The ASCEND project

ASsessing paediatric **C**aseload Complexity
and **E**nteral **N**utrition **D**emand

IMPORTANT DEFINITIONS

Please use these operational definitions when completing the ASCEND surveys. They are intended to support consistent interpretation across services in the United Kingdom and, if participation is enabled, the Republic of Ireland.

Where appropriate, the definitions align with the BDA Safe Staffing and Safe Workload Guidance (2024), the BDA-endorsed Universal Dietetic Patient Complexity Tool (UDPCT), validated version V11, and the terminology used in the ASCEND surveys. A definition may therefore be more specific than everyday local usage.

Please follow any narrower instruction shown beside an individual survey question. Use the best information reasonably available, and use '0' only when the true value is none; where offered, select 'unknown' or 'not recorded' when the information is unavailable. Do not enter names or other details that could identify a person, patient, service or organisation.

Table of Contents

1. Scope, services and participation

Home enteral tube feeding (HETF): For ASCEND, HETF means community-based dietetic care for children and young people within the survey age range who have a nasogastric, gastrostomy, gastrojejunostomy, jejunostomy or other post-pyloric feeding tube. It includes people whose tube is currently used for nutrition, hydration or medicines, those on an agreed pathway towards tube placement, and those transitioning away from tube feeding or awaiting tube removal, where the community service retains HETF responsibility. Do not include other community paediatric dietetic referrals unless HETF responsibility is also held.

Feeding-route reporting: The overall HETF scope above is broader than some feeding-route questions. Where a question asks for the percentage receiving tube-delivered nutrition, follow the categories and exclusions stated in that question. For example, a tube used only for hydration or medicines should not be placed in a tube-feeding route category if the question provides a separate category for this situation. Count each patient once in the single category that best describes their position at the specified time.

Community paediatric HETF service/team: The community dietetic service or team responsible for providing, coordinating or overseeing HETF care outside an inpatient setting for the defined population or area. It may be organised by geography, pathway, provider or specialist function.

Operationally distinct service/team: A service or team with a meaningfully separate caseload, workforce, leadership, pathway or reporting arrangement that can provide its own coherent set of survey answers. One Service | Team Survey should be submitted for each participating service or operationally distinct team; overlapping submissions for the same service should be avoided.

External teams, services or agencies: The different types of service outside the responding HETF team with which it routinely coordinates care. Count each distinct service type once, not every professional, provider, site or geographical boundary. For example, several paediatricians from different hospitals count as one paediatrics service type; several acute dietetic services count as one acute-dietetics service type; and an augmentative and alternative communication service and a general community speech and language therapy service count as two where their functions are distinct.

Documented care pathway: A current written pathway, protocol or agreed process that describes how relevant HETF referrals, assessment, care, review, escalation, transition or discharge should be managed. It may be an organisational, cross-service or locally approved document.

Confidential survey linkage code: The agreed service code word plus an individual numerical suffix, used to connect related survey submissions without asking ASCEND to hold names or a code key. The service code must not be the service, organisation or place name, and the suffix must not be a date of birth, staff number, telephone number or other identifier. Each individual respondent should use a different suffix and retain their full code privately if they may need to find, amend or request withdrawal of their submission.

2. Caseload, referrals and service demand

Accepted HETF referral: A new referral that the community paediatric HETF service has accepted for assessment or care, whether or not the first substantive dietetic contact has yet occurred. Do not include enquiries or referrals that were declined, redirected or remain awaiting an acceptance decision.

Caseload: The children and young people for whom the service currently retains HETF-related dietetic responsibility, including those actively receiving care and those awaiting a planned review, transition or discharge. Caseload is a count of people; it is not a measure of the time, complexity or workload associated with their care.

Active caseload: The caseload for which the service retains current clinical responsibility at the point specified by the survey. Include patients whose care remains open even when no contact occurred during the selected reference period. Exclude patients whose responsibility has formally transferred or ended.

Attributable caseload: The part of the active HETF caseload for which an individual clinician or support worker has identifiable ongoing responsibility or contributes directly as part of their role. Use a reasonable estimate where care is shared; do not double-count within your own response.

Discharge/transfer out: The end of an HETF episode of care where the community service no longer retains responsibility because care has ended, the patient has moved, aged or transitioned out, or responsibility has formally transferred to another service. A temporary gap between contacts is not a discharge.

Patient turnover: Movement into and out of the active HETF caseload during a defined period, principally through accepted referrals, transfers in, discharges and transfers out. Turnover is different from the total active caseload at a single point in time.

Service demand: The volume and nature of work generated by accepted referrals, the active caseload, planned and unplanned care, changing complexity, liaison, travel, service responsibilities and unmet or delayed work. Demand cannot be inferred from caseload size alone.

