Renal Nutrition
Specialist Group

Document endorsed by BDA The Association of UK Dietitians

Recommendations for the UK Adult Renal Dietitians Workforce 2021

Written on behalf of the Renal Nutrition Specialist Group (RNG) of the British Dietetic Association (BDA), UK.

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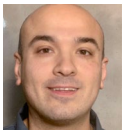

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Introduction

Dietary management plays a key role in the care of people living with chronic kidney disease (CKD). Specialist renal dietitians hold central responsibility for the nutritional assessment and dietary therapy in the prevention and management of CKD, and in the nutritional management of more advanced stages of acute kidney injury (AKI), renal replacement therapy, and other renal related conditions. People living with CKD often have multi-morbidities leading to complex dietary requirements, which influence their nutritional status and nutritional management.

Individualised dietary advice from a specialist renal dietitian working as an integral part of the multidisciplinary team (MDT) has been shown to improve patient outcomes (NICE 2021, KDOQI 2020). Specialist renal dietitians use a holistic approach tailoring dietary advice and prioritising nutritional goals to the person's clinical, physical, social and psychological status.

In March 2019, the Renal Nutrition Group (RNG) of the British Dietetic Association (BDA) established a working party to investigate the renal dietetic workforce in the UK. Two comprehensive surveys were designed; a departmental survey and an individual survey. These were designed to explore dietetic staffing levels, dietetic activities, patient contacts and views on safe staffing levels. The surveys were advertised via the monthly RNG newsletter and were open to all of the renal dietetic workforce.

The aim of the RNG workforce working party was to analyse and present the data and to feed into other UK wide workforce documents (including the British Renal Society (BRS) workforce document. The report highlighted that within renal dietetics there is a lack of data regarding patient centred outcomes and renal dietetic staffing levels. We need to provide evidence and increase data collection in this area in the future, so that we can demonstrate tangible and objective outcomes of dietetic practice. The long-term aim of this working party is that all patients with CKD should have the ability to access individualised renal dietary intervention by a specialist/advanced practitioner renal dietitian at the appropriate time within their CKD journey.

On behalf of the RNG, I would like to extend my gratitude to all the authors of this document who volunteered their time and energy in pulling together this data, to the BDA for their support and guidance and to all our members who took their time to complete the surveys.

Bruno Mafrici
Chair of the Renal Nutrition Group
2018-2022

Abbreviations

AHP	Allied health professional
AFC	Agenda for Change
ANR	Additional NHS responsibilities
AKI	Acute Kidney Injury
BDA	British Dietetic Association
BRS	British Renal Society
CKD	Chronic Kidney Disease
CPD	Continuing Professional Development
COVID-19	Corona Virus Disease 2019
DCC	Direct clinical care
ED	External duties
EPS	Encapsulating Sclerosis Peritonitis
FUP	Follow up
HD	Haemodialysis
HDU	High dependency unit
HHD	Home Haemodialysis
ICHD	In centre Haemodialysis
ICU	Intensive Care Unit
IQR	Inter quartile range
KDOQI	Kidney Disease Outcomes Quality Initiative
MBD	Mineral Bone Disease
MDT	Multi-disciplinary team
MUST	Malnutrition Universal Screening Tool
NHS	National Health Service

NHSI	NHS Improvement
NICE	National Institute for Health and Care Excellence
NP	New patient
ONS	Oral Nutritional Supplements
PD	Peritoneal dialysis
PN	Parenteral Nutrition
PO_4	Phosphate
PREMS	Patient Related experience measures
Px	Prescriptions
Renal iNUT	Renal inpatient Nutrition screening Tool
RNG	Renal Nutrition Group
RRT	Renal Replacement therapy
SGA	Subjective global assessment
SP	Supplementary prescriber
SPA	Supporting professional activities
TP	transplant
UKKA	UK Kidney Association
UKRR	UK Renal Registry
WTE	whole time equivalent

Contents

Background

In 2020, the British Dietetic Association Renal Nutrition Group (BDA RNG) collaborated with the British Renal Society (BRS) to update the renal multi-professional workforce guidelines (originally published in 2002). The RNG updated the renal dietetic section using the approach set out in 'Development Workforce Safeguards' (NHSI 2018) combining:

- Evidence based dietetic practice
- Patients centred outcomes
- Professional judgment
- Consideration of the patients' needs acuity, dependency and risks.

To support these recommendations and investigate the current dietetic workforce in terms of staffing levels, skills mix, roles and risks the RNG designed two workforce surveys.
This is the comprehensive report of the findings from both surveys and recommendations for further work to support the renal dietetic workforce. The results are divided into sections and the key workforce recommendations are given at the start of each section.

Methods

Survey Monkey was the platform used to design the two workforce surveys. The survey questions are attached in appendix 1 and 2.

Survey 1	a comprehensive renal dietetic departmental survey for the renal dietetic lead to complete on behalf of each UK renal unit (appendix 1).
Survey 2	a short individual survey to be completed by all renal dietitians and renal dietetic assistants working in UK renal units (appendix 2).

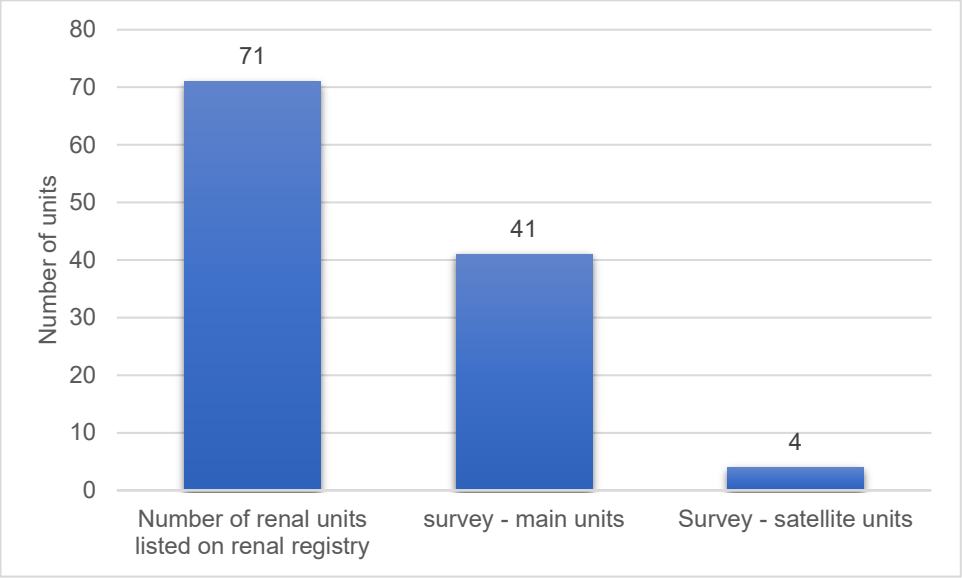
Nine UK renal units piloted the department survey and the results were presented at the RNG meeting in October 2019. The final surveys were advertised to all RNG members and sent out in May 2020. Data was requested for the financial year 2019/2020 prior to the start of the COVID-19 pandemic, which influenced working patterns. The project took longer than planned as we had not anticipated the unprecedented pressures the NHS and renal dietitians were under due to COVID-19, which necessitated extending the closing date of the survey and the working party requiring further time to complete the analysis and report.

The results were analysed by the working group. The RNG contacted renal units where clarification of the data was required due to inaccurate or missing data. Data was analysed to include the mean, median and ranges, where appropriate and it was anonymised.

Response Rate

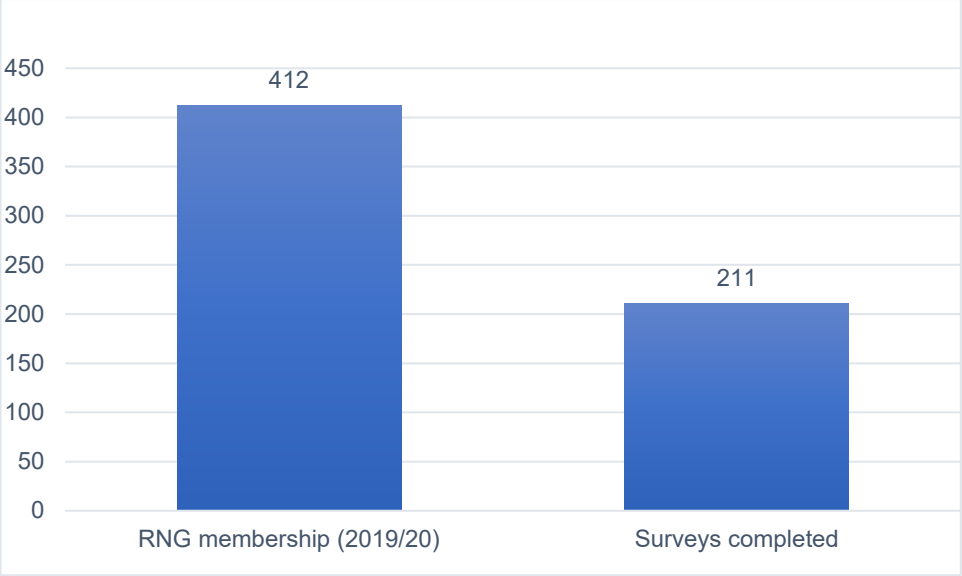
We had 45 responses, one of which was excluded as the only data completed was the name of the unit. Of the 44 remaining responses 40 were from renal dietetic teams providing services to main units as listed in the Renal Registry. The remaining 4 units were satellite renal units where the renal dietetic team was separate from the team covering the main unit. Overall we received data from 40 of the 71 renal units listed on the UK renal registry; a 56% response rate (Figure A).

Figure A. Departmental Survey response rate compared with number of units from UKRR 2018.



There were 211 responses to the individual survey, but not all respondents completed the full survey. The RNG membership for 2019/20 totalled 412, giving a response rate of 51% from RNG members (figure B).

Figure B. Individual Survey response rate compared with the RNG membership (2019).



For the purpose of this report, 'total n' is used to denote the total number of complete responses to a question from which data can be interpreted.

Summary of Recommendations

Section 1 – Introduction

- All people with chronic kidney disease (CKD) stage 4-5, receiving renal replacement therapy (RRT) and those with a declining kidney transplant function in the UK, should have access to a renal dietitian.
- Individualised management of nutritional intake is a crucial aspect of care for individuals diagnosed with CKD, including those receiving maintenance dialysis and those who have received a kidney transplant.
- People with CKD are vulnerable for nutritional abnormalities, which are associated with higher risk for morbidity, mortality and if hospital admission is required, longer lengths of stay.
- Nutritional needs change throughout the disease course, from the earlier stages of CKD to the post transplant period. The metabolic abnormalities and comorbid diseases that often accompany CKD further emphasize the need for specialized nutrition health care. It is essential that such individuals receive tailored nutrition assessment and counselling (KDOQI 2020).
- Renal dietetic business cases should consider the amount of time spent in MDT working and in additional workplace activities, such as education, training of other members of the MDT and any extended scope of clinical practice. Direct clinical care of patients should not exceed 75% of a renal dietitian's time.
- Consideration should be given to appropriate use of dietetic staff skill mix to support prudent healthcare.
- Advanced renal dietetic practitioner roles within renal practice need to be established to maximise the potential of the dietetic workforce.

