where the area covered was up to 30 square miles. Staffing ratio recommendations were updated in 1998 [14]and 2006 [15].

In 1998 recommendations of a maximum case load of 100 children per paediatric diabetes liaison nurse (WTE) with considerably less for a clinical nurse specialist were made. With the evolving nurse specialist role [14], the 2006 update [15] recommended a maximum of 70 patients per paediatric diabetes nurse (WTE). Additional guidance stated that the caseload would need to be reduced for very rural areas; areas of high deprivation and poverty; areas where there are large social/economic challenges and clinics with high numbers of more complicated types of diabetes and where individuals had additional responsibilities such as staff and service management responsibilities.

RCN Workforce standards (2021) apply across all areas of nursing and all sectors within the United Kingdom and are designed to support a safe and effective nursing workforce alongside each nation's legislation. These standards include:

- Each clinical team or service that provides nursing care will have a registered nurse lead.
- Having the right number of registered nurses and nursing support workers with the right knowledge, skills, and experience in the right place at the right time is critical to the delivery of safe and effective care for all those who use health

and care services. When calculating inpatient nursing workforce WTE an uplift will be applied that allows for the management of planned and unplanned leave and absence.

- Registered nurses must be appropriately prepared and work within their scope of practice for the people who use services, their families, and the population they are working with. This includes access to CPD (Continuing Professional Development), education, support, and development to ensure the nursing workforce has the knowledge, skills and competencies required to deliver evidence based, safe, person- centred care that is of high-quality.
- A registered nurse lead must receive sufficient dedicated time and resources to undertake activities to ensure the delivery of safe and effective care. Their role in the leadership team must be reflected and incorporated into job descriptions to ensure the additional workload and time management are included.

## Dietetics

The British Dietetic Association (BDA) [16] has guidance on staffing, caseload management as well as competency standards for paediatric dietitians working within diabetes and advanced practice guidelines. There are no speciality-based staffing recommendations. There is guidance on safe staffing levels and workload guidance with a recommendation that average clinical contact time should not exceed 75% of the working time to ensure safe clinical practice. The percentage of clinical contact time will be lower for higher bands with management, service development and research/audit responsibilities.

## Psychology

There is currently no guidance on staffing or caseload management for psychologists working in paediatric diabetes services. These staffing recommendations should be read alongside recommendations from The

Standards of Psychological Care for Children and Families with Diabetes document.

The ISPAD guidelines recommend easy access to psychosocial care for children and adolescents with Type 1 Diabetes and their families. The Standards of Psychological Care for Children and Young People with Diabetes recommends that an integrated diabetes psychology service coordinates the provision of psychological care to families with diabetes.

There is guidance from the BPS (British Psychological Society) [17] that average direct clinical contact time should approximate 60% of the working time, for a Band 8a psychologist, to ensure safe clinical practice. Similar to the dietitians, the percentage of direct clinical contact time may be lower for higher bands with management, service development and research/audit responsibilities. In this context, direct clinical contact time also includes work with parents/carers, clinical administrative time, clinical liaison, and providing consultation. This recommendation may vary with additional responsibilities within the individual clinician's role and would need agreement at a local level with the psychologist's supervision/line manager through appropriate job planning and should be reviewed regularly.

## Administrative support

Appropriate administrative support is essential to allow all MDT members to focus on clinical care delivery. A 2021 Kings Fund report [18] highlights the impact of administrative resource on both patients and staff and concludes "High-quality admin has the potential to improve patient experience, reduce inequalities, promote better care – and contribute to a better working environment for staff." The 2020/21 NPDA report included recommendations for adequate staffing to support data management and submission to the NPDA. Detailed recommendations for administrative support made by this group in 2023 are included in Appendix 1.

