2010 Dietitian Workforce Survey Report

March 2012
Acknowledgements

We would like to thank everyone who has supported this piece of work along the way and in particular the managers and dietitians who responded to the survey itself. Thanks also go to Lindsay Oliver, Chair of DMEG, Adam Sweeney and Gavin Terry from Diabetes UK and Gillian Johnson, Programme Manager, NHS Diabetes.
Within an effective diabetes service, dietitians are expertly placed to encourage people to make healthier lifestyle choices and self-manage their diabetes through careful attention to diet. Dietitians can also help to prevent the ever-increasing rise in the number of people developing type 2 diabetes.

Both NHS Diabetes and Diabetes UK believe access to expert nutritional advice is a vital component of diabetes care. Statement two of the NICE Quality Standard for diabetes in adults focuses on nutrition. It calls for people with diabetes to “receive personalised advice on nutrition and physical activity from an appropriately trained healthcare professional or as part of a structured educational programme”.

During the ongoing uncertainty about reforms to the NHS, both of our organisations have been consistently highlighting the need to maintain and develop specialist staff and the services they provide to ensure effective integrated care. Staffing levels for nutrition specialists fall well below our recommended levels, and such short-sighted cost saving measures can only increase the burden on an already overstretched NHS.

By carrying out the workforce survey, we have been able to start to create a picture of how many dietitians we have to support people, where they work and what levels of expertise and experience they have. Unfortunately, we know from the survey and through other means there is an average of only two fulltime specialist diabetes dietitians supporting each diabetes service.

The results show differences in the quantity of dietetic services and level of specialist service across the country, with half of diabetes dietetic care being provided by non-specialists. Also, nearly half of those surveyed said their staff have access to less than three hours of professional development per month, which has dire implications for the continuing development of these skilled specialists and the service they are delivering.

Perhaps most worrying is of those surveyed, no service delivers a comprehensive range of services across all settings, and they also feel unable to influence systematic commissioning. This is vital if services are to be developed and maintained to meet the needs of people with diabetes, and the rising need in the future.
Improving diabetes care

Diabetes is serious. If diagnosed late, left untreated, or poorly managed, it can lead to life-threatening complications. Between 1996 and 2011 the prevalence of diabetes has leapt from 1.4 million to 2.9 million. By 2025 it is estimated that over four million people will have diabetes. Most of these cases will be type 2 diabetes, because of our ageing population and rapidly rising numbers of overweight and obese people.

Alarmingly, estimates show that around 850,000 people already have type 2 diabetes but haven’t yet been diagnosed. The facts are shocking and confirm that diabetes is one of the biggest public health challenges facing the UK today:

- Diabetes is the leading cause of blindness in the working age population in the UK.
- Diabetes causes at least 300 hospital admissions from heart attacks a week in the UK.
- Treatment costs the NHS 10% of its annual resources – £9bn a year.
- Cardiovascular disease is a major cause of death and disability in people with diabetes, accounting for 44% of fatalities in people with type 1 diabetes and 52% in people with type 2 diabetes.
- Diabetes causes at least 100 lower-limb amputations a week in the UK.

NHS Diabetes and Diabetes UK are working in partnership to improve care for people with diabetes. As a national diabetes service improvement team, the role of NHS Diabetes is to work with managers, commissioners and providers of diabetes services. Diabetes UK complements this work by representing the people with diabetes.
About NHS Diabetes

**NHS Diabetes** provides the essential link between diabetes strategy and frontline service improvements for patients. Through their integrated work programmes they provide national leadership and direction and support local teams working to champion good quality diabetes care.

About Diabetes UK

**Diabetes UK** is the largest organisation working for people with diabetes. The charity funds research, raises awareness, campaigns and helps people live with the condition. Diabetes UK’s mission is to improve the lives of people with diabetes and work towards a future without diabetes.