Section 2 – Inpatients

- Dietary management by specialist renal dietitians is an integral part of the care of people with kidney disease admitted to hospital.

Setting	**Recommendations per bed per year**
Renal bed (either with or without transplant) no HDU no ICU	0.05-0.06 WTE of a renal dietitian
Renal HDU bed covered by renal dietitian	0.06-0.1 WTE of a renal dietitian
Renal ICU bed covered by renal dietitian	0.15 WTE of a renal dietitian

- When estimating inpatient numbers consider renal outliers and additional local requirements (for example parenteral nutrition, complexity of caseload, attendance at ward rounds, service development, local performance indicators, new patient to follow up ratio).
- All inpatients should be screened for nutritional risk; this may be using a validated screening tool or triage by the dietitian.

- For example, a renal ward with 30 beds: 0.05-0.06 hours X 30 beds = 1.5- 1.8 WTE.

Section 3 – Outpatients (CKD)

- All people with CKD 4-5 should have access to a renal dietitian.
- An average of 60 minutes is required for the first renal dietetic appointment (this would allow for time with the patient and pre and post consultation work).
- For people with CKD 4-5, if dietary intervention is agreed, this should be provided alongside education, detailed dietary assessment and supervision to ensure malnutrition is prevented (NICE 2021).
- People with CKD should be seen for an initial assessment, plus at least one review to establish outcomes of dietetic intervention. Provide further review as clinically indicated (empower patients to contact the dietitian when they feel they require further input and promote self-management).
- To deliver one CKD stage 4 or 5 clinic, with the aim to see between 6 to 10 patients (either new and review), 0.2 WTE specialist renal dietitian will be needed when the dietitian run or attend a consultant/nurse led clinic (this would include pre and post consultation work).
- Contact with people with kidney disease may include video consultations, patient education via websites, video and mobile applications as well as more traditional face to face or telephone consultations/group consultation where appropriate.

CKD stage	**Recommended frequency of renal dietetic reviews**	**Referral**	**Time required (either face to face/ telephone of video)**
CKD 1-3	As required	Referred by MDT	While CKD 1-3 should be managed in primary care, our survey showed that renal dietitians are referred patients at this early stage of CKD.
CKD 4	3-6 months (depending on level of dietetic intervention required)	Referred by MDT Self-referral by the patient People with progressive CKD 4 should be seen by dietitian	60 minutes first appointment & 45 minutes review
CKD 5	1-3 months (depending on level of dietetic intervention required)	Aim to see all	
Active supportive care (conservative management)	3-6 months (depending on level of dietetic intervention required)	Referral by MDT Self-referral by the patient	
Group session	Group session Telephone/video	Referral by MDT	This approach may be considered at any stage.

Section 4 – Dialysis

- An average of 60 minutes is required for the first renal dietetic appointment. (This would allow for time with the patient and pre and post consultation work)
- People on dialysis, in centre haemodialysis (ICHD), peritoneal dialysis (PD), and home haemodialysis (HHD) should be reviewed as a minimum:
    - The prioritisation and frequency of review will be decided by the specialist renal dietitian (NHS England).
    - Once every 6 months, if clinically and nutritionally stable (min standard as per NHS England)
    - Once every 3 months or more often depending on the patient's clinical needs
    - The frequency of monitoring / dietetic intervention may need to increase to monthly in a proportion of patients who have a reduced appetite, weight loss or complex electrolytes or bone biochemistry or fluid management issues.
- Patients who are on assisted PD, or those known to be frail may require more frequent reviews.

Dialysis Modality	Average time per year, per patient	Frequency of dietetic reviews	Average time required
ICHD	6-8 hours	0-4 weeks of starting dialysis	30-60 minutes first appointment
HHD	4 hours		
PD	4 hours		

- MDT attendance is an important part of holistic care for people with CKD and must be taken into consideration when estimating workforce needs (see section 6).
- For example, ICHD:100 patients with 40 new patients/ year (6-8 hours x 100 patients) + (1 hour x 40 new patients) = 640-840 hours per year (average = 740 hours/year). Each specialist renal dietitian will spend ~ 75% of their time in direct clinical patient care and 25% in additional workplace activities. Take into consideration 20% absence for annual leave/ sickness/study. Hours available would be 37.5 x 52 x (75/100) x (80/100) =1170 hours; 740 /1170 = 0.63 WTE specialist renal dietitian.

Section 5 – Kidney Transplantation

- People waiting for a kidney transplant should have access to a renal dietitian accordingly to their clinical needs (group education, seen in clinic and/or dialysis, refer to section 3 and 4).
- People waiting for a kidney transplant with a BMI of over 35 kg/m^2 should be provided lifestyle advice including healthy eating and exercise.
- All new kidney transplant recipients should be seen by a renal dietitian prior to discharge or as soon as possible in an outpatient clinic.
- People with existing transplants should be seen according to clinical needs as identified by the MDT and ideally they should have an annual dietetic review.

- People with a kidney transplant, whose kidney function is declining should have the same access to a renal dietitian as those with CKD 4-5 (refer to section 3).
- Further research is undertaken to investigate the potential impact of an improved dietetic service on the nutritional profile of this patient group.

Section 6 – MDT Attendance, CKD- MBD, transitional and young adults services, renal diabetes services and additional activities

- Renal dietitians form an integral part of the renal multi-disciplinary team (MDT). Provision for the time taken for this activity should be included in renal dietetic business cases.
- Renal dietitians should play an integral role in the management of CKD-MBD. A supplementary prescribing qualification is desirable for renal dietitians undertaking this enhanced role.
- Renal dietitians are an important member of the renal multi-disciplinary team (MDT) including young adult/transition services and renal diabetes services. Business cases should therefore include for provision of dietetic care within these services and ideally have 0.2WTE as time dedicated per clinic.
- Specialist renal dietitians should be involved in the care of young people and transitions services. The time required to provide this service is difficult to quantify and dependent on their stage of CKD, but should be considered within staffing requirements. Children who transition to adult services may require more dietetic input (i.e. artificially fed) for the first 3-6 months of transition (for example two hours in the first month; one hour in first six months).

Section 7 – Safe staffing levels

- The individual survey showed that out of 211 renal dietitians 59% felt their current workload was either not safe or not ideal. The departmental survey undertaken at the same time, showed that, out of 40 units, 57% reported that they had safety concerns. As over half the departmental and individual respondents had some safety concerns, this should be taken into account when making recommendations, as current practice is not likely to reflect a ‘gold standard’.
- As well as time spent with individual patients, recorded as contacts, most renal dietitians are involved in a wide range of workplace activities, many of which are not a recognised part of patient activity yet are essential in supporting patient care and enabling teams to practice safely. This includes work that is deemed to be an extended scope of practice. These additional activities should be considered in all renal dietetic workforce and recruitment planning.
- Due to difficulties with recruitment problems and high staff turnover, it is recommended that renal rotations or attachments should be provided to enable training for short term back fill opportunities or recruitment options, rather than relying on inexperienced staff to fill in the gaps.

Section 1 - Introduction to staffing levels and workforce skill mix

Recommendations:

- All people with chronic kidney disease (CKD) stage 4-5, receiving renal replacement therapy (RRT) and those with a declining kidney transplant function in the UK, should have access to a renal dietitian.
- Individualised management of nutritional intake is a crucial aspect of care for individuals diagnosed with CKD, including those receiving maintenance dialysis and those who have received a kidney transplant.
- People with CKD are vulnerable for nutritional abnormalities, which are associated with higher risk for morbidity, mortality, and, if hospital admission is required, longer lengths of stay.
- Nutritional needs change throughout the disease course, from the earlier stages of CKD to the post transplant period. The metabolic abnormalities and comorbid diseases that often accompany CKD further emphasize the need for specialized nutrition health care. It is essential that such individuals receive tailored nutrition assessment and counselling (KDOQI 2020).
- Renal dietetic business cases should consider the amount of time spent in MDT working and in additional workplace activities, such as education, training of other members of the MDT and any extended scope of clinical practice. Direct clinical care of patients should not exceed 75% of a renal dietitian's time.
- Consideration should be given to appropriate use of dietetic staff skill mix to support prudent healthcare.
- Advanced renal dietetic practitioner roles within renal practice need to be established to maximise the potential of the dietetic workforce.

1.1 The renal dietetic workforce

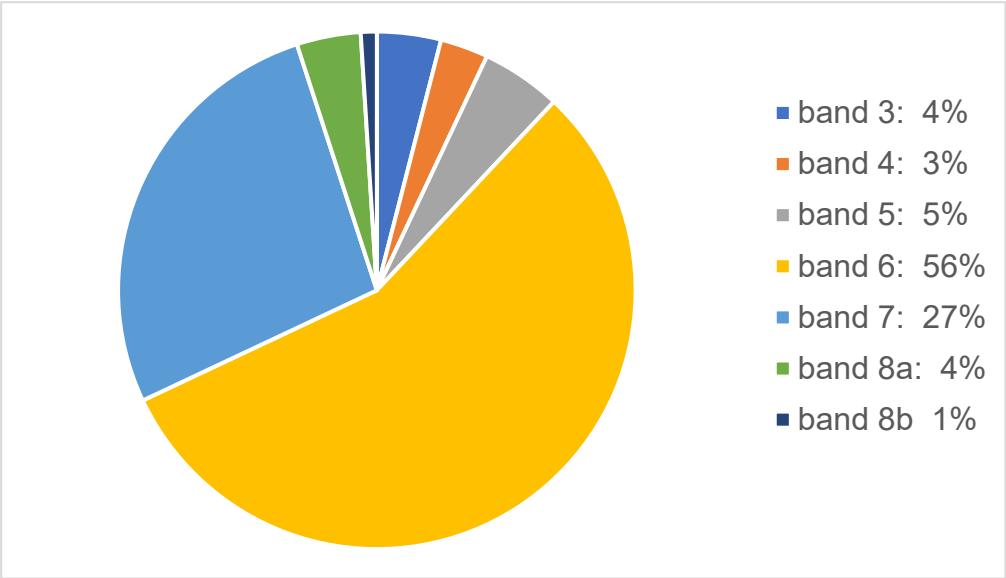
Renal dietitians have long been established as key members of the renal dietetic team present within all UK renal units. The 2020 departmental workforce survey reported a total of 188.7 WTE renal dietetic staff employed across 40 renal units with heterogeneity in the size and structure of the renal dietetic teams. Noting the 56% response rate from UK renal units, this suggests a growth in workforce from 2001 where a survey reported 180 renal dietetic posts across the UK (146.7WTE).

