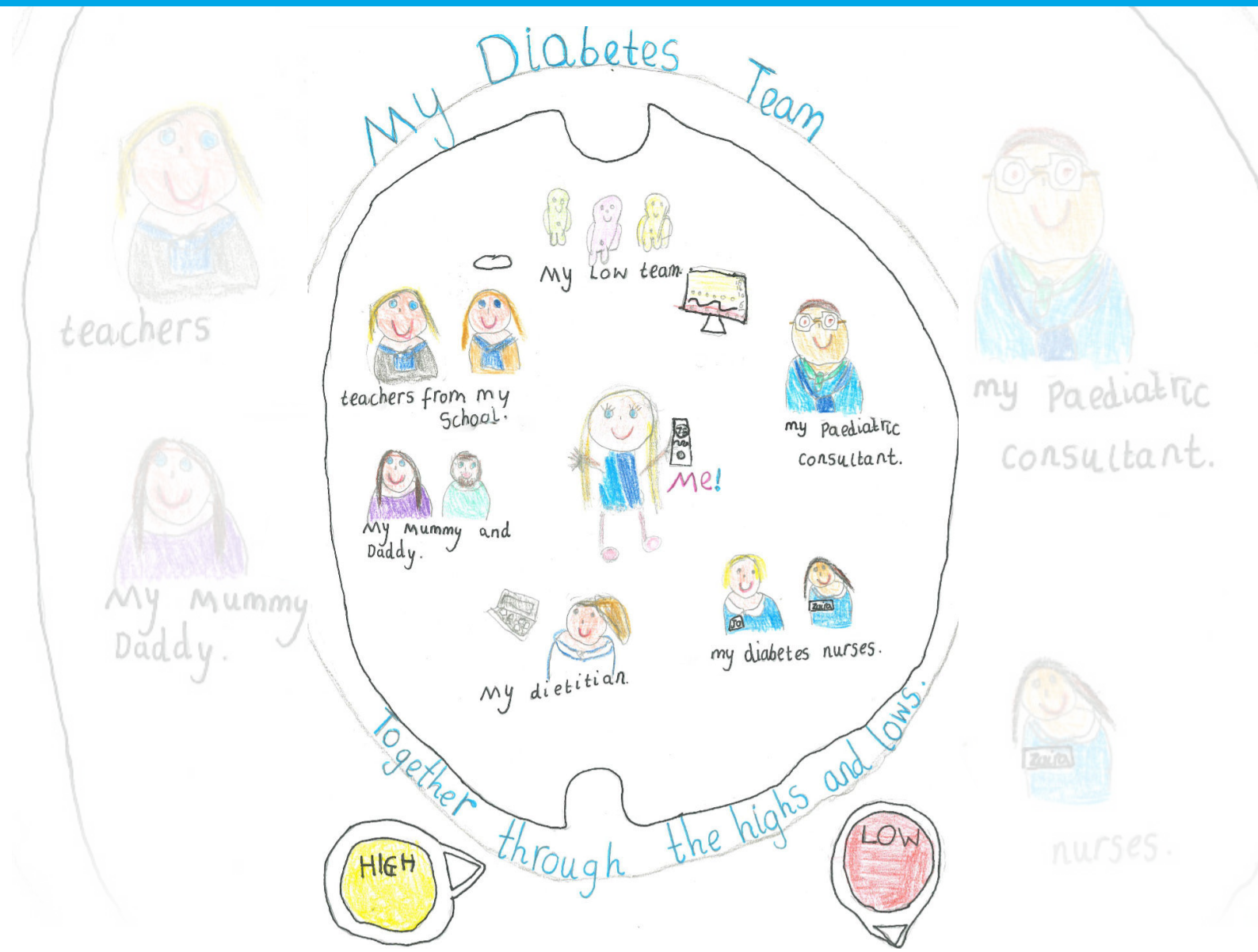
NPDA
National Paediatric Diabetes Audit

RCPCH Audits

Workforce Spotlight Audit 2024/25

Published November 2026



HQIP
Healthcare Quality Improvement Partnership

RCPCH
Royal College of Paediatrics and Child Health
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NPDA National Paediatric Diabetes Audit

The National Paediatric Diabetes Audit (NPDA) is managed by the Royal College of Paediatrics and Child Health (RCPCH), commissioned by the Healthcare Quality Improvement Partnership (HQIP) and funded by NHS England and the Governments of Wales and Jersey as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP).

HQIP is led by a consortium of the Academy of Medical Royal Colleges, and the Royal College of Nursing. Its aim is to promote quality improvement in patient outcomes, and in particular, to increase the impact that clinical audit, outcome review programmes and registries have on healthcare quality. For the NPDA this covers England, Wales and Jersey.

HQIP holds the contract to commission, manage, and develop the National Clinical Audit and Patient Outcomes Programme (NCAPOP), comprising around 40 projects covering care provided to people with a wide range of medical, surgical and mental health conditions. The programme is funded by NHS England, the Welsh Government and, with some individual projects, other devolved administrations and crown dependencies.

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Further information:

Further information on the background, aims, and scope of the NPDA is available at:

www.rcpch.ac.uk/npda

Extended analysis:

Extended analysis of the 2024/25 Workforce Spotlight Audit, a glossary of terms used in this report, and unit-level reports are available on our **spotlight reports page**.

Paediatric diabetes unit, CYP Diabetes Network, NHS England Region, NHS Wales Local Health Board, and country-level results are also available and can be downloaded on our **data files page**.

Front cover art competition winner:

Amber H.



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Introduction

The NPDA was established in 2003 to stimulate improvements in care for children and young people with diabetes who receive care from Paediatric Diabetes Units (PDUs), by measuring variations in quality, experience, and outcomes of care in England, Wales, and Jersey. It has been managed by the RCPCH since 2011.

Since the previous Workforce Spotlight Audit in 2017/18, the number of children and young people receiving care from a PDU in England and Wales has increased by 20% (21% in England, 12% in Wales). In light of this increase, the NPDA sought to understand how the structure and delivery of care in PDUs, including staffing provision, has changed in that time, and the relationship this has with diabetes care and outcomes.

In Summary: Services continue to provide comprehensive care despite increasing workforce pressures. Staffing levels per 100 patients have generally fallen, vacancies have increased, and most services remain below recommended workforce standards. Better staffed services tended to achieve better outcomes, including lower HbA1c levels and higher uptake of hybrid closed loop technology. Levels of funding was also associated with outcomes, yet many services reported limited transparency around how diabetes funding is allocated and used.

Scope of the Workforce Spotlight Audit

This national report covers all PDUs in England, Wales, and Jersey as at 31st March 2025.