# Competency, education and training

## Medical

Medical training is provided by the Royal College of Paediatrics and Child Health. The syllabus allows for accreditation as a General Paediatrician with an interest in Paediatric Endocrinology or a Specialist in Paediatric Endocrinology [19] The term endocrinology is used to embrace endocrinology and diabetes. Currently the General Paediatrician with an interest in diabetes follows the Paediatric Diabetes SPIN (Special Interest) Module of the College [20] whereas the Specialist training follows the original Training Endocrinology programme devised by the Union of European Medical Specialists and adapted for use in the UK. Both SPIN and the Specialist programmes need revising, and a proposed revision is due for consideration by the College in 2024 and will have either a predominance of endocrine or diabetes training depending on trainee needs. https://www.rcpch.ac.uk/resources/paediatric-diabetes- endocrinology-sub-specialty

Continuous professional development is provided by the British Society for Paediatric Endocrinology and Diabetes, American Diabetes Association, Association of Children's Diabetes Clinicians, Diabetes UK, and International Society for Paediatric and Adolescent Diabetes

## Nursing

### Competency framework

Adult and paediatric competency documents are available to guide learning and development. TREND Diabetes 'Integrated Career and Competency Framework for Adult Diabetes Nursing' (2022) describes the knowledge and skills across five competency levels. This framework can guide nurses to identify what appropriate learning is required and facilitate providing or receiving feedback through assessment of competence, benchmarked against the relevant topics and level of practice.

The Competencies for Nurses Caring for Children and Adolescents with Diabetes (2021) document provides a competency and role development framework for nurses caring for children and young people with diabetes and their families. Based on the work of Waldron et al 2012 a National Curriculum for health care professionals was developed in England. The 2021 competencies provide a nursing specific update and set out to identify the progression of knowledge and skills for a nurse employed from band 5 through to band 8, demonstrating how they can build a career within CYP diabetes care. The identification of the different roles/titles used together with real life exemplars can be found here Specialist and advanced children's and young people's nursing practice in contemporary health care | Royal College of Nursing (rcn.org.uk)

## Dietetics

### Competency Framework

The BDA post registration professional development framework forms the basis of the competencies for dietitians working within diabetes. The interactive competency framework for dietitians working in diabetes and the Band 6 core skills guide and Band 7 core skills guides can be used to support professional development. Consideration should be given to ensuring that appropriate practice supervision can be provided to single handed post holders to support achieving the required competencies.

## Advanced and consultant level practice

The four pillars of advanced level practice are clinical practice, leadership and management, education, and research. Advanced clinical practitioners (ACPs) are educated to Masters level (level 7). The term is an umbrella term that can be applied across a range of professional backgrounds including nurses and AHPs. ACP qualifications map to NHS England's (2017) Multi-professional framework for advanced clinical practice in England. Definitions of levels of practice can be found in the Skills for Health Key Elements of the Career Framework

Advanced practice is characterised by high levels of autonomy and complex decision making and may be used to support and develop patient care pathways. Consultant level practice expands on the domains of advanced practice and usually includes a clinical academic component. Resources to support practice capability and impact assessment can be found here. Nurses and AHPs working at specialist, advanced and consultant level can make a significant contribution to the redesign, development, and delivery of CYP diabetes services.

## Composition of the multidisciplinary diabetes team

### CORE STAFFING

The core staffing for any diabetes service should comprise the following HCPs who have a job description or job plan specific to diabetes.

- Medical Consultant
- Clinical Nurse Specialist
- Specialist Dietitian
- Clinical psychologist
- Administrative staff

### ADDITIONAL STAFFING

Additional roles required to support the delivery of care in diabetes may be shared across paediatric services with input into diabetes care or may be directly employed within the diabetes service. This will depend on local service size and delivery factors.

- Social work or safeguarding support
- Family support worker
- Youth support worker
- Play specialist.
- Health care assistants

## MINIMUM STAFFING STANDARDS

Paediatric diabetes services should have at least a minimum level of staffing to support safe effective delivery of care. Each team should comprise of the core members of the MDT. Local service business planning should be used to increase the staffing numbers as appropriate to local need. Examples of where additional staffing may be required include highly rural services, high deprivation, and ethnicity, high number of patients with Type 2 Diabetes. Additional staffing may be core specialists or additional support staff e.g., family support workers.

Caseload management and safe staffing has been considered across these workforce recommendations. It would be expected that between 50 and 90% of time will be clinical dependant on grade (90% at band 6, 75% at band 7 and 50% at band 8a and above). Smaller services require a greater staffing allocation to cover services across 365 days. Allocating time for CPD, audit, service evaluation, management across team members is an essential part of delivering a quality service.