Table 1.1 and figure 1.1 shows the Banding of renal dietetic staffing. At the time of the survey, the overall vacancy rate was 5.3%.

Table 1.1 Composition of renal dietetic staffing within departmental workforce survey (2020) (total n=40).

Dietetic resource	WTE	Percentage	Number of depts with Band
Specialist Dietitian (Band 6)	105.4	56%	40
Advanced Renal Dietitian (Band 7)	51.3	27%	39
Dietitian (Band 5)	9.41	5%	13
Dietetic Assistant (Band 3)	8.4	4%	11
Consultant Dietitian (Band 8a)	7.01	4%	10
Dietetic Assistant Practitioner (Band 4)	5.87	3%	10
Dietetic Manager (Band 8b)	1.3	1%	2

Figure 1.1 Percentages of renal dietetic staffing within departmental workforce survey (2020).



It is acknowledged that the delivery of quality renal dietetic care involves a significant amount of time spent on patient related activities, defined as direct clinical care (DCC) and wider supporting activities that are defined as supporting professional activities (SPA). Occasionally there may be additional NHS/Trust responsibilities (ANR) or external duties (ED). DCC is subdivided into Individual Patient Attributable (intervention with patients) and non-Individual patient attributable (e.g. multi professional work) categories. These definitions are taken from the document AHP Job Planning the Clinical Workforce – allied health professionals (2019).

Key questions within both surveys aimed to elucidate the time spent within different workplace activities as well as the renal dietetic clinical workload. Responses are given for the departmental survey first.

1.2 Renal dietetic clinical workload

The responses from the departmental survey are shown in figure 1.2. This survey found that the greatest amount of time spent in DCC was in the main haemodialysis units (27%) and renal inpatients (26%). The least amount of time was spent in transplant clinics, home dialysis and CKD 1-3 outpatients, at 4%, 3% and 3% retrospectively.

Figure 1.2 Mean percentage time spent in DCC within each renal area (n=44).

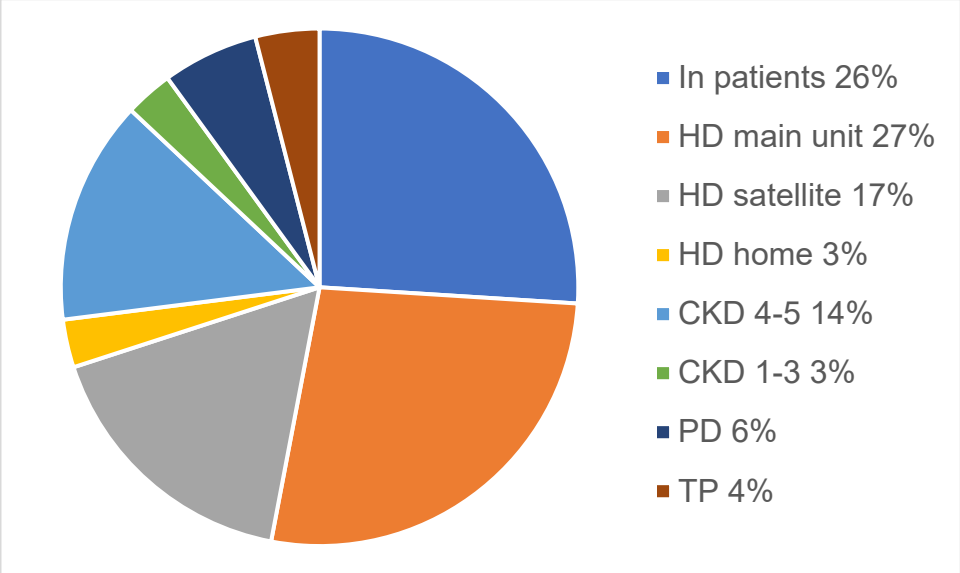


Table 1.2 and figure 1.3 show a more detailed breakdown of the percentage of DCC spent within each area of renal medicine, accordingly to Band. It is of note that the majority of Band 3, 4, 5 and 8a were part time posts, whereas a larger number of Band 6 and 7 posts were full time. Careful interpretation of this data is therefore needed.

Band 5 and Band 6 posts spent most of their working time (82% and 85% respectively) in DCC, with Band 7 dietitians also largely involved in DCC (72.8%). The mean percentage of time spent in DCC was lower for unregistered staff (Band 3 and 4 (67 and 58%) and for those working at Band 8 (30-39.5%).

Table 1.2. Mean percentage of DCC time spent in each clinical area from all respondents by Band (departmental survey).
Note: n denotes the number of departments who had staff at each Band working within each specific renal area.

	Band 3 (n=9)	Band 4 (n=6)	Band 5 (n=7)	Band 6 (n=36)	Band 7 (n=32)	Band 8a (n=10)	Band 8b (n=1)
Renal Inpatients	16.7% (8)	24.7% (6)	34.3% (5)	20% (35)	10.2% (20)	2.1% (1)	
Outpatients CKD 1-3		3.6% (1)	2.6% (1)	3.3% (16)	3.3% (6)		
Outpatients CKD 4-5 (not on RTT)	8.4% (5)	5.4% (2)	9% (2)	10.5% (33)	9.6% (29)	7.8% (7)	
Transplant outpatients	3.5% (2)		2.6% (1)	4.2% (17)	6% (12)		
Main Haemodialysis Unit	24.6% (7)	15.4% (4)	23.7% (5)	19.2% (32)	15.7% (24)	11.1% (3)	
Satellite Units	9.3% (6)	8.4% (3)	2.6% (1)	17.5% (24)	17.3% 23	13.2% (5)	30% (1)
Home Haemodialysis	1.4% (1)			3.8% (17)	5% (17)	3.1% (2)	
Peritoneal Dialysis	2.8% (3)		7.9% (1)	6.1% (22)	5.7% (23)	2.1% (1)	
Overall direct clinical care	**66.70%**	**57.50%**	**82.70%**	**84.50%**	**72.80%**	**39.50%**	**30%**

Figure 1.3 Percentage of time spent on different clinical and non-clinical areas by Band.

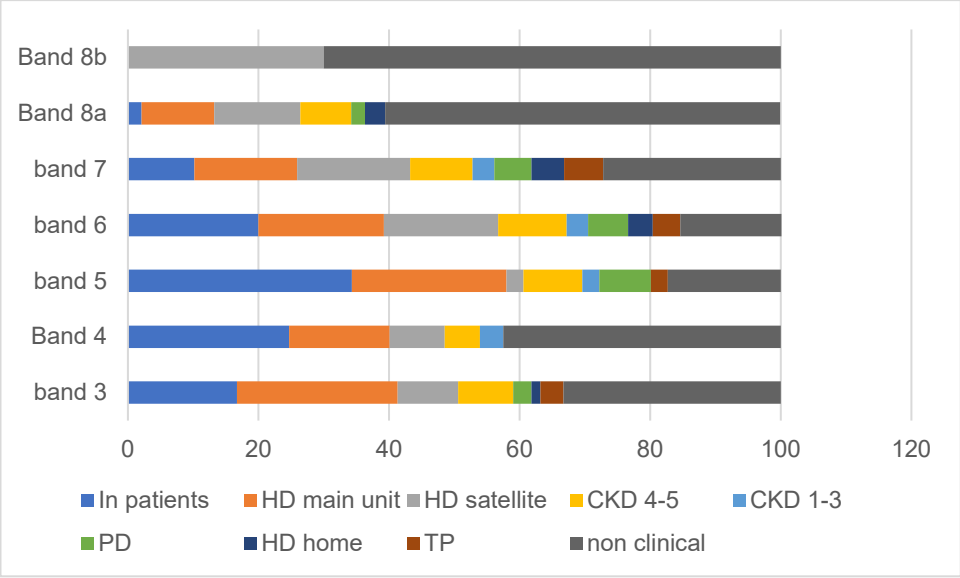


Table 1.2 shows that the majority of Band 5 (n= 5, 23.7%) and Band 6 (n=32, 19.2%) renal dietitians spent a large proportion of their DCC time on the main haemodialysis units. The majority of Band 3 (n=7, 24.6%) DCC time was spent supporting the main haemodialysis unit (24.6%).

Peritoneal dialysis, home dialysis, transplant and outpatient CKD 1-3 were the areas where all Bands of staff spent the least amount of DCC time, between 2.1 and 7.9% of time for each of these areas.

Further questions were asked regarding other dietetic workforce activities (i.e. SPA, ANR or ED).

1.3 Advanced renal dietetic practitioner

No department reported that they had an advanced care renal dietitian practitioner exclusively dedicated for renal dietetics. However, there were Band 7, 8a and 8b renal dietitians with aspects of their role (including research, leadership and management), within renal dietetics and considered themselves having an aspect of their role as advanced renal dietetic practitioner.

1.4 Academic teaching

Of the 40 departmental responses, 8 were involved with academic teaching as guest lecturers (5 dietetic department taught on a BSc dietetic course, 2 on a MSc dietetic course and 1 taught on a nursing diploma).

1.5 Management and leadership

From the departmental survey, the majority of management and leadership duties were found to be undertaken by Band 7 and Band 8a, with a mean value of 0.3 WTE dedicated for this role. The remaining 0.7 WTE was dedicated to clinical duties and no clear dedicated time was stated for CPD or service development. Four renal dietetic units reported that a small proportion of Band 6 had management responsibilities equal to 0.1 WTE of their role.

1.6 Administration support

Only 26 of the 40 units reported to have administration support and the Banding of these posts varied from Band 2 to Band 4.

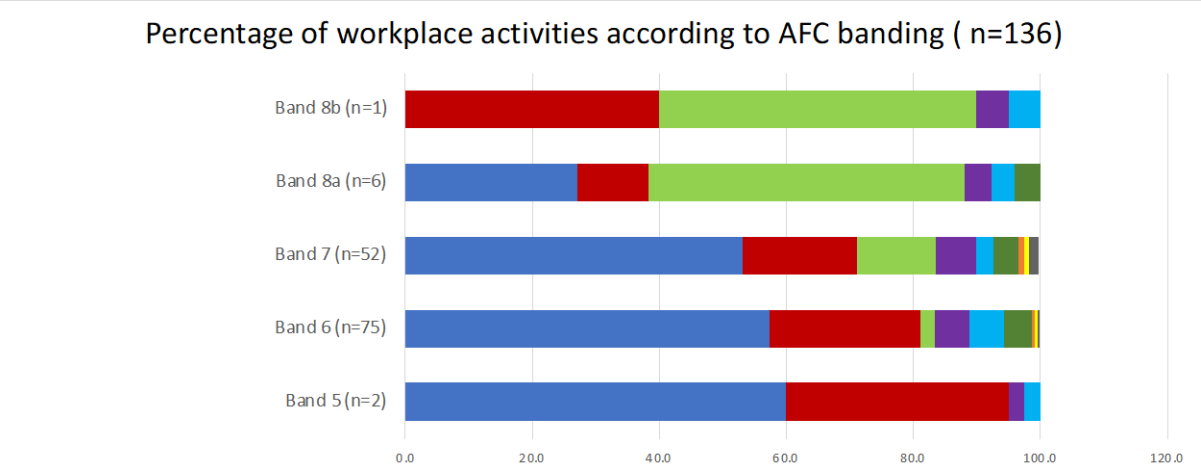
1.7 Bank and agency staff

Of the 40 respondents, 11 departments used bank or agency staff for shortages within administration, Band 6 and Band 7 staff. Most of these (81%) felt the implications of using bank or agency staff was the time required for staff training, the cost, and inconsistency of patient care. Reasons stated for agency or bank usage were gaps in inability to recruit, recruitment time, maternity and parental leave and secondment cover.