100% of participating paediatric diabetes teams within PDUs (161/161) submitted a response to the Workforce spotlight audit.

There were 172 PDUs providing care to 32,613 patients on 31st March 2025 (excluding patients who transitioned to adult care or died before that date). PDUs were welcome to submit jointly to the Workforce Spotlight Audit where the exact same team covered multiple PDUs; 21 units did so across 10 submissions.

All PDUs were asked to submit information on their:

- Clinic structure
- Caseload with additional care needs
- Safeguarding and psychology provision
- Structured education and transition support
- Out of hours advice
- Funding
- Staffing, staff training, and vacancies.

The data received were linked to the care and outcomes data published in the **2024/25 NPDA Report on Care and Outcomes**, published in March 2026 (referred to as the '2024/25 core audit'). National findings for England and Wales were compared to the **2017/18 Workforce Spotlight Report** published in September 2019, prior to Jersey joining the audit.

Staffing provision was compared against the recommended ratios published by the National Children and Young People's Diabetes Network, as part of the **Workforce Standards for Children and Young People's Diabetes Services**.

Key Messages and Recommendations

KEY MESSAGE 01

Workforce

Fewer patients are offered 4 appointments per year and staffing has not kept pace with growing patient numbers, leaving most PDUs operating below recommended workforce standards.



Core multidisciplinary team (MDT) staffing per 100 patients has decreased since 2017/18 (Figure 1), with all staff groups seeing a reduction in staff to patient ratios, apart from Paediatric Diabetes Specialist Nurses (PDSNs). The overall MDT whole time equivalent (WTE) per 100 patients in 2024/25 was **3.24**, a reduction from 3.33 in 2017/18.

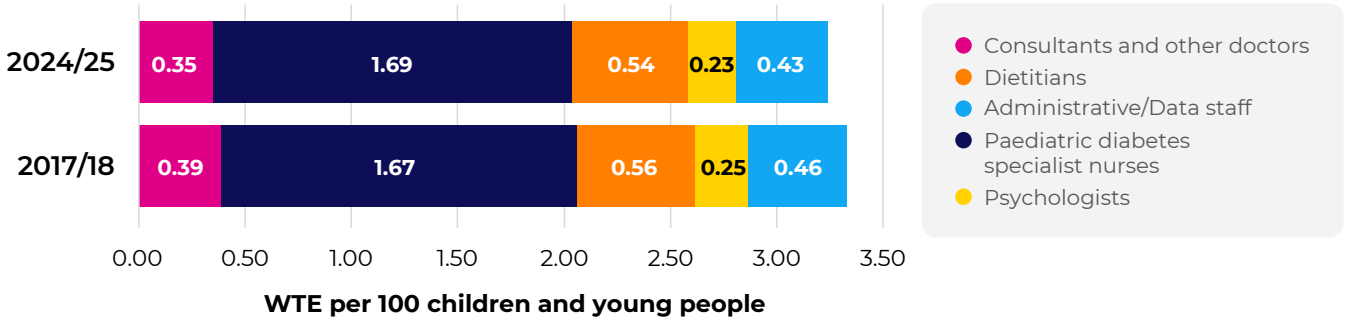


Figure 1: Core MDT WTE per 100 children and young people with diabetes in 2024/25 and 2017/18.

Additionally, there was an increase in the number of vacancies nationally, with **54%** of services reporting at least one vacancy, an increase from 39% in 2017/18.

- Consultant vacancies totalled **50.8** programmed activities (PAs) or **5.08** WTE. 74% of these roles were vacant for more than 3 months.
- Other vacancies totalled **69.9** WTE. **96%** of these roles were vacant for more than 3 months.

Very few services met the recommended minimum standard for the core MDT staffing (Table 1).

Team member	Services with <150 patients		Services with ≥150 patients	
	Minimum standard	Standard met	Minimum standard	Standard met
Consultants and other doctors	0.50	17% (9/53)	0.50	10% (11/108)
PDSNs	1.70	58% (31/53)	1.60	56% (61/108)
Dietitians	0.80	9% (5/53)	0.75	14% (15/108)
Psychologists	0.50	15% (8/53)	0.40	9% (10/108)
Administrative/Data staff	0.80	17% (9/53)	0.70	10% (11/108)
Total core MDT	**4.30**	**17% (9/53)**	**3.95**	**15% (16/108)**

Table 1: Core diabetes MDT staffing ratios (WTE per 100 patients) compared to the minimum standard (NCYPDN, 2024), broken down by PDUs with < or ≥150 patients.

Fewer PDUs offered all patients with Type 1 or Type 2 diabetes at least four appointments with a consultant in the 2024/25 audit year compared to that in 2017/18 (Figure 2).

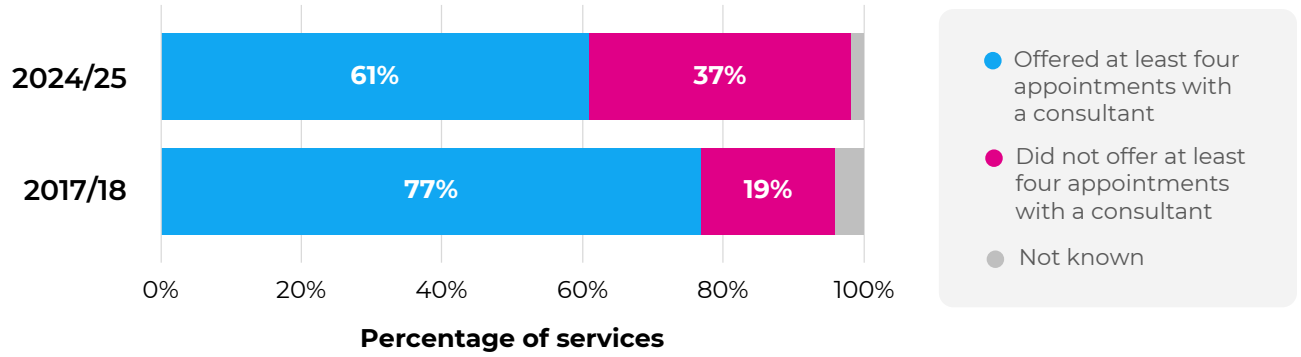


Figure 2: Percentage of services in England, Wales, and Jersey that offered all patients with Type 1 or Type 2 diabetes at least four appointments with a consultant in the 2024/25 audit year.

Additionally, of the PDUs that had a known 'Was Not Brought' (WNB) rate, the average WNB rate[1] was **10.5%**, ranging from **2.5% to 38.0%** (Figure 3). PDUs with more children living in areas within the most deprived quintile had a higher WNB rate.