ISPAD recommendations on staffing ratios are based on a European survey in 2008, models of healthcare across Europe are different to those in England and Wales with greater medical staffing compared to the non-medical professionals. The original 2012 recommendations published by de Beaufort et al[2] does not consider safe caseload management. It is these recommendation on which the current ISPAD consensus guidelines are based. The ISPAD guidelines are presented for comparison.

The recommendations for staffing standards are made below.

| Table 3. Minimum staffing standards for Core Diabetes MDT | | | | |
|---|---|---|---|---|
| Staff group | WTE per 100 patients<br>(10 PAs = 1 WTE) | | | ISPAD recommendations[3] |
| | <150 patients | 150 -250 patients | >250 patients | |
| Medical Consultants | 0.5 | 0.5 | 0.5 | 0.75-1 |
| Clinical Nurse Specialists | 1.7 | 1.6 | 1.6 | 1-1.25 |
| Dietitians | 0.8 | 0.75 | 0.75 | 0.5 |
| Clinical Psychologists | 0.5 | 0.4 | 0.4 | 0.3 |
| Administrative staff | 0.8 | 0.7 | 0.7 | N/A |
| Total WTE per 100 patients | 4.3 | 3.95 | 3.95 | 2.55-3.05 |

| Table 4. Minimum standards for additional staffing | |
|---|---|
| Staff group | WTE per 100 patients |
| Social work/safeguarding time | 0.1 |
| Support worker (Play specialist/youth or family support workers) | 0.6 |
| Health Care Assistant (HCA) | 0.2 |

The increasing complexity of care, and the needs of the children and families living with diabetes mean that where additional support staff are not available the numbers of core staff members will need to be higher.

A workforce calculation tool has been created to support diabetes teams with assessment of staffing needs to meet these standards and is hosted on the CYP National Network website.

## Skill Mix

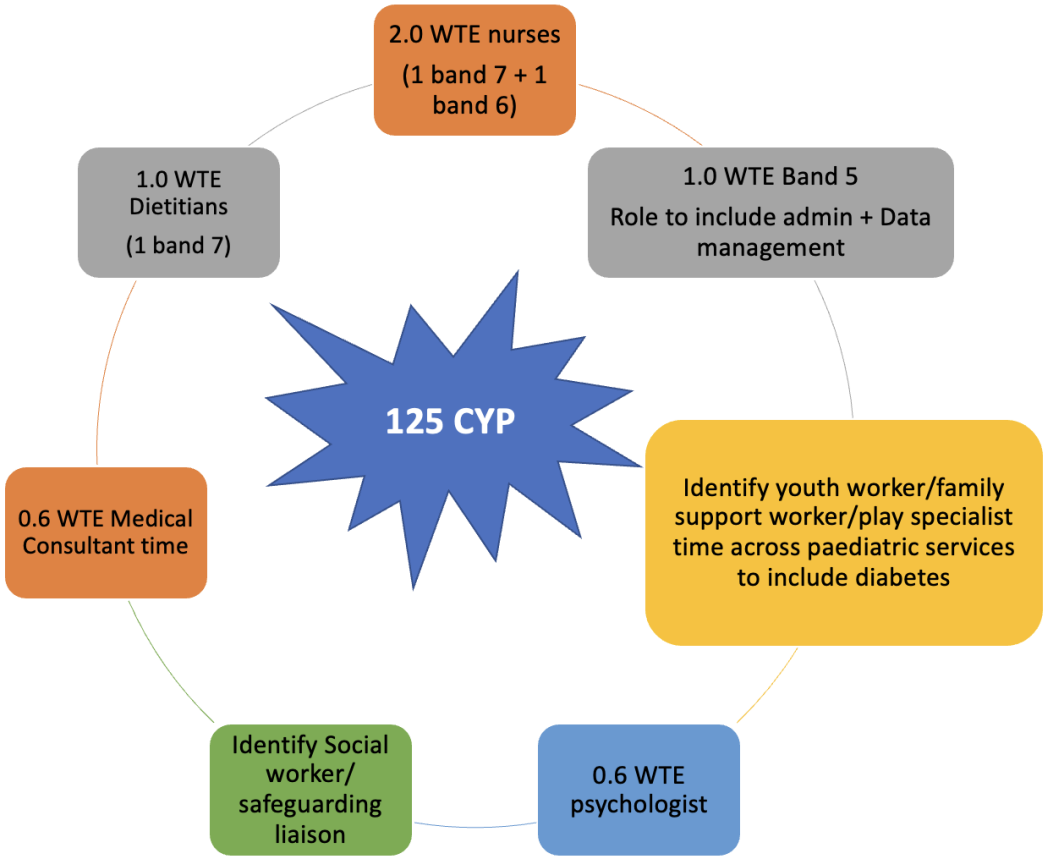
Making the most of the skills available will support development of highly functioning teams able to deliver care to diverse populations. Clinic size will determine the amount of skill mix that can be utilised.