1.8 Individual survey results

For the individual survey, staff were also asked to indicate the percentage of their time spent within different workplace activities. There were 136 respondents to this question out of 211. The results are shown in figure 1.4.

Figure 1.4. Percentage of workforce activities per Band (total n=136).



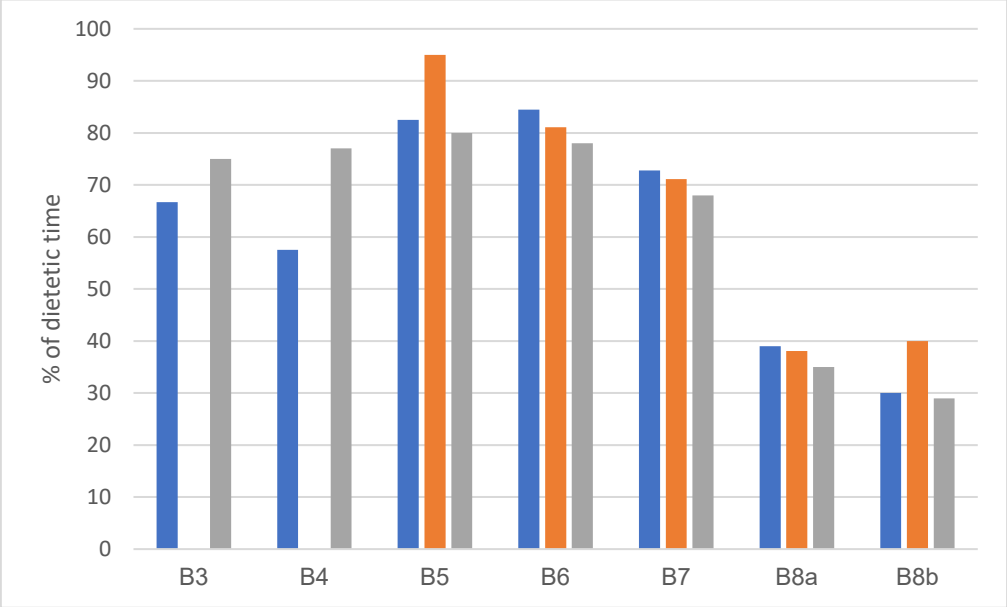
	Band 5 (n=2)	Band 6 (n=75)	Band 7 (n=52)	Band 8a (n=6)	Band 8b (n=1)
Individual patient attributable direct clinical care	60.0	57.3	53.1	27.1	0
Non Individual patient attributable direct clinical care	35.0	23.8	18.0	11.1	40
Management of renal dietetic services	0.0	2.3	12.5	50.0	50
Training of others (within trust) including staff and students	2.5	5.5	6.3	4.2	5
Own Training including CPD, appraisals	2.5	5.4	2.7	3.7	5
Additional Activities eg Audits, CKD-MBD Management	0.0	4.4	3.9	4.0	0
Role as Supplementary prescriber	0.0	0.4	1.0	0.0	0
Education and teaching (externally funded) including academic teaching	0.0	0.6	0.7	0.0	0
Research (externally funded)	0.0	0.3	1.6	0.0	0

Table 1.3 and figure 1.5 show the mean percentage of time spent in DCC found in both surveys. It is of interest that the figures show a similar trend across the Bands.

Table 1.3 Mean percentage of time spent on direct clinical care by Band according to respondents from both surveys.

	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b
Departmental survey	66.7 (n=9)	57.5 (n=6)	82.7 (n=7)	84.5 (n=36)	72.8 (n=32)	39.5 (n=10)	30 (n=1)
Individual survey	No data	No data	95 (n=2)	81.1 (n=75)	71.1 (n=52)	38.1 (n=6)	40 (n=1)

Figure 1.5. Percentage of time spent on clinical work by Banding (departmental survey in blue, individual survey in orange and BDA safe staffing guidelines in grey).



Conclusion

There were good responses to both workforce surveys, in particular AFC Band 6 and Band 7. Both surveys showed that a high percentage of contracted hours in the majority of cases were spent in direct clinical care. The percentage of direct clinical care should not exceed 75% (BDA, 2017).

Despite high levels of clinical commitment, dietitians were also engaged in other workforce activities, including MDT working. For some dietitians, academic teaching, research and management were significant activities but, despite this, no advanced dietetic practitioners were identified.

Section 2 - Inpatients

Recommendations:

- Dietary management by specialist renal dietitians is an integral part of the care of people with kidney disease admitted to hospital.

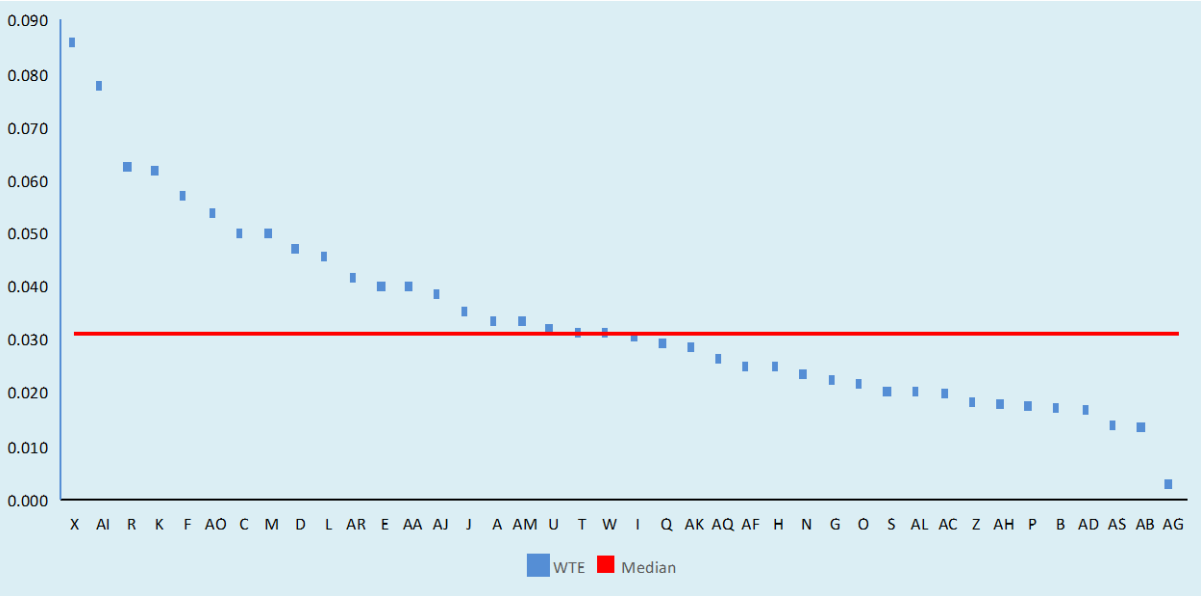
Setting	Recommendations per bed per year
Renal bed (either with or without transplant) no HDU no ICU	0.05-0.06 WTE of a renal dietitian
Renal HDU bed covered by renal dietitian	0.06-0.1 WTE of a renal dietitian
Renal ICU bed covered by renal dietitian	0.15 WTE of a renal dietitian

- When estimating inpatient numbers consider renal outliers and additional local requirements (for example parenteral nutrition, complexity of caseload, attendance at ward rounds, service development, local performance indicators, new patient to follow up ratio).
- All inpatients should be screened for nutritional risk; this may be using a validated screening tool or triage by the dietitian.
- For example, a renal ward with 30 beds: 0.05-0.06 hours X 30 beds = 1.5- 1.8 WTE.

2.1 Renal dietitian WTE per bed

40 units reported data on their renal dietetic inpatient activity. On average there were 1128 renal inpatients beds with 34.39 WTE renal dietitians. This equals a mean of 0.03 WTE of a renal dietitian per bed per year (excluding high dependency units and/or Intensive care), figure 2.1.

Figure 2.1 WTE renal dietetic input per renal bed (excluding HDU and ICU).



Inpatient acute services tend to be prioritised over dialysis and outpatient services. This is an important factor to consider as this may skew results, with time spent on inpatient care falsely under-represented within the survey.

Renal services and patient care have evolved over recent decades; clinical management is generally more complex; patients often present with multiple morbidities, chronic conditions and live longer (Kings fund 2012). As a result, renal dietetic input has also increased in complexity, and this is mirrored in our new recommendation of **0.05-0.06 WTE of renal dietitian per bed**.

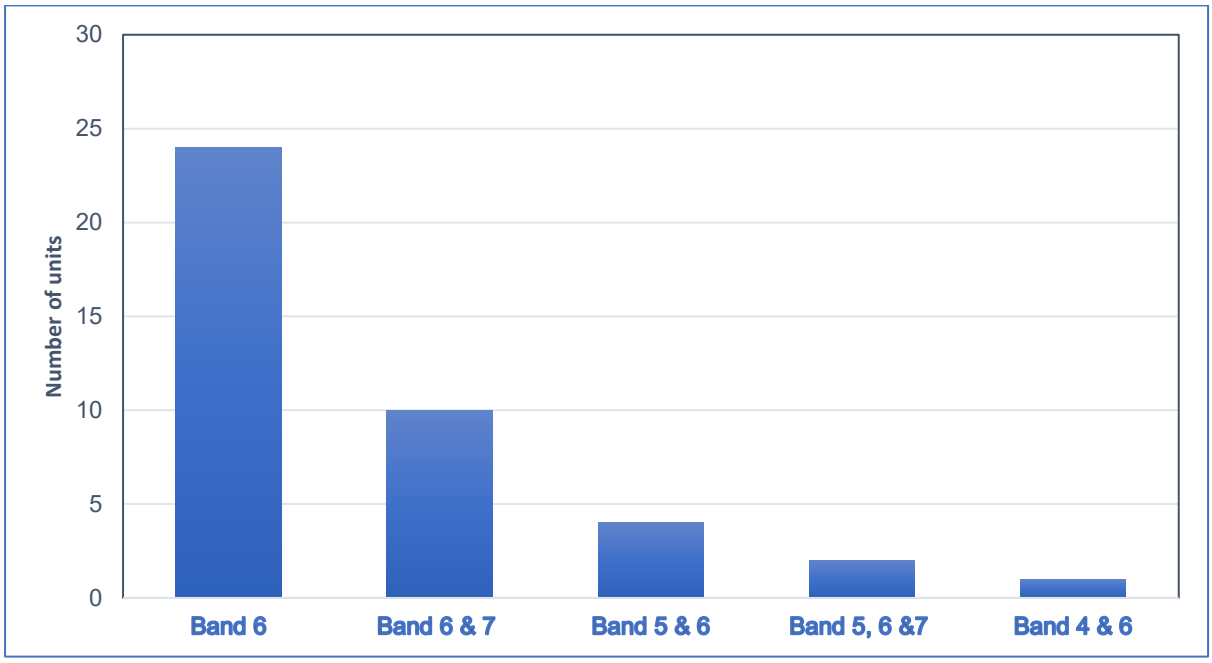
WTE requirements may be further increased (above 0.05-0.06WTE dietitian / bed) if:

- the renal dietitian lead on their own inpatients parenteral nutrition (PN)
- centres provide service for patients with Encapsulating Peritoneal Sclerosis (EPS)
- the renal dietitian provides the dietetic service to all patient with AKI requiring renal replacement therapies (UKKA 2019).