After accounting for unit size and patient demographics, higher core MDT staffing was associated with better HbA1c outcomes and higher uptake of hybrid closed loop (HCL) systems. In both models, MDT staffing explained **5%** of the variation observed between PDUs (Figure 4).

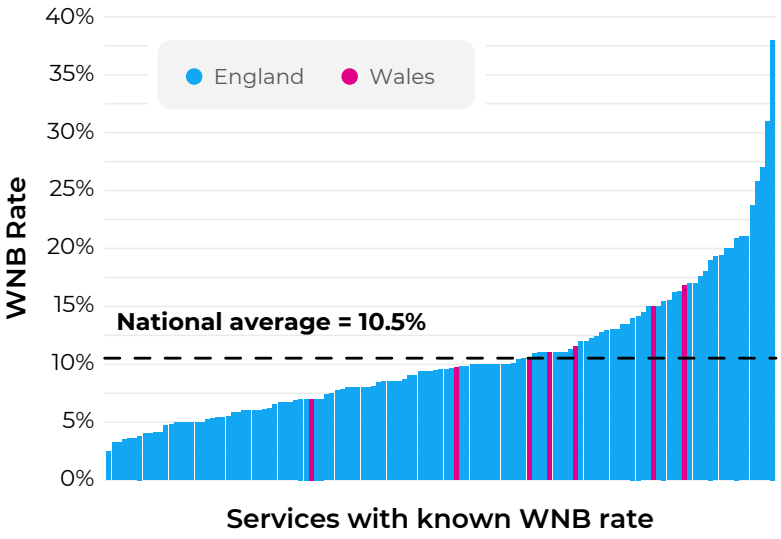


Figure 3: 'Was Not Brought' rates for all PDUs in England and Wales. 32 PDUs (28 in England, 3 in Wales, and 1 in Jersey) are omitted as the 'Was Not Brought' rate was not known.

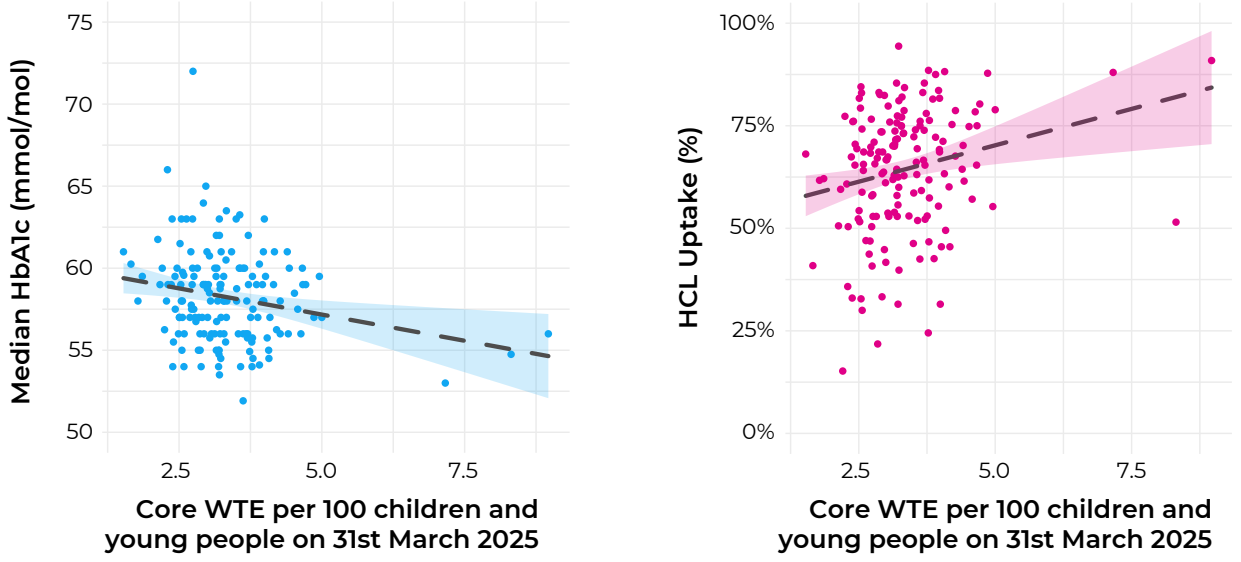


Figure 4: Median HbA1c and HCL uptake by core diabetes MDT WTE per 100 patients. The dashed line indicates the linear relationship and the shaded areas the 95% confidence interval.

[1]'Was not brought' is a health and social care term used when a child reliant on a carer misses a scheduled appointment because they were not taken by their responsible caregiver, rather than choosing not to attend. It replaces the term 'Did not attend', which wrongly puts the blame on the patient when they depend on someone else for transport or care.

Almost all units had a nurse who was able to work in hospital and community settings (**99%**), start patients on HCLs (**99%**), and/or adjust insulin under protocol (**95%**). However, only **59%** of units had a nurse who was a nurse prescriber in post. Greater WTE per 100 patients for specific nursing responsibilities was generally associated with improved core audit outcomes at PDU level, particularly lower median HbA1c and higher HCL uptake (Table 2).

Nursing responsibilities	Median HbA1c	Health check completion rate	HCL uptake
Work in both hospital and community settings	-0.32	0.18	X
Nurse prescriber	-0.16	X	0.20
Adjust insulin under protocol	-0.26	X	0.18
Start patients on HCL systems	-0.27	X	0.31

Table 2: Pairwise Pearson correlations between each nursing role or responsibility (WTE per 100 patients) and core audit outcomes. A positive correlation means both measures tend to increase together. A negative correlation means one tends to decrease as the other increases. Values closer to 1 or -1 show a stronger relationship, while values near 0 show little or no relationship. An 'X' indicates that no significant relationship was found between a nursing responsibility and an outcome.

92% of services had a dietitian in post who was able to work in hospital and community settings, and this was associated with higher HCL uptake **(r = 0.16)**. However, only **12%** of services had a dietitian in post that was a supplementary prescriber and **49%** had a dietitian that was able to adjust insulin doses under protocol. These were not associated with differences in HbA1c, health check completion, or HCL uptake.

Recommendation 1

Commissioners should proactively undertake regular reviews of their PDU workforce capacity against current patient numbers, case-mix, and service demand, using relevant national and professional guidance to inform local workforce planning and service development.

Action by: Integrated Care Boards in England, Health Boards in Wales, and The Government of Jersey.

KEY MESSAGE 02

Funding and Tertiary Care

Fewer PDUs are receiving the national funding rate to cover a full year of care for a child or young person with diabetes. Additionally, a quarter of PDUs deliver tertiary care, requiring further funding.