About DMEG (Diabetes Management and Education Group)

DMEG is the diabetes specialist interest group of the British Dietetic Association. It aims to support dietitians who work in the area of diabetes through the promotion of high-quality evidence-based dietetic practice. The group acts as the voice for specialist diabetes dietitians at a national level, but also provides resources to support the day to day activities of dietitians working in the area of diabetes.
Key findings for the services that took part in the survey

**Staffing levels**
- The average number of specialist diabetes dietitians in a dietetic service in whole time equivalent is 1.85, or just under two full-time members of staff. This is below Diabetes UK’s recommended minimum staffing levels.
- There is inequity in terms of the quantity of dietetic service and level of specialist service provided in Trusts across England. One half of diabetes care is provided by non-specialists.
- There has been very little growth in the workforce in the last two years.

**Quality and comprehensiveness of service provision**
- None deliver a comprehensive range of services across all settings, and dietetic managers feel unable to influence systematic commissioning.
- 65% of services do not deliver any support to people in care homes, prisons and other institutions.
- 70% of services do no work in diabetes prevention, despite strong evidence of the impact of this on lifestyle change and prevention of diabetes.
- 30% of services provide no type 2 structured education.
- Services such as “Group Education for Type 1” and “Type 1 diabetes (pumps and problem solving)” were reported as being more integrated into diabetes services with fewer gaps in provision.

**Professional development**
- 43% of dietetic services state their staff spend less than three hours a month on continued professional development.
- Dietetic managers clearly indicated that the training provision which would best enhance the diabetes dietetic workforce would be postgraduate courses relevant to diabetes.
Summary of main issues identified from the survey

Dietetic services deliver a range of interventions across a host of different settings – primary care, specialist diabetes care and secondary care. This manifests itself in services that either provide a very superficial service across all areas or deliver high-quality services across a limited number of areas. Very few services deliver a high-quality comprehensive service.

The lack of sufficient staff, particularly at senior grades, has been identified as being a problem in that it limits opportunities to influence commissioning and service development.

Much of the care delivered to people with diabetes is by non specialist dietitians and there is inequity between different organisations in terms of the amount of provision and the areas of work this time is invested in.

Overall, services are struggling to cope with the expansion expected of their services, whilst not being afforded the resource (staff and training) to ensure these developments are made cost-effective. In addition there is much inequity between services in both the total amount of sessions provided and the degree of specialist sessions provided.

In terms of training and education to maintain a skilled workforce, most departments have very limited time to access professional development. In addition, there is a lack of suitable training courses specifically provided for diabetes and dietetics. Despite this, many dietitians have skills in both advanced communication and adult education.

These findings are currently out of line with the recommendations made by Diabetes UK “Commissioning Specialist Diabetes Services for Adults with Diabetes - a Diabetes UK Task and Finish Group Report - October 2010” which states for a total population of 250,000 people with an average of 5% prevalence of diabetes, there should be four whole time equivalent specialist diabetes dietitians. One WTE (1.0) is 37.5 hours.

Recommendations

- Dietitians have unique skills and should be responsible for the training and quality assurance of all healthcare professionals who deliver nutritional advice as part of their role, both in the treatment and prevention of diabetes.
- Commissioners need to work with and ensure access to specialist dietetic services meeting the nationally identified competencies for people with diabetes for support, education and care, as well as the facilitation of integrated diabetes services. Diabetes UK has made key recommendations in its report on Commissioning Specialist Services for Adults with Diabetes.
- Dietetic services should be seen as core to the delivery of diabetes care and as such need to be appropriately commissioned to meet the needs of the local population. Dietetic services should be involved in the whole commissioning process including needs assessment, prioritisation and development of the service specification. This is essential to highlight constraints and opportunities to shape an innovative service.
- Dietitians should have access to high-quality post graduate education, specific to diabetes and provided on a routine basis which should be part of their ongoing professional development.
- Dietitians should be delivering care as part of an integrated multidisciplinary team, linked to the strategic objectives of the diabetes whole service.
The role of dietitians in diabetes care and management

Nutrition is core to the management of diabetes and as such, access to evidence based dietary advice should be seen as an essential component of diabetes care. Health policy recognises the only affordable long term option for healthcare delivery is to engage the public and people with long term conditions to make healthier lifestyle choices and to self manage their conditions. The dietetic workforce has the specialist and key skills required to meet this need.