2.2 Renal dietetic workforce in the inpatient settings

The departmental survey found that most of the workforce working in renal inpatients was mainly represented by Band 6 renal dietitians, with no Band 8a involvement of and rarely the involvement of Band 3. Figure 2.2 shows the results for the pay Bands of dietetic staff who support renal inpatient services. Where Bands 4 and 5 are involved, then this is under the supervision of Band 6 staff. There were no nutrition apprentices in any units, working in the inpatient setting.

Figure 2.2 Bands of dietetic staff who cover inpatients at UK renal units.



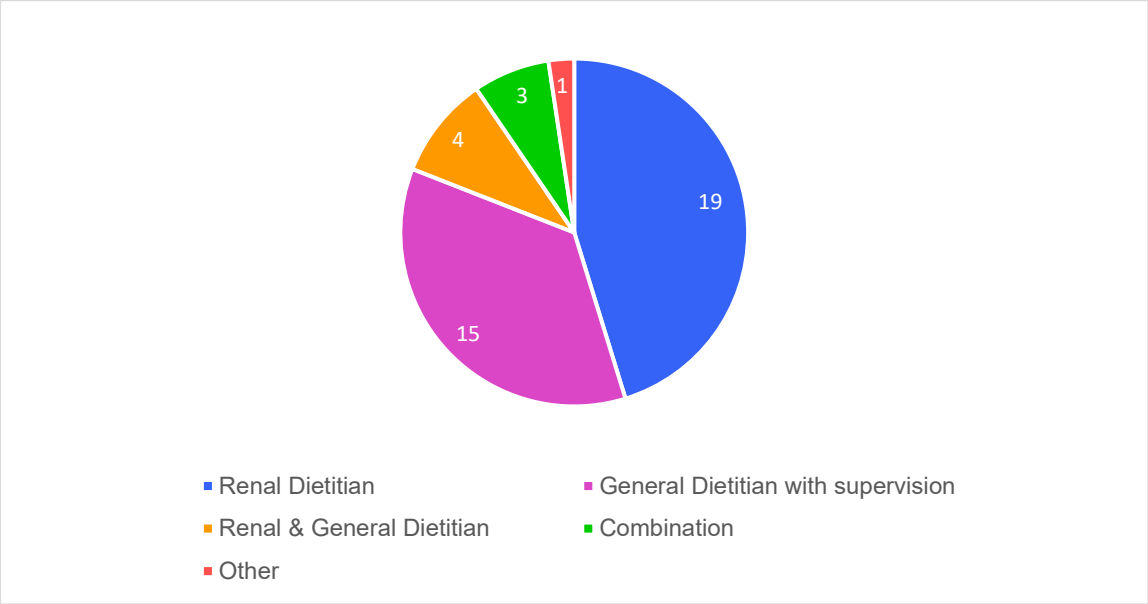
2.3 Renal Inpatients outliers

The number of renal outliers should be taken into consideration proportionally with the size of the hospital. 34 units stated that at any one time there were between 0 and 20 inpatients defined as renal outliers:

- 33 units reported 1-10 outliers exist at any one time
- 1 unit reported up to 20 renal outliers.

Units reported between 0 and 12 referrals to dietetics each week for renal outliers. 29 units suggested <5 referrals per week and 6 units suggested 6-10 referrals per week. Three units suggested no referrals on a weekly basis.
19 units reported that, for renal outliers, dietetic intervention was delivered by renal dietitians,15 units by a combination of a renal dietitian and a general dietitian (without renal competencies but with supervision from a renal dietitian), and 4 units reported outliers would be assessed by general dietitians alone. Three units suggested a mixture of 3 types of dietitians delivering intervention. One unit reported outliers were treated by a non-renal dietitian who had specific renal competencies, figure 2.3.

Figure 2.3 Provision of Renal Dietetic intervention to renal inpatient outliers.

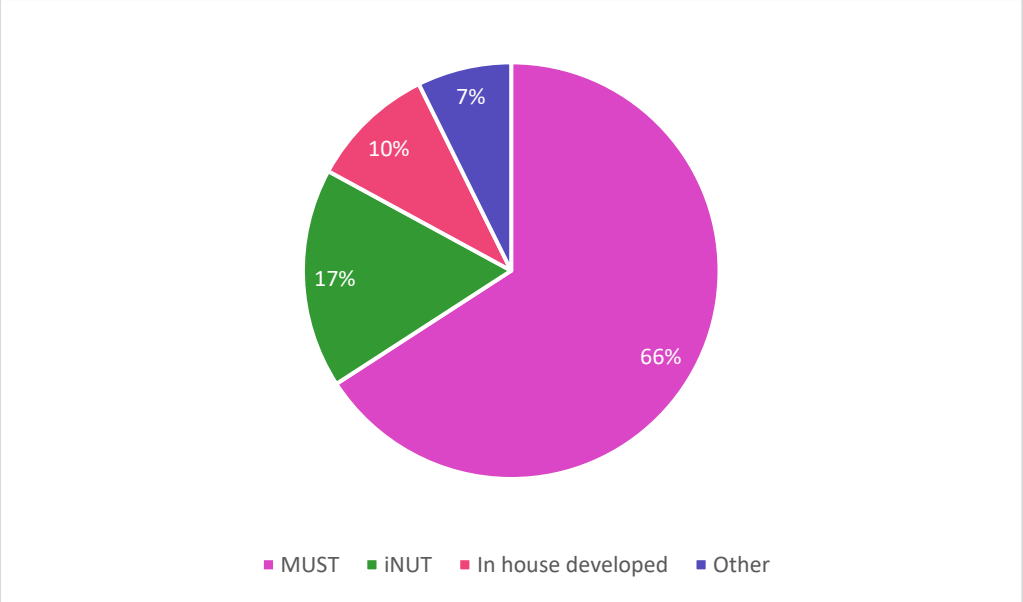


Some renal dietetic departments provided dietetic services to a number of renal inpatient outliers at any one time. It is important to consider this, when estimating renal dietetic staffing workforce requirements as an addition to the above recommendations.

2.4 Inpatient nutritional screening

The majority of the units have a nutritional screening tool in place to identify malnutrition. 39 units reported use of a screening tool for inpatients. Four units stated that there was no screening tool in place and 2 units did not answered. Of the units reporting use of a screening tool, 26 used Malnutrition Universal Screening tool (MUST), 6 used Renal iNUT, 4 used an inhouse tool, 3 stated other, figure 2.4.

Figure 2.4 Percentage of units who used each type of nutrition screening tool.



Most renal units do not rely on a nutrition screening tool alone to identify patients who require renal dietetic input. The survey showed the following:

- 30 units used both the screening tool in combination with the dietitian self-triage
- 4 screening tool only
- 2 dietitian self-triage only
- 8 used mix methods (screening, verbal referral, self-triage and ward round).

Section 3 – Outpatients (CKD)

Recommendations:

- All people with CKD 4-5 should have access to a renal dietitian.
- An average of 60 minutes is required for the first renal dietetic appointment (this would allow for time with the patient and pre and post consultation work).
- For people with CKD 4-5, if dietary intervention is agreed, this should be provided alongside education, detailed dietary assessment and supervision to ensure malnutrition is prevented (NICE 2021).
- People with CKD should be seen for an initial assessment, plus at least one review to establish outcomes of dietetic intervention. Provide further review as clinically indicated (empower patients to contact the dietitian when they feel they require further input and promote self-management).
- To deliver one CKD stage 4 or 5 clinic, with the aim to see between 6 to 10 patients (either new and review), 0.2 WTE specialist renal dietitian will be needed when the dietitian run or attend a consultant/nurse led clinic (this would include pre and post consultation work).
- Contact with people with kidney disease may include video consultations, patient education via websites, video and mobile applications as well as more traditional face to face or telephone consultations/group consultation where appropriate.

CKD stage	**Recommended frequency of renal dietetic reviews**	**Referral**	**Time required (either face to face/ telephone of video)**
CKD 1-3	As required	Referred by MDT	While CKD 1-3 should be managed in primary care, our survey showed that renal dietitians are referred patients at this early stage of CKD.
CKD 4	3-6 months (depending on level of dietetic intervention required)	Referred by MDT Self-referral by the patient People with progressive CKD 4 should be seen by dietitian	60 minutes first appointment & 45 minutes review
CKD 5	1-3 months (depending on level of dietetic intervention required)	Aim to see all	
Active supportive care (conservative management)	3-6 months (depending on level of dietetic intervention required)	Referral by MDT Self-referral by the patient	
Group session	Group session Telephone/video	Referral by MDT	This approach may be considered at any stage.

Rationale

The prevalence of stage 3-5 CKD in England is estimated to be 7% in those aged 35 and over (Health Survey for England 2016) with the incidence increasing with age, estimated 15% prevalence in those age 60 and over (Hirst 2020). Although there are indications that the prevalence of CKD is not increasing, the absolute CKD burden is likely to rise with population growth, aging and rises in diabetes (Hounkpati 2016). Data on people with stage 4-5 CKD managed by renal centres is limited. The renal registry reported this data for the first time in 2021 and only a small subset of centres contributed to the data set (UK Renal Registry, 2021).
In the pre-dialysis population dietary management focuses on delaying progression of CKD by lifestyle advice and management of risk factors such as diabetes and hypertension. As CKD progresses dietary advice about potassium, phosphate, calorie and salt intake appropriate to the severity of CKD should be offered. Detailed assessment and supervision are recommended to ensure malnutrition is prevented (NICE NG203 2021) The UKKA recommends that all patients should be assessed by a specialist renal dietitian when they begin education about renal replacement treatment (UKKA 2019).