Best Practice Tariff (England only)

89% of PDUs in England knew whether they were receiving Best Practice Tariff (BPT) payments or not. Of these, **81%** stated that they were receiving BPT payments, down from 94% in 2017/18.

Of those receiving payments, **50%** received BPT payments based on current patient numbers. Of those not receiving BPT payments, **19%** expected to start within 12 months.

On average, **27%** of BPT payments went directly into diabetes care (Figure 5), down from 40% in 2017/18. However, many PDUs receiving BPT did not know how much of that funding went into diabetes care.

All funding sources (England, Wales, and Jersey)

Regardless of funding source (block payment or BPT), **16%** of PDUs in England, Wales, and Jersey received at least £3,453 per patient receiving a full year care in 2024/25. PDUs that received that amount of funding had a lower median HbA1c (Figure 6).

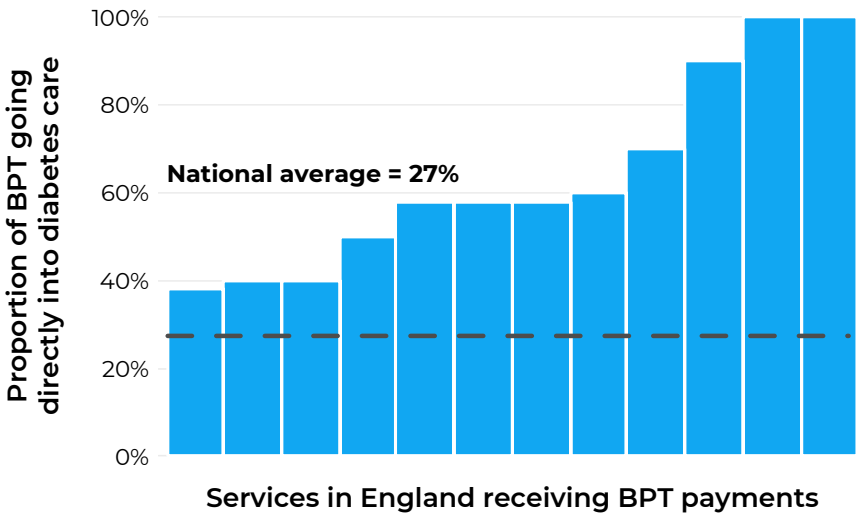


Figure 5: Column chart of the proportion of BPT payments going directly into diabetes care*.

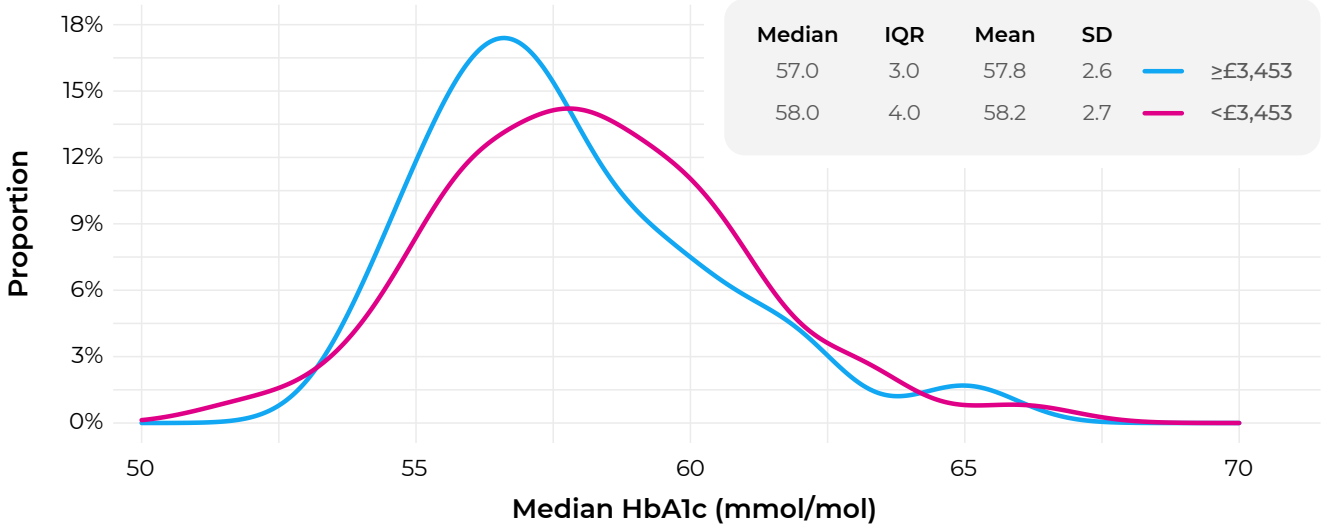


Figure 6: HbA1c by funding at or above £3,453 per patient with a full year of care in 2024/25 in England, Wales, and Jersey.

26% of PDUs offered tertiary-level diabetes support for patients beyond their secondary catchment area (paediatric intensive care for DKA, elective surgical procedures such as endoscopy, and second opinion for complex cases). Tertiary workload can be considerable and unaccounted for in the secondary workload provision. However, provision of tertiary-level support was associated with receiving at least £3,453 per patient with a full year of care in 2024/25.

Additionally, **47%** of services provided peripheral, rural, or cross-site clinics in addition to their main service location.

Recommendation 2

Commissioners and service providers should ensure that arrangements for funding paediatric diabetes services are transparent and regularly reviewed to ensure that resources appropriately reflect service activity, patient numbers and the complexity of care being delivered, including tertiary care and the multi-site services where applicable.

Action by: Integrated Care Boards in England, Health Boards in Wales, and The Government of Jersey.

*Only includes PDUs in England with a known proportion going into diabetes care.

KEY MESSAGE 03

Safeguarding

Children and young people with diabetes are more likely to have a child protection plan or be a child in care. However, fewer PDUs have protected time for safeguarding and almost all did not have a dedicated social worker.

Nationally, there was a total of **0.85** WTE social workers in 2024/25, compared to 1.70 in 2017/18. Only **two** services had a dedicated diabetes social worker in post, and only **one** met the minimum standard of 0.10 WTE per 100 patients.

On average, PDUs made **6** safeguarding referrals within the audit year (range **0 to 20**). PDSNs were responsible for safeguarding referrals in **98%** of PDUs, however they were only provided protected time for safeguarding in **17%** of PDUs. In **72%** of PDUs, no team members had protected time for safeguarding (Figure 7).