Waiting time: The elapsed time between the point specified in the survey question and the first substantive HETF dietetic contact. Use the question's stated start point consistently, such as acceptance of referral or discharge from hospital, whichever applies.

Unmet or delayed demand: Work that is clinically indicated or expected but cannot be delivered within the intended or locally agreed timeframe. This includes accepted referrals awaiting first contact and active patients whose planned review or intervention is overdue. It does not imply fault by an individual clinician or team.

3. Workforce, working time and job-plan activity

Headcount: The number of individual people contributing to the service. Count each person once, regardless of the number of hours or FTE they work.

Full-time equivalent (FTE)/whole-time equivalent (WTE): A measure of contracted working time, where 1.0 FTE/WTE represents the organisation's full-time hours for that role. Report the proportion contractually assigned or regularly included; do not include ad hoc overtime unless the question expressly asks for additional hours.

HETF FTE: The proportion of a person's contracted time assigned to, or regularly used for, community paediatric HETF work. Where the post covers several services or specialties, report only the HETF share. The total contracted FTE across all roles and the HETF FTE are separate measures.

Substantive and non-substantive staffing: Substantive staff hold an established permanent or fixed-term post within the service's normal workforce. Non-substantive staffing includes bank, agency, locum, temporary cover, externally supplied staff or other arrangements used outside the established substantive workforce. Follow the survey question if it asks for these categories separately.

Vacancy: An approved post, or approved proportion of a post, that is unfilled at the time specified. Report only the unfilled FTE where part of a post is occupied. Do not count unapproved desired capacity as a vacancy; it may instead contribute to perceived staffing need or unmet demand.

Additional hours and time off in lieu (TOIL): Time worked beyond contracted hours to meet HETF responsibilities. Record paid additional hours, hours taken or accrued as TOIL, and unpaid additional hours in the category requested. Do not count ordinary contracted hours twice.

Dietetic activities and job-plan categories: ASCEND uses the BDA job-planning categories below so that activity can be described consistently. Allocate each activity once to the category that best reflects its purpose and follow any examples provided in the survey.

- Direct Clinical Care (DCC): clinical-care activity, divided into individual patient-attributable and non-individual patient-attributable activity.
- Individual patient-attributable (IPA) DCC: activity that can be attributed to a named patient's care, including contact and associated patient-specific work.
- Non-individual patient-attributable (non-IPA) DCC: clinical service activity that cannot reasonably be attributed to one patient, such as general MDT or pathway work, clinical administration, stock or equipment tasks and service-level liaison.

- Supporting Professional Activities (SPA): work supporting safe professional practice and service quality, such as supervision, continuing professional development, audit, governance, staff or student development and service improvement.
- Additional responsibilities (ANR): formally appointed responsibilities additional to the core role, often at organisational level.
- External duties (ED): externally commissioned or funded duties such as agreed education, teaching, research or professional work.
- Travel: record separately from, but alongside, the activity it supports, using the relevant travel field in the survey.

4. Patient contacts, liaison and travel

Patient contact (care episode/package): A distinct new or review episode of dietetic care involving the child or young person and/or their parent or carer. Count the episode once. Preparation, assessment, intervention, documentation, correspondence and routine patient-specific liaison that form part of that same episode are included within the care package and are not additional contacts.

New patient contact: The first substantive dietetic care contact following acceptance into the HETF service. Administrative booking or an unsuccessful contact attempt is not, by itself, a new patient contact.

Review patient contact: A substantive follow-up episode of dietetic care for a patient already known to the HETF service. Count each distinct review care package once, regardless of the number of tasks completed within it.

Additional patient-specific liaison episode: A separate episode of patient-specific communication or coordination occurring between new or review contacts and not already included within one of those care packages. It remains IPA DCC. Several messages or calls forming one continuous piece of work should be counted as one liaison episode; avoid counting routine correspondence twice.

Remote contact: A substantive patient-care contact delivered without everyone being in the same physical location, for example by telephone or video. Count it as a new or review contact according to its purpose, not as an additional category unless the survey asks for the mode separately.

Home-visit episode: A substantive patient-care contact delivered in the patient's home or another community location that requires travel for that episode. Follow the survey instruction when calculating average return travel time, including any contacts with zero travel in the denominator where expressly requested.

Travel: Work-related travel undertaken as part of contracted community paediatric HETF duties, including travel to or between patient contacts, clinics, schools, MDT meetings and other approved service locations. Exclude ordinary commuting between home and the normal work base unless local policy treats a journey as business travel. Record travel separately beside the activity it supports so its contribution to workload is visible without double-counting the underlying activity.