1. Where the nursing or dietetic team consists of one individual, these posts would need to be at a minimum of band 7 grades to ensure that the postholder has sufficient experience/ knowledge/skills to be able to fulfil the role expectation with arrangements for clinical supervision from HCPs with appropriate professional paediatric diabetes knowledge and skill.
2. Where there are multiple posts within a team, staffing can comprise multiple bands to deliver care. For example, services may wish to utilise band 5 training posts, dietetic, nursing or psychology assistants to support delivery of safe and effective care. There is also opportunity to consider Nurse/ AHP Consultant posts and/or Advanced Practitioner roles.
3. There are several different specialist psychological therapists who may be able to provide psychology care for paediatric diabetes patients. They all have different training, competencies and consequently their knowledge and skills vary. A clinical psychologist would have the skills and training to fulfil all aspects of the standard for psychological care, however larger teams may also wish to consider alternative psychological therapists to work under the supervision, support, and guidance of the embedded clinical psychologist within the diabetes MDT. More information on this can be found in the Standards for Psychological Care for Children and Young People with Diabetes document.
4. For larger services and those run across multiple sites, both the staffing skill mix and WTE numbers will need to consider additional responsibilities such as staff and service management responsibilities. Individuals will need to be allocated management time with an associated reduction in their clinical time.