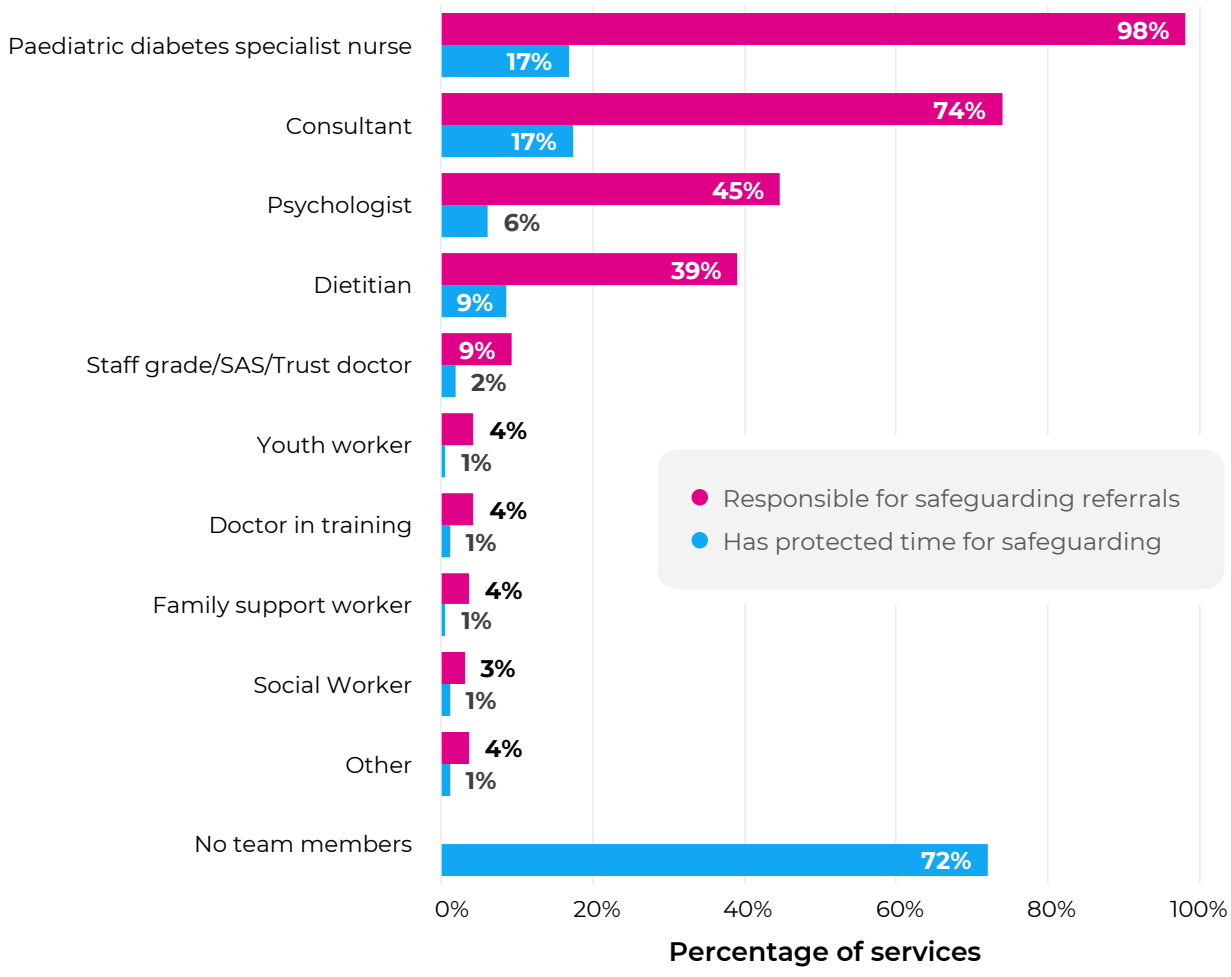


Figure 7: Percentage of services where each team member has protected time for safeguarding or is responsible for safeguarding referrals.

Children and young people managed within a PDU in 2024/25 were less likely than the general population aged 0-17 years to be considered a 'child in need'[2], but more likely to be a 'child in care'[3] or on a child protection plan[4]/register[5] (Figure 8).

[2] 'A 'child in need' refers to a child that is unlikely to achieve or maintain a reasonable standard of health or development without the provision of service support.
[3] A 'child in care' refers to a child that is looked after by the local authority, is subject to a care order, or is subject to a placement order (to put the child up for adoption).
[4] A 'child protection plan' in England is a formal written document that sets out specific steps to keep a child safe from significant harm.
[5] The 'child protection register' in Wales is a confidential list of all children in the local area who have been identified as being at risk of significant harm.

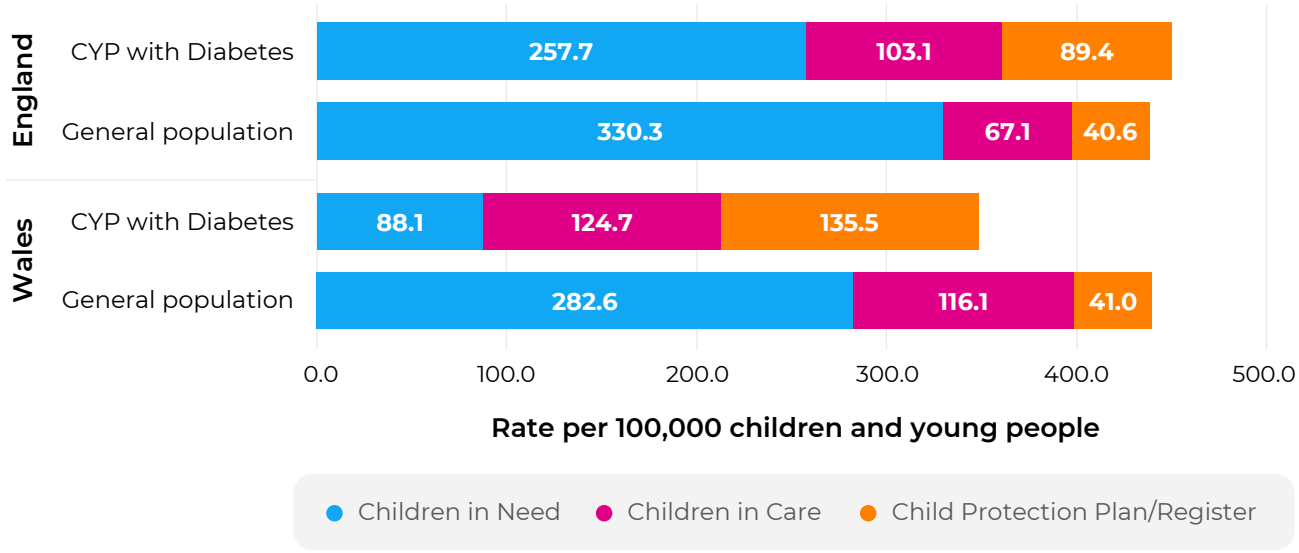


Figure 8: Rate per 100,000 children and young people with diabetes in the child protection system in England and Wales in 2024/25, compared to the general population. Jersey has been omitted due to small numbers.