5. Complexity, safety and supervision

Additional or special educational needs and/or disabilities: An ASCEND cross-national umbrella term covering recognised additional learning needs (Wales), additional support needs (Scotland), special educational needs and disabilities (England), special educational needs (Northern Ireland), and comparable terminology used in the Republic of Ireland. Apply the status recognised in the child or young person's care or education context; do not infer a diagnosis that has not been recorded.

Patient complexity: ASCEND uses the BDA-endorsed UDPCT, validated version V11. Classify the needs and intervention required as Low (12–17), Medium (18–26) or High (27 or above), using the V11 scoring criteria. Complexity describes the patient's needs and required intervention, not how personally difficult a clinician finds the case. For percentage questions, count each patient once in the category that best represents the specified group and time point.

Patient-safety incident and near miss: An HETF-related event that caused, or had the potential to cause, avoidable harm and is known to the responding clinician or service through its work or reporting arrangements. Use local incident-reporting definitions where applicable. Report only the number or category requested; do not enter patient details or descriptions of identifiable incidents.

Safety indicators: Measures that help show whether staffing, workload and service conditions are supporting safe and sustainable care. ASCEND considers indicators such as time sufficiency, excessive or unsafe workload, additional or unpaid hours, waiting and review pressures, vacancies, skill mix, supervision, speaking up, incidents or near misses, work-related stress and work-related ill health. No single indicator determines safety on its own.

Triangulation: The structured interpretation of several related sources of evidence together. ASCEND combines staffing, caseload, demand, activity, patient complexity, service context and safety indicators because staffing numbers or caseload size alone cannot determine a safe workload or safe staffing requirement. This approach supports more balanced conclusions and helps prevent one measure being interpreted in isolation.

Supervision: A formal, planned process of professional support, reflection and development with an appropriately skilled supervisor. Terminology varies: the BDA commonly uses practice supervision, while clinical or professional supervision may be used locally. Informal day-to-day advice does not normally constitute formal supervision unless it forms part of an agreed supervision arrangement.

Workload: The total work required of a clinician or team within the available time. It includes direct and indirect patient care, professional and service activities, travel, additional responsibilities and other work required by the role. Workload is influenced by demand, complexity, pathway and organisational factors; it is not interchangeable with caseload.

Workload safety: The extent to which the required work can be delivered within available staffing, time, skills and support without creating unacceptable risk to patients, staff or service quality. ASCEND assesses this through several objective and experience-based indicators rather than a single threshold. Responses describe conditions and experience; they are not judgments about an individual clinician's competence or a service's performance.

Optional wellbeing information: Questions about work-related stress and feeling unwell because of work-related stress are safety indicators used alongside the other evidence needed to understand safe workload and staffing. They are optional. Where a coded response could potentially relate to an indirectly identifiable person, ASCEND will treat the answers as special-category health information and apply the safeguards described in the Survey Privacy Notice. Findings will be reported only in aggregated, disclosure-controlled form.

6. Survey periods, estimates and reporting conventions

Current / at the time of completing the survey: The position that applies on the date the response is completed, unless the question specifies another date or period. Use the same point in time consistently across related questions where reasonably possible.

Reference period: The period expressly named in a question, such as the last week, a representative four-week period or a representative month. Use only activity or events belonging to that period and avoid mixing periods within the same answer.

Representative period: A recent period that reasonably reflects usual working conditions for the respondent or service. Where possible, avoid atypical weeks affected by annual leave, exceptional sickness, major disruption or unusual peaks unless these are themselves representative. If no period is fully typical, use the best available period and any explanation box provided without identifying people or services.

Estimate: A reasoned approximation based on the best information reasonably available where an exact figure is not held. Apply a consistent method and do not create false precision. Select 'unknown' or 'not recorded' instead where offered and where no defensible estimate can be made.

Zero, unknown and not recorded: Enter '0' only when the true value is none. 'Unknown' means the value cannot reasonably be established by the respondent. 'Not recorded' or leaving the answer blank may be taken to mean the service does not hold the requested information in an accessible record or the answer is unknown. Do not use zero as a substitute for missing information.

Percentages: Use the denominator specified in the question. Categories intended to describe the whole should total 100%, allowing only minor rounding differences. Count each person, patient or unit of time once unless the question says otherwise.

7. Sources and related ASCEND documents

These definitions should be read with:

- BDA Safe Staffing and Safe Workload Guidance (2024);
- Universal Dietetic Patient Complexity Tool (UDPCT), validated version V11;
- ASCEND Survey Guidance: Before You Begin;
- ASCEND Survey Privacy Notice; and
- the question-specific instructions in the Individual Clinician Survey and Service | Team Survey.

If a term remains unclear, please contact the ASCEND project team before submitting rather than including identifying information in a free-text response.