Diabetes specialist dietitians (DSDs) work as members of multidisciplinary teams across a variety of healthcare settings, including primary and specialist care. Their caseload encompasses the breadth and depth of people with diabetes including problem solving with groups and individuals with complex needs.

There are a number of essential and desirable criteria in the job descriptions of DSDs, who usually work at Agenda for Change band 6–7 or higher if there is a managerial aspect to the job, or if the DSD is working as a consultant dietitian.

In terms of dietetic input into diabetes care there has never been information on the numbers of dietitians in place, where care is delivered, or the clinical competencies held or required for them to deliver quality diabetes care. This audit begins to put a framework around this information.

An introduction to the workforce surveys

Despite the important, skilled healthcare they deliver, there are still aspects of the diverse specialist diabetes management and care workforce we do not have knowledge of. Since 2009, a Diabetes Specialist Nurse Workforce survey has been carried out, and in 2010 this was extended to the specialties of dietetics and podiatry.

This audit was funded by NHS Diabetes and delivered by Diabetes UK, supported by the British Dietetic Association (BDA) and the Diabetes Management and Education Group of the BDA (DMEG). Its aim was to gather baseline information about the quality and quantity of dietetic services specifically for diabetes, from those providing it in England.

NHS Diabetes and Diabetes UK have highlighted the need for specialist skills and services to be accessible in all localities, in order to ensure the delivery of effective integrated care. The delivery of high-quality care for the whole diabetes population requires local models of care to have in place appropriate staffing levels, accessible facilities and structured care processes.

Diabetes UK has published a report with a set of recommended minimum core staffing levels for district specialist diabetes care teams: Commissioning Specialist Diabetes Services for Adults with Diabetes (2010). For an area with a population of 250,000 with an average of 5% prevalence of diabetes, where 20% of the diabetes population require access to specialist diabetes services, there should be at least four registered dietitians with a special interest in diabetes.
Given the lack of direct contact data available for dietetic staff, various routes were used to contact dietetic managers who could then complete the survey on behalf of the services they manage. These included using the BDA’s dietetic managers cascade system, advertisements in “Dietetics Today” and cascade via the regional DMEG representative’s networks. This method produced 107 responses across 146 trusts, and was considered an exceptional response rate.

Snap Surveys v.10 and Snap WebHost were used to design and host the online questionnaire. This enabled direct emailing of the survey to known contacts, and also participation in the survey for dietetic managers for whom contact data is not held. Data analysis took place in Excel and Snap Surveys v.10.

Some of the analysis was impeded due to difficulties in joining up respondents given whole time equivalent (WTE) data for staffing levels, diabetes sessions and others. A session of time is defined as 3.75 hours and one WTE equivalent is a full time post. Despite this limitation there are clear outcomes from the survey.
Respondents were asked to select which trusts they provided services to. The primary care trusts that were selected by respondents in this survey had an average population of 390,601.

<table>
<thead>
<tr>
<th>Number of dietetic services</th>
<th>107</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of trusts worked in</td>
<td>146</td>
</tr>
<tr>
<td>Average trusts served by each dietetic service</td>
<td>1.36</td>
</tr>
</tbody>
</table>

This shows that in terms of location, the configuration of dietetic provision is very complex with many dietetic services operating in more than one trust (the list included acute trusts as well as primary care trusts). This is important to bear in mind in the context of the incoming clinical commissioning consortia.

1. Service profile

WTE sessions in trusts

There is a wide variation in the range of WTE per service.