Recommendation 3

There should be a review of the support available to children and young people with diabetes who are involved with safeguarding services, ensuring access to appropriate safeguarding expertise and multidisciplinary support to meet identified needs.

Action by: Integrated Care Boards in England, Health Boards in Wales, The Government of Jersey, and the social care working group within the National Children and Young People's Diabetes Network.

Future Work

Further evaluation and research should be undertaken to better understand the reasons why children and young people with diabetes are disproportionately represented within the child protection system, particularly at higher levels of intervention, including being looked after or subject to a child protection plan/placed on a child protection register.

KEY MESSAGE 04

Psychological support

Most PDUs are screening for emotional wellbeing but only a quarter screen for eating disorders. Most PDUs have a psychologist in post but many do not offer the recommended interventions.

91% of services reported data on the number of children and young people with diabetes under their care that had a diagnosis of a learning disability/global developmental delay, autistic spectrum disorder, attention deficit hyperactivity disorder, and/or eating disorders (Figure 9).

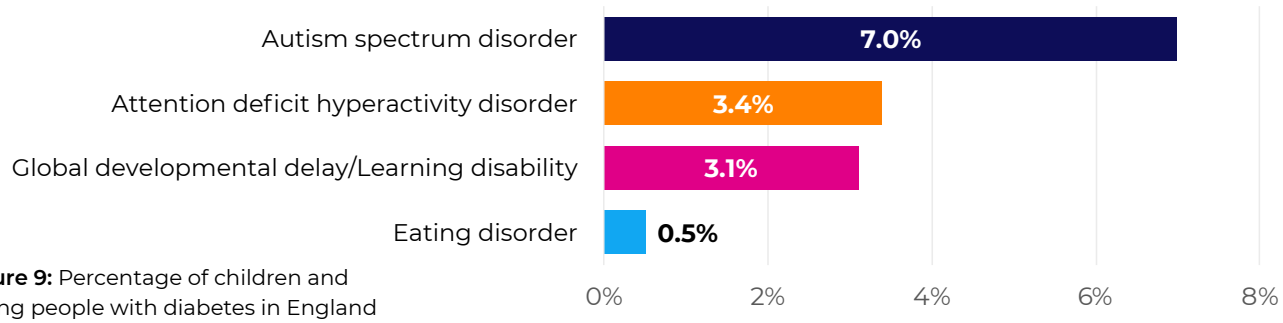


Figure 9: Percentage of children and young people with diabetes in England and Wales with diagnoses of mental health and neurodevelopmental conditions. Jersey excluded due to small numbers.

92% of PDUs formally screened for emotional wellbeing of the child and/or their family. Most commonly, they screened using a validated questionnaire. 24% of PDUs routinely formally screened for eating disorders. Figure 10 shows the methods used by PDUs to screen for emotional wellbeing or eating disorders.

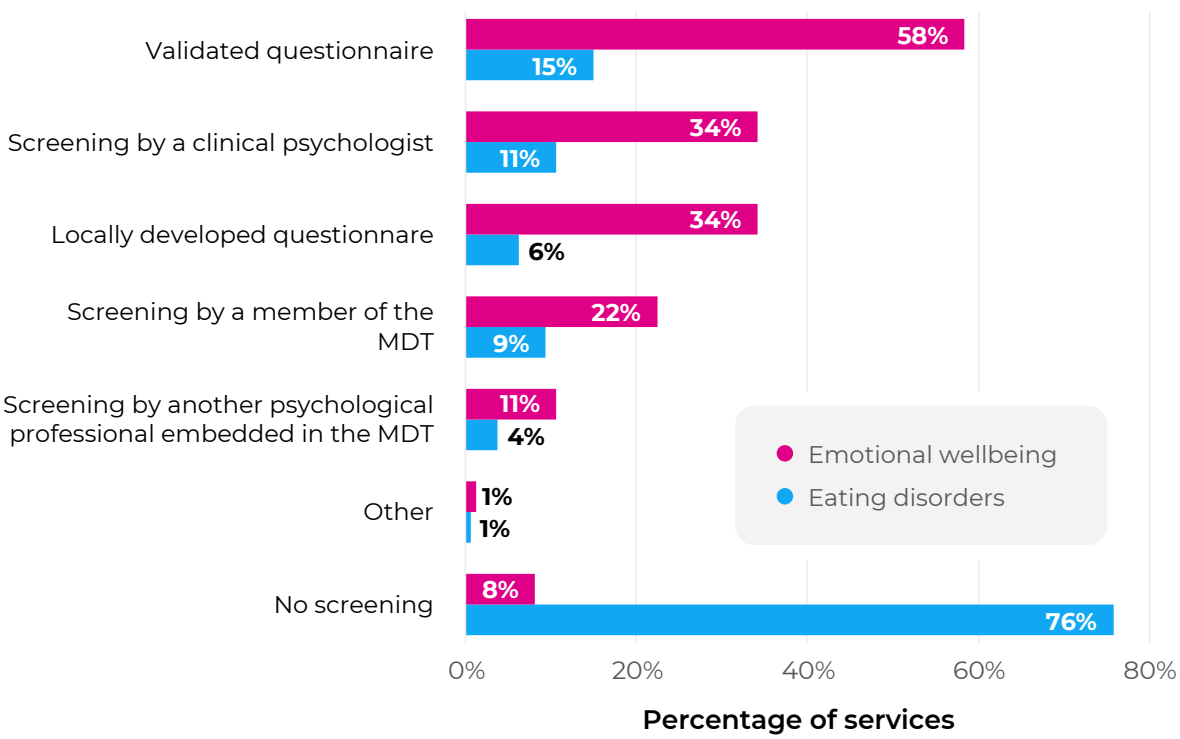


Figure 10: Screening for emotional wellbeing and eating disorders offered by paediatric diabetes services.

80% of PDUs had a clinical psychologist in post in 2024/25, compared to **89%** in 2017/18. Additionally, **12%** of PDUs had an assistant psychologist in post and **6%** of services had another psychological practitioner in post.

60% of PDUs had a high HbA1c protocol which included assessment and intervention by a clinical psychologist, **26%** had a DKA protocol which included assessment and intervention by a clinical psychologist, and **28%** had a process to identify the need for and to complete cognitive assessments either within or outside the team (Figure 11).