3.1. Renal dietetic outpatients contacts

The results of the renal dietetic workforce survey (2020) suggests that outpatient CKD 1-5 makes up a small part of renal dietetic workload. Overall, 14% of dietetic time is spent on CKD 4-5 and only 3% on CKD 1-3 (figure 1.1a-c).

Data on the number of dietetic contacts for CKD 1-3, CKD 4-5 and supportive care are presented in tables 3.1a-c. It should be noted that 5 units were unable to separate out conservative care patients from CKD 4-5 and their data is just reported in CKD 4-5. There is a wide variation in the number of contacts which is likely related to the size of the renal units and the dietetic provision. Eight of the 25 units who were able to provide data on CKD 1-3 did not see any CKD 1-3 patients in the year 2019 - 2020.

Table 3.1.a Number of new patient (NP) renal dietetic contacts per year.

	Total (n)	Mean	Median	IQR	Range
Total annual NP dietetic contacts					
CKD 1-3	26	32	16	32	0-300
CKD 4-5	32	178	145	151	22-500
Conservative management	21	17	10	12	0-50

Table 3.1.b Number of follow up (FUP) renal dietetic contacts per year.

	Total (n)	Mean	Median	IQR	Range
Total annual FUP dietetic contacts					
CKD 1-3	24	28	8	37	0-164
CKD 4-5	30	352	290	419	15-1206
Conservative management	19	54	20	36	0-320

Table 3.1.c Total number of renal dietetic contacts per year.

	Total (n)	Mean	Median	IQR	Range
Total annual FUP dietetic contacts					
CKD 1-3	24	28	8	37	0-164
CKD 4-5	30	352	290	419	15-1206
Conservative management	19	54	20	36	0-320

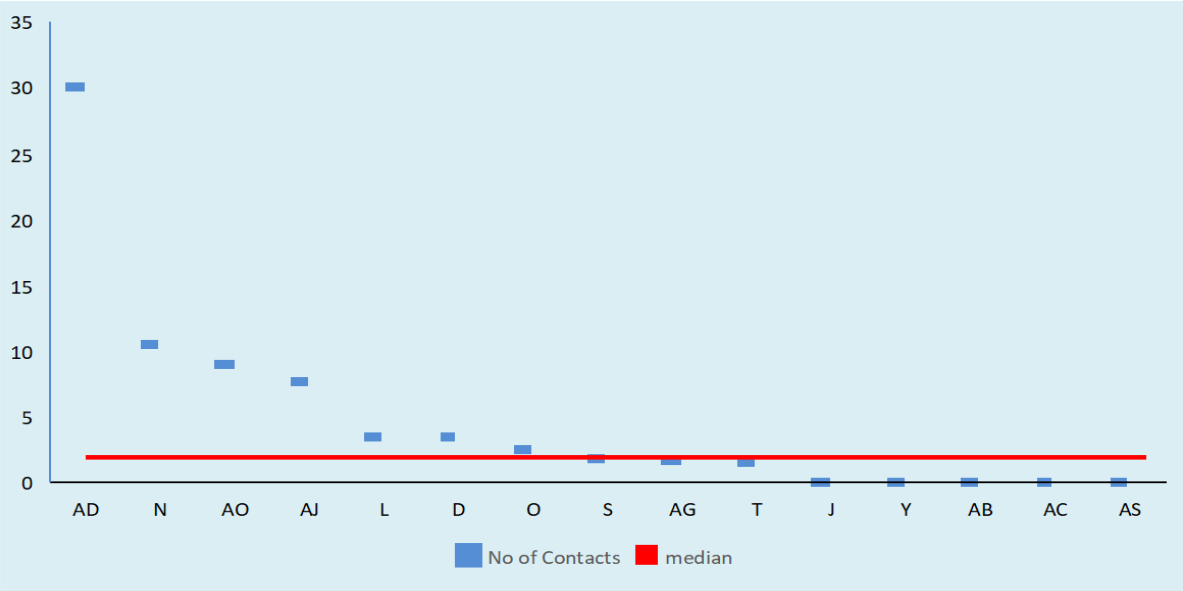
3.2 Dietetic Contacts compared with numbers of patients

The survey asked in the survey for the numbers of patients managed by the renal unit for each stage of CKD. This data can be used in combination with the total number of dietetic contacts to calculate the average number of dietetic contacts per patient (or per 100 patients) per year. Only a limited number of units could provide both data, this is particularly so for CKD 1-3 and conservative management (data from 14 units), which therefore reduces the validity of generalizing to all units.

On average for every 100 CKD 1-3 patients there were 3 dietetic contacts per year (data from 14 units), figure 3.1a. CKD 4-5 and conservative management patients were seen more frequently, figure 3.1b and 3.1c. The average number of dietetic contacts per CKD 4-5 patient per year was 1.03 (data from 20 units) and the average number of dietetic contacts per conservative management patient per year was 1.53 (data from 14 units), figure 3.1b & fig 3.1c.

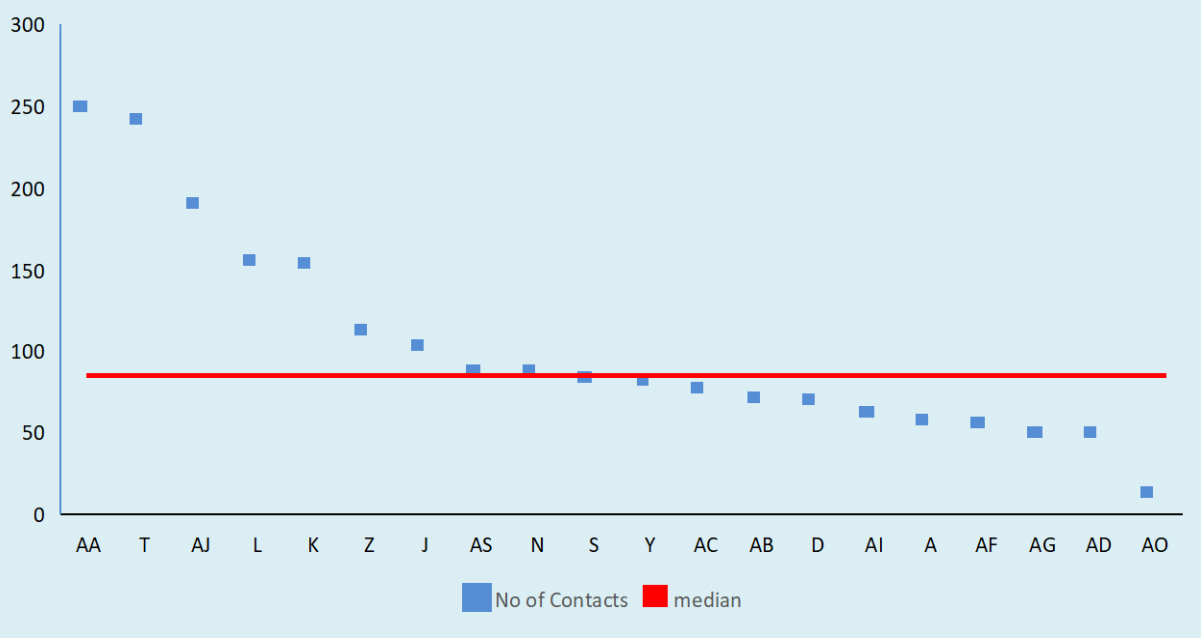
Due to the difficulty to report accurate data, only 14 units provided numbers of patients and contacts (new and follow up) per year. Amongst these, the mean dietetic contacts per 100 people with CKD 1-3 per annum was 3 (range 0-10), with a median of 2, figure 3.1.a.

Figure 3.1a. Mean number of dietetic contacts per 100 CKD 1-3 patients per annum.



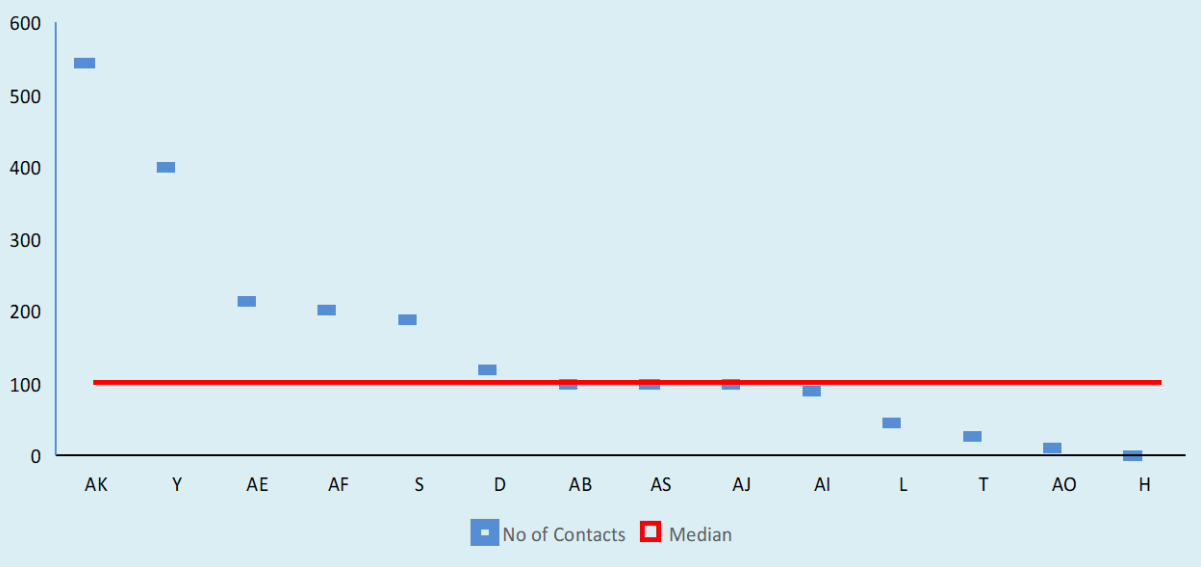
20 units provided data for people with stage 4-5 CKD (pre-dialysis / transplant); the mean number of dietetic contacts per 100 patients was 103 (median 83, range 14-250), figure 3.1.b.

Figure 3.1.b Mean dietetic contacts per 100 CKD 4-5 patients per year.



14 units (31%) provided data on conservative management; the mean number of contacts per 100 patients was 153 (median 100, range 0-543) figure 3.1.c.

Figure 3.1.c Mean dietetic contacts per 100 conservative management patients per year.



For each of the modalities the units were asked how often these patients were seen by a renal dietitian. 78 – 80 % of units were able to provide this information (table 3.1.e).
The majority of patients with CKD 1-3 were only seen if referred. This figure was lower (31%) for CKD 4-5 patients. 17% were seen every 1-3 months and 34% every 3-5 months. 61% of conservative management patients were seen if referred and 18% every 3-5 months.