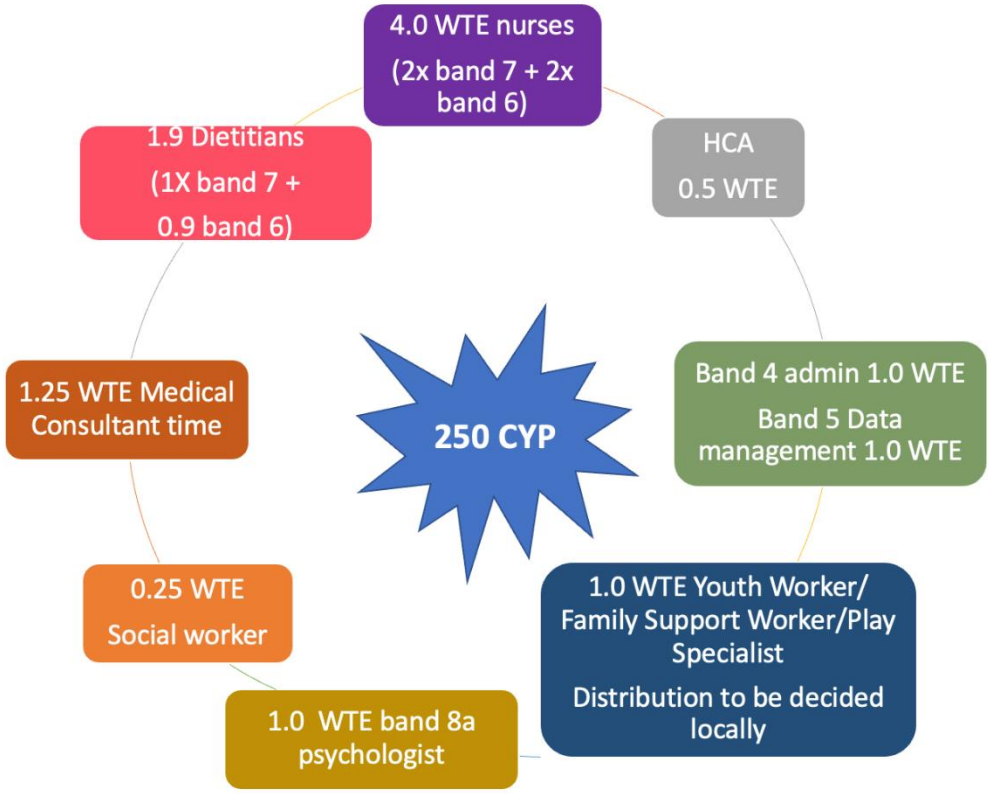
## STAFFING MODELS

Staffing model examples have been created to illustrate skill mix and composition of the team. These models are illustrated in the figures below. A clinic model of 250 patients was chosen as a baseline for the calculations of staffing requirements as it provides a resilient staffing provision with potential for career progression within a service and is known to be within the total income available from current BPT funding. The calculations of staffing costs include overheads associated with staffing. Staffing recommendations for other unit sizes are not proportional to the 250-patient model. Smaller services will require more staff per patient to provide safe and effective care whereas larger services will benefit from economies of scale. Staffing costs for units with fewer than 150 patients will not be covered by available BPT income.