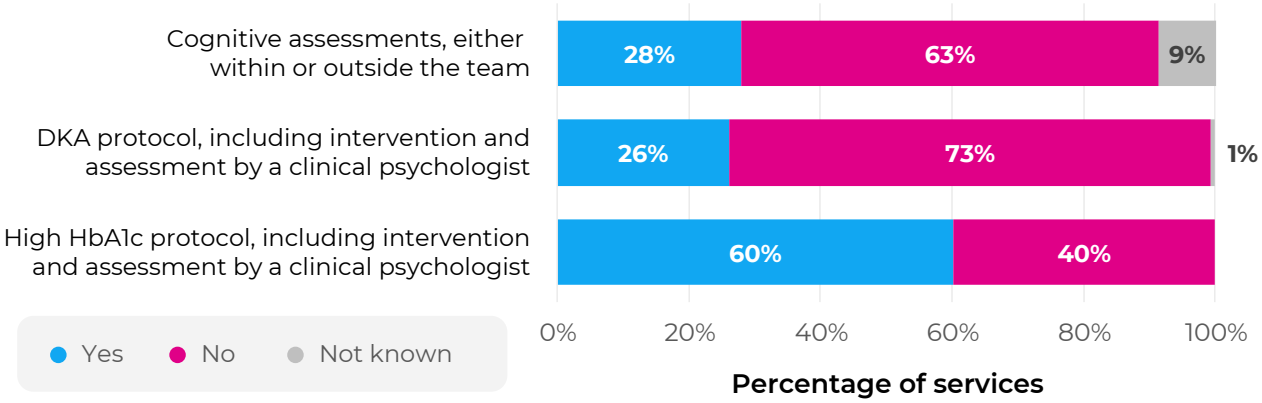


Figure 11: Percentage of services offering psychology interventions.

73% of PDUs routinely offered contact with a psychologist following diagnosis of diabetes, with **43%** offering contact within 4 weeks of diagnosis.

Recommendation 4

Guidance should be developed for PDUs on the identification, diagnosis, management and prevention of eating disorders in children and young people with diabetes, including a standardised approach to screening for emotional wellbeing and eating disorders within routine care.

Action by: The Type 1 Diabetes and Disordered Eating (T1DE) working group within the National Children and Young People's Diabetes Network, the National Institute for Health and Care Excellence (NICE), and diabetes charities, such as Diabetes UK and Breakthrough T1D.

KEY MESSAGE 05

Advice, Education, and Transition

All PDUs provided structured education, and almost all delivered a transition clinic and provided 24/7 out-of-hours support.

94% of PDUs had a dedicated transition clinic or service, run jointly with the adult diabetes service. On average, these services accepted young people at age **16** (range **14 to 19**). In most services, the primary method of transition was through a gradual process over 1-2 years, meeting members of the adult team during the process (Figure 12). However, **18%** of PDUs did not transfer any young people through this method, similar to 20% in 2017/18.

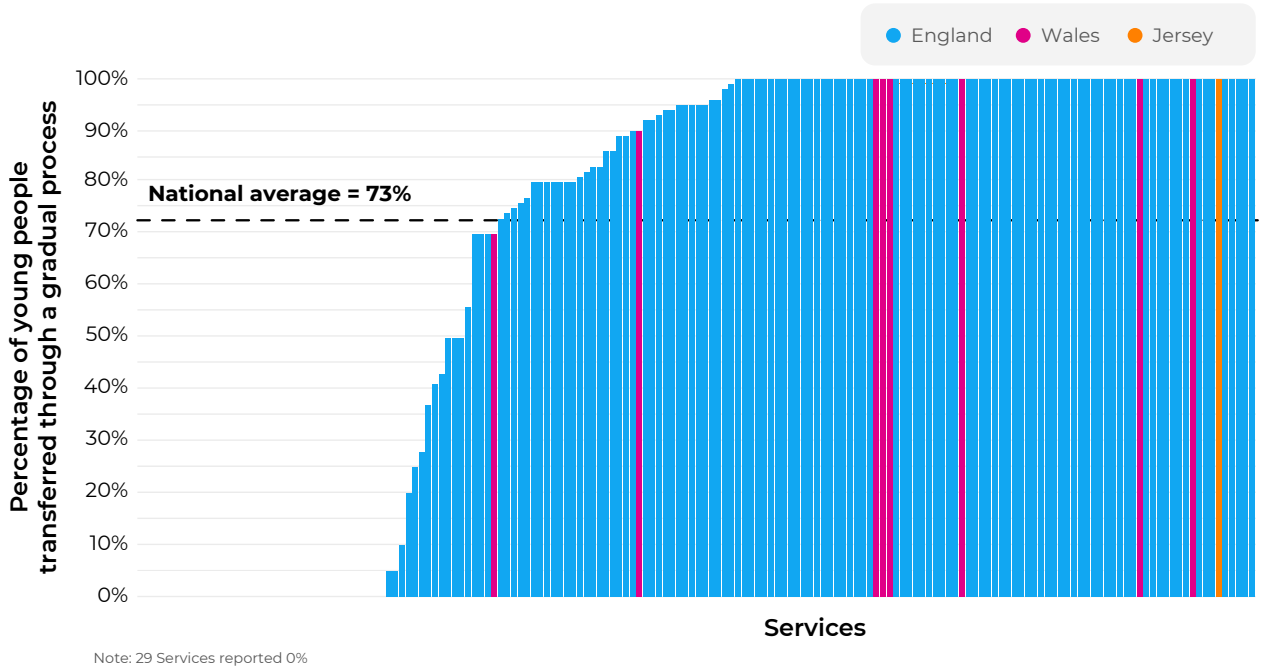


Figure 12: Percentage of young people transitioning to adult services through a gradual process over 1-2 years, meeting members of the adult team during the process.

95% of PDUs provided access to 24/7 telephone advice on diabetes management for children and young people, parents and/or carers. Figure 13 shows the team members responsible for providing this advice.