In designing this first dietetic workforce survey we attempted to identify how a dietetic service would divide their time, and piloted this with dietetic managers. Despite this, there were still difficulties experienced during the survey to identify these divisions, and this serves to highlight just how complex the delivery and organisation of dietetic services is. Anecdotal evidence from respondents suggests that some found this question to be too rigid to enable them to portray accurately the many areas of work in their service, accounting for the variations in data.

In future surveys, we would look to simplify the questions around how workforce capacity is accounted for, and in addition ask participants to identify their total population numbers, in place of using trust location as a surrogate measure for this.

Specialist diabetes dietitians in whole time equivalents (WTE, those working mostly in diabetes)

The average WTE specialist diabetes dietitians for a service are 1.85 WTE, or just under two full-time staff members.

Trust sessions dedicated to diabetes
Approximately 9% of the surveyed services have no sessions dedicated exclusively to diabetes. At the other end of the scale, approximately 9% have ten or more sessions exclusively for diabetes. This demonstrates the variability and inequity in dietetic provision for diabetes between services.

**Dietetic assistants**

48% of services have no dietetic assistants, but of those that do, the average is 1.1 WTE dietetic assistant. This is an interesting development, but it should be noted there should be adequate supervision provided by registered dietitians for these individuals.

**Specialist diabetes dietitians in each band**

Once the data was cleaned, 82 responses were analysed.

91% of dietitians are either band 6 or 7, with very few at band 8 (3%). This may in part explain why few dietitians feel able to influence the commissioning of services.

**2. Service activities**
The above is a breakdown of the total sessions that dietetic managers state their teams spend in each of these settings, as well as the range of sessions indicating variability and the percentage of services with no sessions in these settings.

The most common activity is specialist diabetes service – provided by 65% of services – with the least common being tertiary referrals, provided by only 11% of services. Primary care has the most variability in provision; however it is also the second-most common activity, with 44% of services providing it.

The high proportions of services not working in certain settings may be as a result of funding being allocated for specific service delivery; for example, patient education or specialist services, rather than for the comprehensive delivery of a service across all areas of patient care.

The high proportion of “no service” in intermediate care and tertiary care may be related to the model of care provided locally, which may not exist in all areas of England. However, there is a huge amount of variability across core services and of particular concern is the lack of input into paediatric care, inpatient care, patient education and staff training, with at least half of the services in this study not providing any time to them.

### Activities provided

All services answered this question. They are shown ranked in order of ascending provision.

<table>
<thead>
<tr>
<th>Type</th>
<th>Provided</th>
<th>Not Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Renal care</td>
<td>29.0%</td>
<td>71.0%</td>
</tr>
<tr>
<td>Prevention of diabetes</td>
<td>29.9%</td>
<td>70.1%</td>
</tr>
<tr>
<td>Institutionalised care (eg care Homes, prisons)</td>
<td>34.6%</td>
<td>65.4%</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>67.3%</td>
<td>32.7%</td>
</tr>
<tr>
<td>Group education - type 2</td>
<td>71.0%</td>
<td>29.0%</td>
</tr>
<tr>
<td>Training healthcare professionals - undergraduate</td>
<td>71.0%</td>
<td>29.0%</td>
</tr>
<tr>
<td>Training healthcare professionals - staff unqualified</td>
<td>72.9%</td>
<td>27.1%</td>
</tr>
<tr>
<td>16-25 transition</td>
<td>74.8%</td>
<td>25.2%</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>75.7%</td>
<td>24.3%</td>
</tr>
<tr>
<td>Type 2 - newly diagnosed, annual review, routine care</td>
<td>82.2%</td>
<td>17.8%</td>
</tr>
<tr>
<td>Group education - type 1</td>
<td>85.1%</td>
<td>15.0%</td>
</tr>
<tr>
<td>Training healthcare professionals - staff qualified</td>
<td>86.0%</td>
<td>14.0%</td>
</tr>
<tr>
<td>Protocol and guideline development</td>
<td>90.7%</td>
<td>9.4%</td>
</tr>
<tr>
<td>Type 1 diabetes (including pumps, problem solving)</td>
<td>93.5%</td>
<td>6.5%</td>
</tr>
</tbody>
</table>
Key points:

- The service with the least reported provision was renal care. This may be because this is provided within specialist renal services. There is potential ambiguity as to who is responsible for the dietetic diabetes care.