Table 3.1.e Frequency of renal dietetic reviews.

How often are these pts reviewed?	0-3 months	3-5 months	6 months	Annually	Never	Only if referred
CKD 1-3	-	-	2	-	2	32
CKD 4-5	6	12	4	2	-	11
Conservative management	3	7	4	1	-	23

Conclusion

Most patients with CKD 1-3 were only seen if referred. Each patient with CKD 4-5 had on average 1 dietetic contact (consultation) per year. This falls short of the minimum recommendation of one dietetic review every 8 months. There are no specific recommendations for dietetic input to those requiring conservative care with which we can compare our results with. Most units (61%), only reported seeing these patients when referred. Although from the limited data we collected on contacts per 100 patients (31% response rate) it appears that these patients are seen more frequently than the CKD 4-5 cohort, with an average of 153 contacts per 100 patients per annum.

Section 4 – Dialysis

Recommendations:

- An average of 60 minutes is required for the first renal dietetic appointment. (This would allow for time with the patient and pre and post consultation work).
- People on dialysis, in centre haemodialysis (ICHD, which include both main centre and satellites units) peritoneal dialysis (PD), and home haemodialysis (HHD) should be reviewed as a minimum:
    - The prioritisation and frequency of review will be decided by the specialist renal dietitian (NHS England).
    - Once every 6 months, if clinically and nutritionally stable (min standard as per NHS England).
    - Once every 3 months or more often depending on the patient's clinical needs.
    - The frequency of monitoring / dietetic intervention may need to increase to monthly in a proportion of patients who have a reduced appetite, weight loss or complex electrolytes or bone biochemistry or fluid management issues.
- Patients who are on assisted PD, or those known to be frail may require more frequent reviews.
- MDT attendance is an important part of holistic care for people with CKD and must be taken into consideration when estimating workforce needs (see section 6).

Dialysis Modality	Average time per year, per patient	Frequency of dietetic reviews	Average time required
ICHD	6-8 hours	0-4 weeks of starting dialysis	30-60 minutes first appointment
HHD	4 hours		
PD	4 hours		
For example, ICHD with100 patients; 40 new patients/ year (6-8 hours x 100 patients) + (1 hour x 40 new patients) = 640-840 hours per year (average = 740 hours/year). Each specialist renal dietitian will spend ~ 75% of their time in direct clinical patient care and 25% in additional workplace activities. Take into consideration 20% absence for annual leave/ sickness/study. Hours available would be 37.5 x 52 x (75/100) x (80/100) =1170 hours; 740 /1170 = 0.63 WTE specialist renal dietitian.			

Rationale

Dietary reassessment is recommended if a person's circumstances change or if indicated by changes in biochemical or body composition measures. NICE (NG107) recommends that all people starting dialysis should be offered a full dietary assessment by a specialist renal dietitian.

In 2018 there were approximately 29000 patients receiving dialysis in the UK (UKRR 2018). We found all HD main centre units and the majority of HD satellite units had a dietetic service. On average patients on HD were seen by a renal dietitian approximately 4 times a year with PD and HHD are seen at least twice a year.

4.1 Number of dietetic contacts for patients on dialysis

The departmental workforce survey data (2020) showed that that main centre HD patients are seen more frequently than satellite HD patients. This may reflect common practice that new HD starters are seen initially at the main centres and later transfer to satellite units. HD main units may also have a higher number of clinically unstable and or complex patients requiring more frequent contact. There may be some geographical constraints however with less visits to satellite units due to travelling distance and due to the recent COVID -19 pandemic. One unit stated it was not funded to provide routine cover to satellite units, although did provide telephone consultation upon referral.

Table 4.1 shows the number of patients per dialysis modality: peritoneal dialysis (PD), home haemodialysis (HHD), main centre Haemodialysis (HD) and Satellite HD within the 2020 survey. Table 4.2 shows the annual dietetic contacts and table 4.3 shows the annual dietetic contacts per patients by modality.

Table 4.1 Patient numbers per dialysis modality.

	No of patients	No of units who replied	Mean	Median	IQR	Range
PD	2354	41	57	51	50	5 - 250
HHD	820	38	22	18	23	1 - 60
HD Main Centre	4978	38	131	114	87	25 - 482
HD Satellite	9302	36	258	209	266	21 - 880

Table 4.2 Annual dietetic contacts per dialysis modality (includes new and follow-up contacts).

	No of patient contacts	No of units who replied	Mean	Median	IQR	Range
PD	4554	30	152	129	109	5 - 472
HHD	1252	24	52	22	41	1 - 240
HD Main Centre	19037	32	595	425	317	200 - 2156
HD Satellite	28921	29	997	606	850	35 - 7392

Table 4.3 Annual dietetic contacts per patient by modality.

	No of units who replied	Mean	Median	IQR	Range
PD	30	2.78	3.14	1.39	0.25 - 6.00
HHD	24	2.69	2.42	1.96	0.27 - 8.00
HD Main Centre	32	4.65	4.47	1.76	1.00 - 15.16
HD Satellite	29	4.13	3.89	2.20	0.33 - 8.40

Figure 4.1 Annual Dietetic contacts per patient on Haemodialysis, n=35 (This includes contacts for new and follow-up patients at both main centre HD and satellite HD patients).

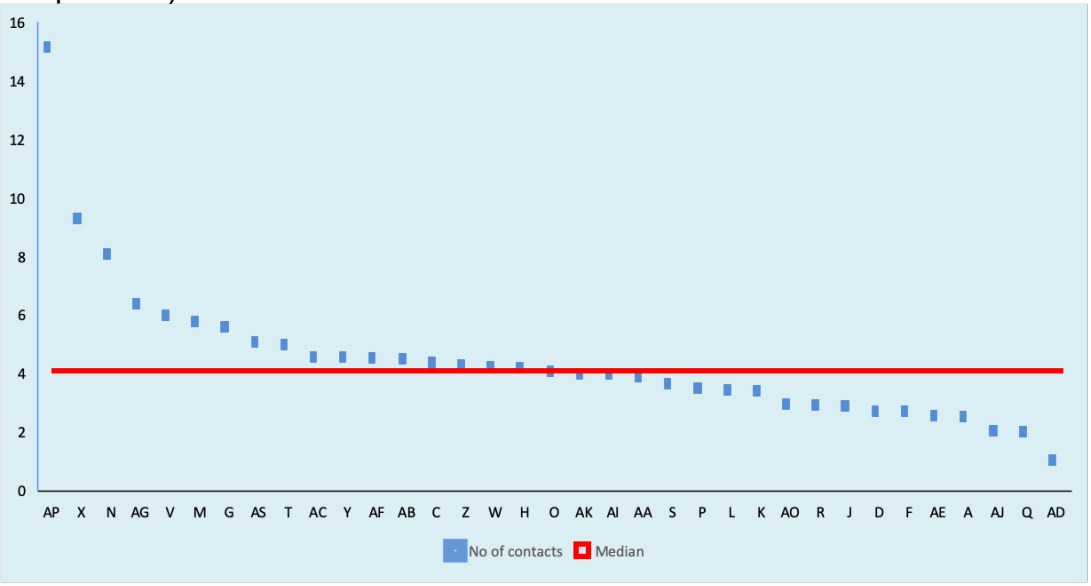


Figure 4.1 shows the mean annual dietetic contacts per patient on haemodialysis from the departmental survey.

4.2 Frequency of dietetic contact of patients on dialysis

Figure 4.2 and table 4.4 show the majority of units routinely provided dietetic patient contact at least every six months. However, 8% of main centre HD patients, 18% of satellite patients and 13% of PD patients were not seen routinely and only seen on referral. Home HD patients had slightly fewer routine dietetic contacts with 25% only being seen on referral.

Figure 4.2 Frequency of dietetic review of patients on dialysis.

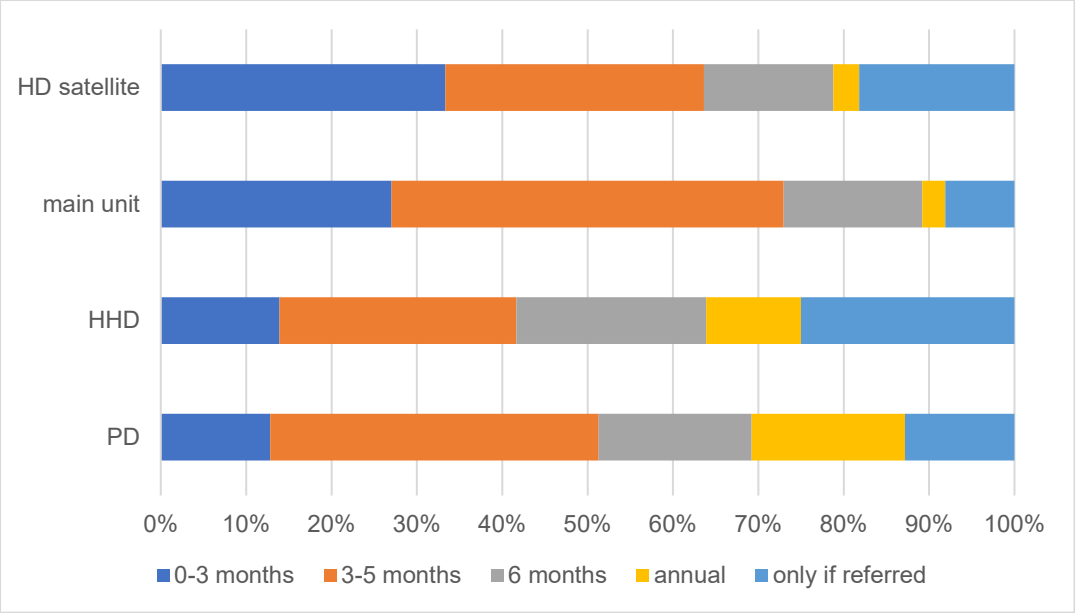


Table 4.4 Frequency of dietetic review of patients on dialysis.

	0-3 months	3-5 months	6 months	Annual	Never	Only if referred	Number unit responses
PD	5	15	7	7	0	5	39
HHD	5	10	8	4	0	9	36
HD Main Centre	10	17	6	1	0	3	37
HD Satellite	11	10	5	1	0	6	33

Figures 4.3- 4.6 show the percentage of patients who had at least one dietetic contact every six months for each dialysis modality. From the responders, 89% of HD main and 79% of satellite patients were seen at least once every six months. PD and HHD patients were seen slightly less often, with 69% and 64% respectively being seen at least every six months.

Figure 4.3 Frequency of renal dietetic input with PD patients.