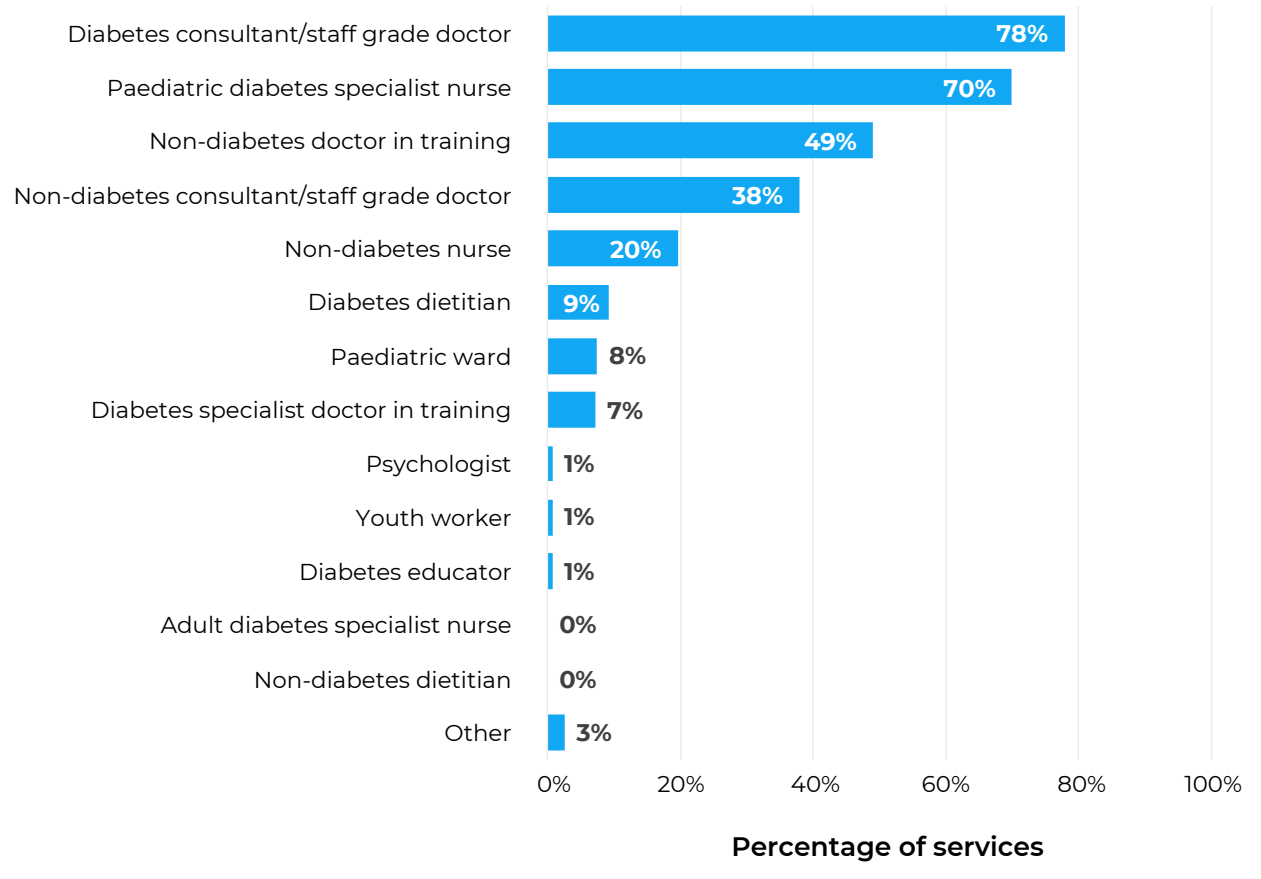


Figure 13: Percentage of services where each team member is responsible for providing 24/7 telephone advice.

All PDUs delivered a structured education programme for children and young people diagnosed with Type 1 diabetes locally (Figure 14). Of these, **63%** delivered a quality assured programme, meaning it has been reviewed by trained independent assessors to ensure consistency.

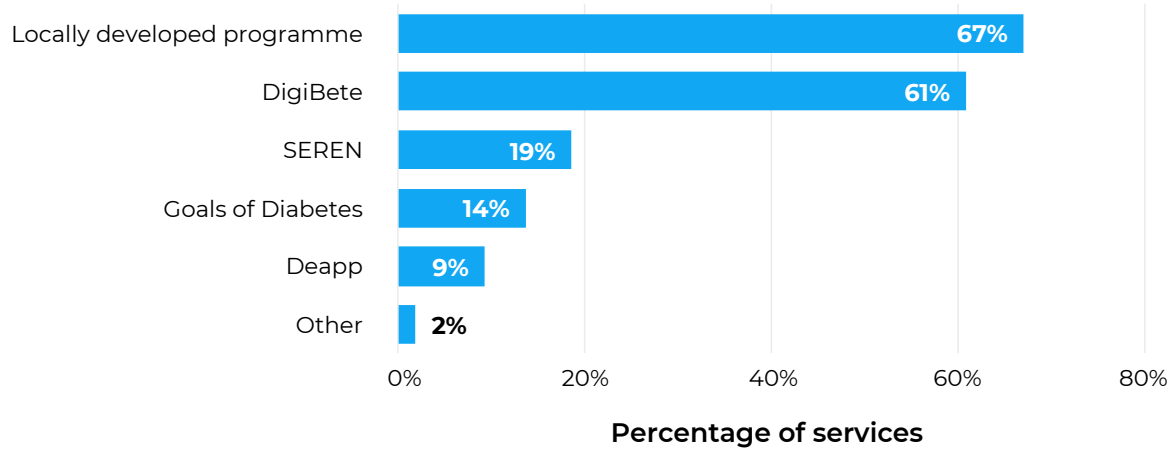


Figure 14: Percentage of services offering each structured education programme.

Special note

This is a positive key message and does not warrant a formal recommendation. PDUs should, however, be commended for their sustained provision of out-of-hours advice, transition services, and structured education programmes for children and young people with diabetes, and their families, despite the reduction in staffing ratios.

Quality Improvement resources

Taken together, these findings highlight opportunities for services to reflect on their workforce capacity, models of care, and support for children, young people, and families. The following resources are intended to help teams consider practical approaches to quality improvement and identify areas where existing national guidance and tools may support local planning.

- The **National Children and Young People's Diabetes Network** have provided tools to support services in assessing and increasing their workforce provision, such as the **workforce standards**, **workforce calculation tool**, and a repository of **example job descriptions**.
- The **Getting It Right First Time (GIRFT)** programme has provided resources for integrated care boards as part of their national review of services for children and young adults living with diabetes in England.
- The **RCPCH Diabetes Quality Improvement Website** provides multidisciplinary teams with the tools to identify, design, and analyse their own interventions specific to the needs of the children, young people, and families that they care for.
- **Unit-level reports** based on the data submitted to this spotlight audit will be shared with each PDU to benchmark themselves against regional and national averages. Additionally, benchmarking data is available from the core audit via **dashboards**, **unit-level reports**, and **data files**.

National Paediatric Diabetes Audit (NPDA)
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