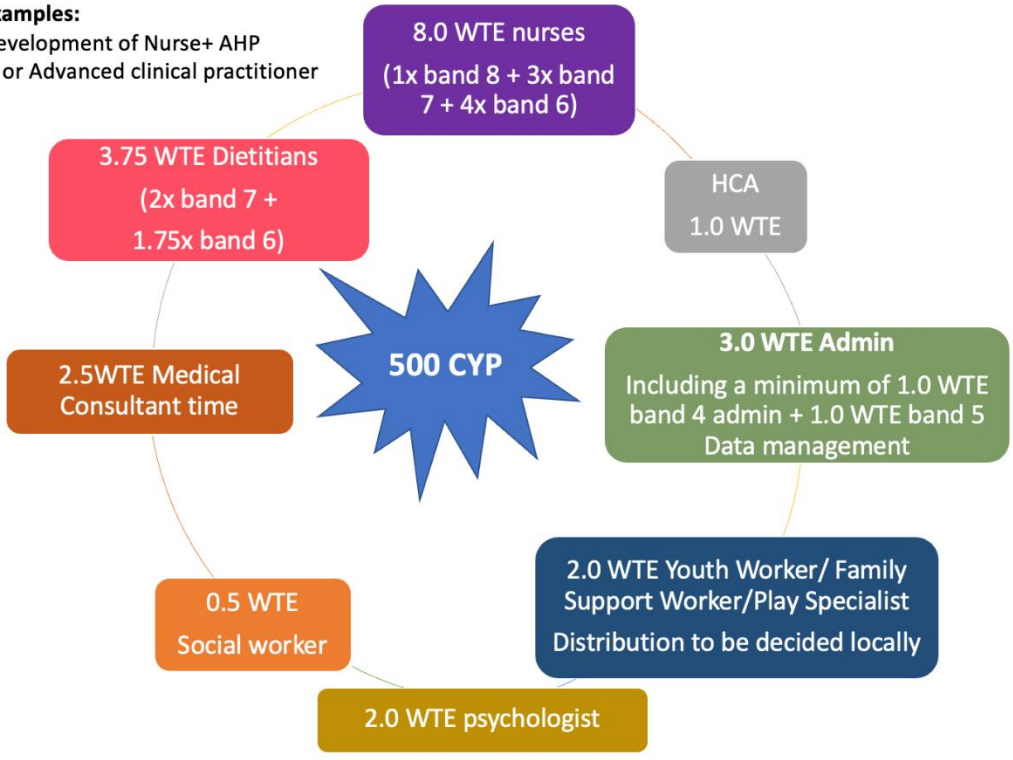
### 125 PATIENTS



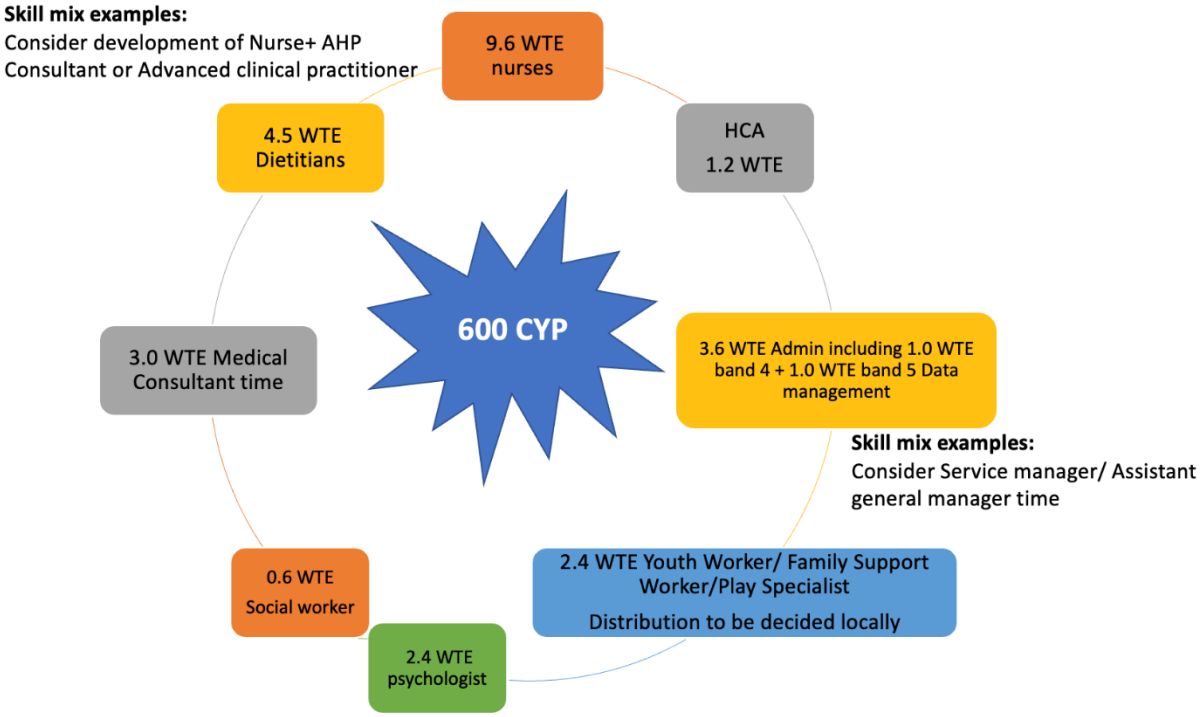
## 250 and 500 PATIENTS




**Skill mix examples:**
Consider development of Nurse+ AHP Consultant or Advanced clinical practitioner



## 600 PATIENTS



Estimated costings using 2023 pay scales mid-point with High-Cost Area Supplement (HCAS) and overheads have been calculated for services with 125 and 250 patients to illustrate the challenges of resourcing services within the current BPT funding available in England. The exact costings for a service will depend on the salary point of staff and the location of the service and inflationary pressures. In England current available BPT funding will not support additional staffing and alternative solutions for youth and family support work, safeguarding advice and support will be required.

| Staffing for 125 patients | | | Mid point | |
|---|---|---|---|---|
| Staff member | Banding | WTE | Per 1wte | Estimated cost |
| Admin/Data Manager | 5 | 1.00 | £45,962 | £45,962 |
| Diabetes specialist nurse | 6 | 1.00 | £56,285 | £56,285 |
| Dietitian | 7 | 1.00 | £67,721 | £67,721 |
| Clinical Nurse Specialist | 7 | 1.00 | £67,721 | £67,721 |
| Psychologist | 8a | 0.50 | £74,073 | £37,037 |
| Medical consultant | | 0.60 | £138,619 | £83,171 |
| | | | | £357,897 |