- 70% of services surveyed do not have input to diabetes prevention despite the strong evidence of the impact of lifestyle change on the prevention of diabetes.

- 30% of services do not deliver type 2 group structured education – despite recommendations that it should be offered routinely to all patients.

- Over 30% of services do not deliver paediatric dietetics. This may be because some of these are within a different organisational structure, for example primary care.

- 65% of services do not deliver support to people in care homes, prisons and other institutions.

These interpretations are substantiated by the comments about staffing received later in the survey.

**Service self-ratings of activities**

For every one of the above functions the service provides, managers were asked to rate their provision using the following framework:

<table>
<thead>
<tr>
<th>Excellent</th>
<th>System in place to allow all patients to be seen and fully integrated into the diabetes service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td>Most people are seen, the service is integrated, with some gaps in provision</td>
</tr>
<tr>
<td>Fair</td>
<td>This area is prioritised but there is no integration of the diabetes service</td>
</tr>
<tr>
<td>Poor</td>
<td>Very little dietetic provision for this service, offered on an ad-hoc basis</td>
</tr>
</tbody>
</table>

These definitions were re-classified around “Acceptable services” – those defined as Excellent or Good; and anything less than this indicating “Unacceptable services”, which is not integrated into the diabetes service or where there is little dietetic provision, including that which is potentially offered on an ad-hoc service.

The average self-ratings for all services which perform these functions is shown in the table **Self-rating of activities** (NB: the total number of services which provide each function changes, so the same percentages do not necessarily imply the same absolute values - see table above).
These are ordered by the prevalence of each function amongst dietetic services (renal care is the least prevalent, and type 1 diabetes is the most prevalent).

The following areas were defined as not acceptable by between 40% and 70% of services managers in the services providing them:

- prevention of diabetes
- institutionalised care
- renal care
- training healthcare professionals.

It is notable that the prevalence of a function does not correlate with its quality. For example, the most widely provided activity (type 1 diabetes, including pumps, problem solving) is rated by 1 in 4 services as unacceptable. Similarly, the training of qualified healthcare professionals, carried out by 86% of services, is rated as unacceptable by 47% of those providing it.
This lack of relationship between how widely a function is provided and it's rating by the service providing it reiterates the problems faced by dietetic managers with limited resources and a broad remit; should this be targeted, to provide a small range of functions that are of high-quality (integrated and with few gaps in provision) or should they provide a broader range of services across all areas that are of poorer quality (not integrated, unplanned and under-resourced)?

**Key findings**

These findings suggest that dietetic services are spending time on many areas of work, perhaps only one or two of which they do well; or, that services are working across so many areas that they are not able to focus on quality. Particularly concerning is the inability to deliver an appropriate level of dietetic service to vulnerable groups in institutionalised care, and those with renal problems; or to work in the area of preventing diabetes, for which a strong evidence base of efficacy exists.

### 3. Staff development

**Hours per month on continuing professional development (CPD)**

<table>
<thead>
<tr>
<th>Number of CPD hours/month</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 3</td>
<td>43.4%</td>
</tr>
<tr>
<td>Less than 6</td>
<td>34.0%</td>
</tr>
<tr>
<td>Less than 9</td>
<td>16.0%</td>
</tr>
<tr>
<td>Less than 15</td>
<td>3.8%</td>
</tr>
<tr>
<td>More than 15</td>
<td>2.8%</td>
</tr>
</tbody>
</table>

43% of managers state that their staff spend on average less than three hours a month on continuing professional development.