| Staffing for 250 patients | | | Mid point | |
|---|---|---|---|---|
| Staff member | Banding | WTE | Per 1wte | Estimated cost |
| Health care assistant | 3 | 0.50 | £36,606 | £18,303 |
| Admin | 4 | 1.00 | £41,282 | £41,282 |
| Play specialist/ youth worker | 5 | 1.00 | £45,962 | £45,962 |
| Data Manager | 5 | 1.00 | £45,962 | £45,962 |
| Dietitian | 6 | 0.90 | £56,285 | £50,656 |
| Diabetes specialist nurse | 6 | 2.00 | £56,285 | £112,569 |
| Dietitian | 7 | 1.00 | £67,721 | £67,721 |
| Clinical Nurse Specialist | 7 | 2.00 | £67,721 | £135,442 |
| Social worker | 7 | 0.30 | £67,721 | £20,316 |
| Psychologist | 8a | 1.00 | £74,073 | £74,073 |

| | | | | |
|---|---|---|---|---|
| Medical consultant | | 1.25 | £138,619 | £173,274 |
| | | | | £785,561 |

# CONCLUSIONS

Supporting CYP living with diabetes requires a wide range of professionals to address medical, health and wellbeing needs in the context of the lives of the families and CYP. These staffing standards identify the minimum staffing required to deliver high quality diabetes care to children and young people in England and Wales.

However, there is no 'one size' staffing model for all paediatric diabetes units. Recommendations have been produced by experienced professionals working within CYP diabetes currently, drawing upon available national and international staffing recommendations. The variation in individual clinic sizes created the need for a range of minimum staffing standards, with suggested workforce presented as the WTE per 100 patients.

The recommendations are for a minimum staffing requirement. In paediatric diabetes units where the staffing numbers are lower than these recommendations or where there are no additional support staff, the WTE per 100 patients will need to be increased for other staff members, to take account for this.

For smaller clinics, the WTE per 100 patients for all staff groups differs from larger clinics to ensure that service delivery can be maintained during planned and unplanned leave. Business plans should consider where an uplift in staffing is needed to provide safe and consistent care.

Recommendations based on patient numbers alone do not account for factors such as

- Locality of the service and the population density
- Ethnicity and deprivation of the local population
- Complexity of caseload
- Extended hours / service provided over 7 days.

Where these factors have been identified, local service business planning should be used to increase the staffing numbers as appropriate to local need.

The staffing recommendations are intended to be used alongside business planning to develop local models that will be resilient and meet the needs of individual services and units. A workforce calculation tool has been created to support units in identifying staffing gaps and strengths. In addition, staffing model examples have been created to illustrate skill mix and composition of the team, that can be used to support the design of services.

# ACKNOWLEDGEMENTS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## Web Resources

National Children and Young People's Diabetes Network resources

Delivery Plan 2020-2025. 2020 https://www.cypdiabetesnetwork.nhs.uk/national-network/ncypdn-delivery-plan-2020- 2025/

Psychology Standards https://www.cypdiabetesnetwork.nhs.uk/national-network/network-projects/

Workforce Calculator

Core20PLUS5 An approach to reducing health inequalities for children and young people, https://www.england.nhs.uk/about/equality/equality- hub/national-healthcare-inequalities-improvement-programme/core20plus5/core20plus5- cyp/

BDA The Association of UK Dietitians, Safe staffing safe workload guidance 2015 https://www.bda.uk.com/uploads/assets/53c343b0-c925-4513-a5d6d08b9b24ba2a/Safe-Staffing-Workload-Guidance.pdf

RCPCH National Paediatric Diabetes resources

https://www.rcpch.ac.uk/resources/npda-spotlight-audit-reports#the-workforce-in-paediatric-diabetes-unitsspotlight-report-2017-18

National Paediatric Diabetes Audit – Paediatric Diabetes Staffing Datasets 2022 and 2023 https://www.rcpch.ac.uk/resources/national-paediatric-diabetes-audit-transparency-open-data

NHS England

NHS England Seven Day Services Clinical Standards 2022 https://www.england.nhs.uk/wp-content/uploads/2022/02/B1230-seven-day-services-clinical-standards-08-feb-2022.pdf

BPT https://www.england.nhs.uk/publication/2023-25-nhs-payment-scheme/

Deprivation https://digital.nhs.uk/data-and-information/publications/statistical/acute-patient-level-activity-and-costing/2019-20/deprivation

The Kings Fund. Admin Matters; the impact of administration on patient care. 2021 https://www.kingsfund.org.uk/publications/admin-matters-nhs-patient-care

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Appendix 1

**Administrative staff recommendations**

- MDTs must include adequate administrative and data staffing resource to meet the requirements of the service across secretarial, administrative and data management functions. This resource must be sufficient for the administration and data management support needs throughout the paediatric diabetes service and provision available to all health and allied professionals within the MDT.
- Considerations for provision should be informed by the range of tasks required. This may vary depending on the wider team circumstances, for example, the effectiveness of local patient data recording systems, local processes for diabetes technologies purchasing, patient caseload, MDT staffing mix, reporting requirements internally and externally, approach to patient / group / school education or activities delivered by the team or other factors.
- Appropriate administrative and data management expertise is likely to bring cost efficiencies and benefits to the MDT:
    - For services in England, the 2023-25 paediatric diabetes Best Practice Tariff (BPT) criteria states quarterly reporting rather than annual. To meet BPT criteria and receive the associated service funding, adequate support for data entry, management and reporting must be available.
    - Reporting will be through the National Paediatric Diabetes Audit (NPDA) platform and specific outcomes made available in the public domain. Service improvement activity to improve patient outcomes, particularly in priority areas under the Long Term Plan and Core20PLUS5 requires robust data to identify and evidence impact.
    - Furthermore, some ICSs/Health Boards may request more frequent reporting or additional datasets for local oversight which form part of funding arrangements.
- Inadequate administrative and data provision will have a detrimental impact on clinical capacity as clinical time is diverted to administrative roles. In the absence of sufficient administrative and data resource, it will be necessary to increase the clinician to patient ratio.

- As National reporting becomes more frequent, administrative and data provision should be reviewed accordingly. This may include technical expertise to support streamlined collection and submission.
- Consultant secretarial support is not included in the suggested administrative time as these roles do not provide support for all MDT members and is not ring-fenced to supporting the activities of the diabetes team.
- Additional input at these or other bandings may be included as required by the team. For example, some teams may require more capacity, or some Trusts may have additional placements such as apprenticeships.
- Administrative and data time should be ring-fenced to the paediatric diabetes team. Cover
- arrangements must be in place for absence such as holidays and sick leave.

Administrative and data support staff are key members of the paediatric diabetes MDT. They provide a critical role in facilitating team efficiency, clinic management, data quality and service improvement. Both administration and data demand on teams have increased in recent years and will continue to do so, for example the greater administrative requirements to deliver virtual appointments, manage procurement of diabetes devices / consumables and support the move to more frequent reporting through the NPDA and NHS funding structures.

These roles must be appropriately recognised and banded accordingly, which may also support staff development and retention.

The NPDA Annual Report, 2020-21 included recommendations for NHS Trusts/Health Boards and paediatric diabetes teams to include dedicated administrative and IT support and regular uploading of data which is checked for completeness and quality and used by the team to monitor and improve performance. The Aim 3 group endorses this message and recognises the impact effective administrative and data expertise can bring to a team. Examples include:

- Optimising clinic and clinician time, freeing clinics staff to focus their specialist expertise where it is needed and making effective use of hospital rooms.
- Supporting good quality data which can be used to improve individual patient outcomes (identifying gaps in key care processes) and caseload outcomes (informing service / quality improvement).
- More specifically, robust data capture and reporting will enable teams to review and act where needed on local uptake of diabetes technologies to identify inequities in line with NHS England CYP Transformation Priorities and Core20PLUS5.

- Increased use of diabetes technologies will have an associated increase in workload – this must be appropriately placed within the MDT.
- Responding to requirements for 1) activity reporting to ICSs within funding structures from 2023/24; and 2) a move to more frequent NPDA submission to support national initiatives.
- Participation in National Quality Assurance Schemes as indicated in Best Practice Tariff criteria.