A small percentage estimate more than 15 hours is spent on CPD per dietitian – this ranged up to 23 hours. It is possible this reflects the range of CPD activities available to dietitians, from set courses such as Masters level modules, to shadowing and mentoring.
Many types of training were identified. The above chart represents the breakdown of recognised qualifications held by staff. For example, Masters level qualifications make up 7% of all the qualifications given by dietetic services, but it can’t be assumed that 7% of dietetic staff hold this qualification.

Dietetic managers identified 581 named training courses their staff had attended. This range raises issues around the quality and consistency of training and the lack of a definitive course for specialist diabetes dietitians.

Patient education, communication skills and teaching make up almost 70% of recognised qualifications demonstrating the importance of these skills within dietetic teams.

Postgraduate training relevant to diabetes make up 18% of the responses given. Amongst those surveyed only 43 Masters/PhD qualifications were held.
The above chart shows training currently being undertaken and not yet completed. The most common training occurring was clinical supervision (31%) and a teaching qualification (29%). Almost 1 in 4 of all qualifications currently being studied for are quality-assured patient education training or advanced communication skills (11% and 15% respectively).

Academic training makes up a small proportion of current training overall (14% made up by postgraduate qualifications relevant to diabetes, masters level study and PhD).

**Advanced communication skills in your service**

The majority of services provide advanced communications skills training for their staff (58%); however well over a third do not (39%). Those who do were asked how this is delivered.

**How is advanced communications training provided?**
Over half of the services who deliver this training provide it using external trainers (56%, 35 services). Just over 1 in 3 provide it using a mixture of in-house and external providers (36%, 22 services). A small percentage provides it entirely in-house.

**Which one aspect of training would improve the specialist diabetes dietetic workforce?**

![Bar chart showing responses to training needs]

Almost half of all dietetic managers responding to this question stated a postgraduate qualification relevant to diabetes would improve the specialist workforce, selecting this well ahead of other courses such as Masters study, advanced communications skills, local clinical supervision, quality-assured patient education training or teaching qualifications. This may be because it is seen as having more value, but most likely this finding relates to the lack of a suitable course specifically for dietitians.

This highlights how training needs are not matched by provision.

**Key findings**

The evidence here points towards strong recommendations that the workforce requires postgraduate diabetes specialist training on a much greater scale than it currently receives. This need, irrefutably identified by dietetic managers, is not being met.
4. Changes to Services

The below relate to the two years preceding October 2010.

Dietetic posts lost versus posts gained
Across 107 services, 34 dietetic posts have been gained and 19 lost representing small net growth across England during the period.

Regraded posts
A total of 23 staff members across 19 services have been regraded. Although 83% of these were upgrades, the potential downgrading of posts needs to be monitored in the coming years.

How have staff changes impacted on your service?
A total of 65 out of 107 services gave comments pertaining to the impact of staffing changes on their service even though only 12 had overall staff loss, and only 23 reported staff re-grading. This suggests that some staffing changes have occurred out of the timeframe in question in the survey, and yet this has had a long term impact on services.

The illustration from these comments overall is of services that are poorly resourced and struggling to cope with managing an expanding caseload, with a tendency to work reactively rather than proactively, and lacking the funding or representation at senior or commissioner levels to develop more cost-effective, high-quality services.

In services that have gained staff the tone is typically more optimistic, with discussion focused on what they can do, rather than what they cannot (staff retention being a key feature of more satisfactory staff levels): although there is also discussion of their limitations, and doubts about the core duties of a dietetic specialist role.
Of the many comments given, the following are a collection of some of the issues reported:

**NEGATIVE**

“0.8 WTE was on long term sick leave then left the department. Due to cost savings we are not recruiting to this post… Working less within the diabetes MDT and more single handed in clinics/groups.”

“Band 7 post was frozen in September 2009 after the dietitian left. The dietitian worked within the diabetes specialist service with a lead in type 2 patient education… 10 hours of the lost post was seconded to the DSN service to (attempt) to coordinate the programme and ongoing development. This is a temporary (and inadequate) measure…”

“No absence cover. No development. No CPD. Reduced morale. Increased stress. Staff resignation(s).”

“With only one specialist dietitian in a large MDT of medics and nurses the dietetic voice can be lost. Isolation within the team has led to rapid turnover within the role and problems with recruitment and retention.”

“No changes in the last two years therefore continue with a very small service, which is inequitable across the county.”

“Unable to keep up with expanding service, caseload number and complexity. Unable to provide Diabetes prevention strategy. Unable to provide paediatric structured education.”

“We simply do not have enough dietitians. Using the BDA calculator we should have 8.0 wte. We provide no service in pregnancy and the rest of the service is poor.”

**POSITIVE**

“Extra staffing has enabled us to provide a better service helping to improve patients understanding around diabetes. It has raised awareness for dietetics in diabetes and has allowed us to be a key member within a multi-disciplinary team.”

“Reduced waiting times for outpatient appointments. More effective supervision of B5 Dietitian. Ability to provide cover for sickness and holidays. Inclusion of one research session per week and team leader role.”

“The recruitment of two band 5 dietitians who work in obesity management as well as diabetes…has allowed us to provide a more equitable and cost-effective service.”

“Creation of a Clinical lead Dietitian…has given opportunity for service improvement.”

One respondent stated their shortfall in staff meant they “could not deliver a cost-effective service”: an important reminder that fewer staff does not necessarily equal lower costs in the longer term, in times when further cuts to staffing in specialist services are a real threat.

**Key findings**

Probably the most revealing part of this study can be found in the respondents’ discussion of the impact of staffing changes on their service. Many services submitted comments, both positive and negative. What was abundantly obvious is that the workforce is committed to trying to provide a quality service – but that it is extremely challenging to develop a comprehensive service from limited resources, and in particular to influence commissioners and those who shape services.
Summary of main issues identified from the survey

Dietetic services deliver a range of interventions across a host of different settings – primary care, specialist diabetes care and secondary care. This manifests itself in services that either provide a very superficial service across all areas or deliver high-quality services across a limited number of areas. Very few services deliver a high-quality comprehensive service.

The lack of sufficient staff, particularly at senior grades, has been identified as being a problem in that it limits opportunities to influence commissioning and service development.

Much of the care delivered to people with diabetes is by non specialist dietitians and there is inequity between different organisations in terms of the amount of provision and the areas of work this time is invested in.

Overall, services are struggling to cope with the expansion expected of their services, whilst not being afforded the resource (staff and training) to ensure these developments are made cost-effective. In addition there is much inequity between services in both the total amount of sessions provided and the degree of specialist sessions provided.

In terms of training and education to maintain a skilled workforce, most departments have very limited time to access professional development. In addition, there is a lack of suitable training courses specifically provided for diabetes and dietetics. Despite this, many dietitians have skills in both advanced communication and adult education.

These findings are currently out of line with the recommendations made by Diabetes UK “Commissioning Specialist Diabetes Services for Adults with Diabetes - a Diabetes UK Task and Finish Group Report - October 2010” which states for a total population of 250,000 people with an average of 5% prevalence of diabetes, there should be four whole time equivalent specialist diabetes dietitians. One WTE (1.0) is 37.5 hours.
References

(All data recorded April 2010 to March 2011)

England - 2010-11 Quality and Outcomes Framework (QOF) for England by The NHS Information Centre for Health and Social Care - (www.ic.nhs.uk)

Northern Ireland - The Department of Health, Social Services Public Safety - (www.dhsspsni.gov.uk)

Scotland - The Scotland QOF figure is lower than last year, this is because the data collected was incomplete and therefore the real figure would be expected to be higher. See the Scotland ISD for further details. When comparing QOF data we have to use the QOF figures to compare like with like. However, when looking for Scotland prevalence on its own we would suggest using the data from the Scottish Diabetes Survey which will be closer to the true figure. The Information Services Division - (www.isdscotland.org)

Wales – Welsh Assembly Government, Stats Wales - (www.wales.gov.uk)


Data and analysis from the NHS Information Centre