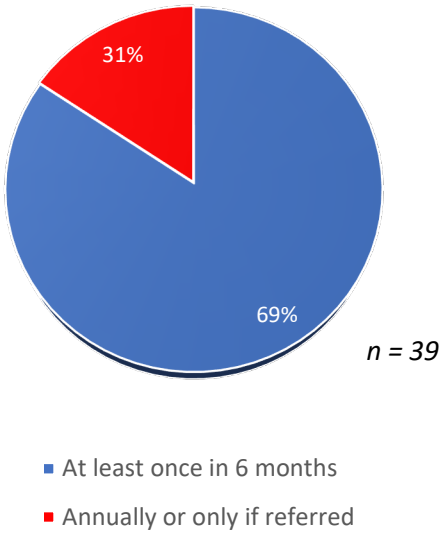


Figure 4.4 Frequency of renal dietetic input with HHD patients.

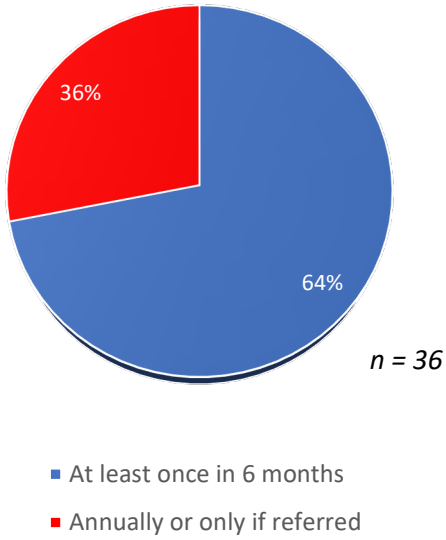


Figure 4.5 Frequency of renal dietetic input with Main centre HD patients.

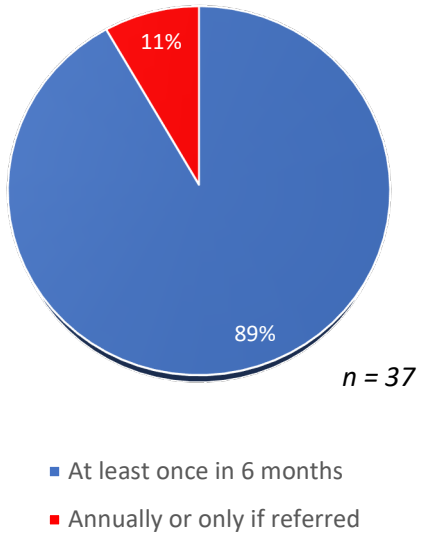
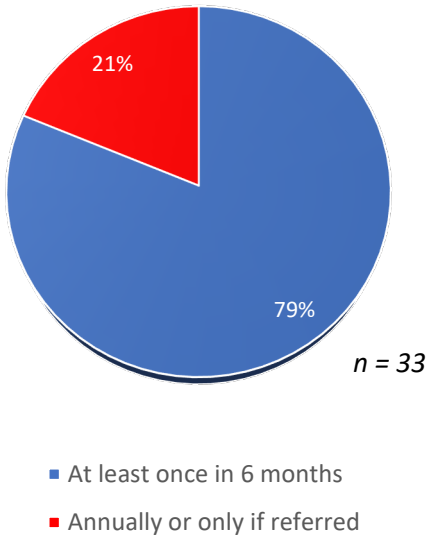


Figure 4.6 Frequency of renal dietetic input with Satellite HD patients.



Section 5 – Kidney Transplantation

Recommendations:

- People waiting for a kidney transplant (pre transplant) should have access to a renal dietitian accordingly to their clinical needs (group education, seen in clinic and/or dialysis, refer to section 3 and 4).
- People waiting for a kidney transplant with a BMI of over 35 kg/m^2 should be provided lifestyle advice including healthy eating and exercise.
- All new kidney transplant recipients should be seen by a renal dietitian prior to discharge or at their earlier outpatients clinic.
- People with existing transplants should be seen according to clinical needs as identified by the MDT and ideally they should have an annual dietetic review.
- People with a kidney transplant, whose kidney function is declining should have the same access to a renal dietitian as those with CKD 4-5 (refer to section 3).
- Further research is undertaken to investigate the potential impact of an improved dietetic service on the nutritional profile of this patient group.

Rationale

The renal registry 2020 reported 37300 people are living with kidney transplants in the UK which has grown by 20% over the last five years (UKRR 2018). Within the 2020 workforce survey only 4% of dietetic time was spent on patients with a kidney transplant. It is recommended that further research is undertaken to investigate the potential impact of an improved dietetic service on the nutritional profile of this patient group.

Data from 18 of the 23 UK kidney transplant centres (of which five perform kidney-pancreas transplant) as listed in the UK Renal Registry (UKRR 2018) from the 2020 workforce survey reported that:

- 77% of new kidney transplant recipients were seen by a dietitian as part of their post-transplant care prior to discharge;
- 35% of renal transplant centres did not offer a post-transplant service;
- One further unit, which was not a kidney transplant centre, provided post-transplant education for out of area transplants five days after surgery.

Between renal centres there is wide variation in the dietetic follow up of new and existing transplants and almost all centres would only see these patients on referral.

Three units reported they did not have a routine service for newly transplanted patients. One of these units reported patients received renal dietary advice as part of an information pack provided by the nursing team but were not seen by a renal dietitian unless referred or at patients request for dietetic input.

A further three units reported transplant patients were only seen upon referral on the ward, or for one unit, seen in the out-patient department. From comments made in the survey, these were more likely to be new referrals for patients with either new or existing transplants requiring nutritional support.

Caution should be taken in interpretation of the 2020 workforce survey data as there was some heterogeneity in the definition of a 'new' patient. For example, some units reported newly transplanted patient contacts for post-transplant dietary education, while others reported new referrals for either new or existing transplant patients requiring nutritional support.

The following tables 5.1 to 5.2 show data reported from the departmental survey.

Table 5.1 New transplant patient numbers and dietetic contacts per annum.

	No of Patients	No of Units	Mean	Median	IQR	Range
Total number of new Tx patients per year	2384	18	132	120	86	53 293
Total number of Tx NP seen in a year by the renal dietetic service	1852	17	109	130	114	15 263

Table 5.1 shows the total number of new kidney transplants per year and the number of new patients seen by the renal dietitian. Renal transplant centres only were invited to respond to this section. Caution should be taken in interpretation of transplant new patients as some units reported new transplant patients requiring post-transplant dietary education only. Whereas other units also included new referrals for existing transplant patients requiring dietetic support.

Table 5.2 Transplant follow-up numbers and dietetic contacts per annum (total n=20).

	No of Patients	% Response Rate	Mean	Median	IQR	Range
Total number of patients with a functioning transplant	13410	44%	671	682	614	172 - 1300
Total number of transplant seen in a year by the dietetic service	2695	44%	135	55	150	6 - 472
Number of dietetic contacts per 100 transplant patients	n/a	n/a	20	8	20	2 - 79

Figure 5.2 – Annual number of dietetic contacts per 100 kidney transplant patients (total n= 20).

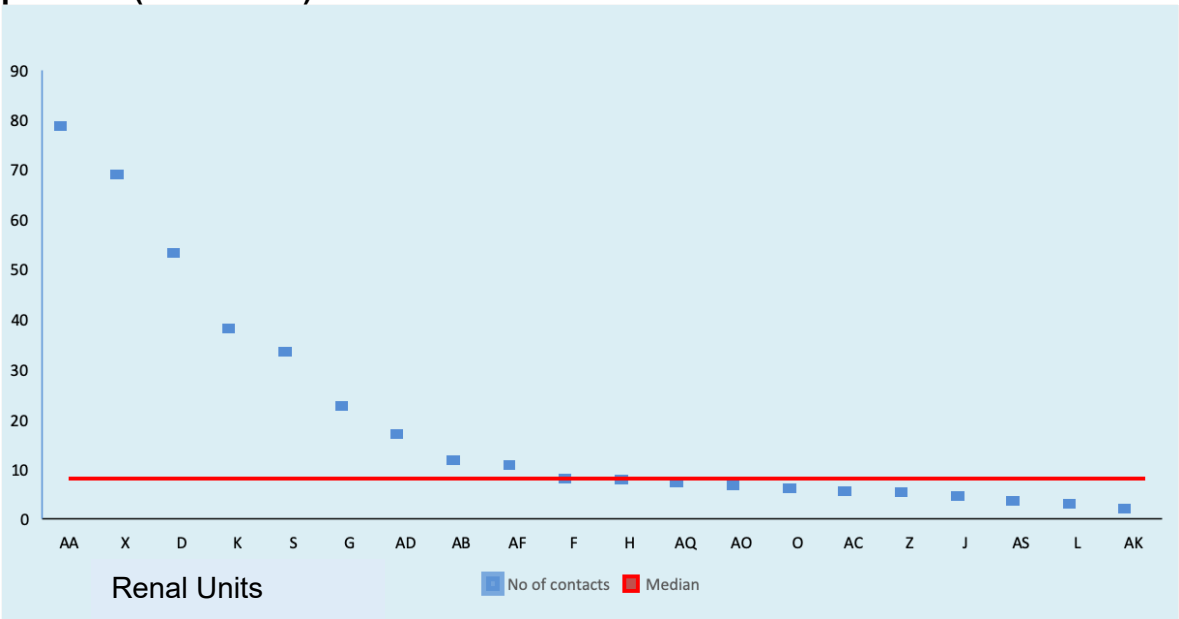


Table 5.2 and Figure 5.2 graph showed there was a wide variation in dietetic contacts with a median of 7.95 contacts per 100 kidney transplant patients.

Table 5.3 Average frequency of kidney transplant follow up (total n=26).

	0-12 months post transplant	After 12 months
0-3 months	7	0
3-5 months	1	1
6 months	1	0
Annually	0	1
Only if referred	17	24
Never	0	0
No of units	26	26
% Response Rate	58%	58%

Table 5.3 shows the average follow up of patients after a kidney transplant by a renal dietitian. Within the 2020 workforce survey, 65% of respondents (n=17) only saw transplant patients on referral within the first 12 months and 92% (n=24) only on referral after 12 months.

Workforce survey results show that within 11 out of 17 units patients were assessed and seen at least once prior to hospital discharge by a renal dietitian; 3 units did not provide a service, and 3 only seeing new transplant patients upon referral.

The departmental survey showed that, following discharge, the majority of patients with a kidney transplant were only seen upon referral, especially after the first 12 months post-transplant. The survey showed a median of 8 contacts per 100 transplanted patients were seen by a renal dietitian per annum. This is significantly less than 3 hours per year per patient as recommended in the BRS workforce plan.

Section 6 – MDT Attendance, CKD- MBD, transitional and young adult services, renal diabetes services and additional activities

Recommendations:

- Renal dietitians form an integral part of the renal multi-disciplinary team (MDT). Provision for the time taken for this activity should be included in renal dietetic business cases.
- Renal dietitians should play an integral role in the management of CKD-MBD. A supplementary prescribing qualification is desirable for renal dietitians undertaking this enhanced role.
- Renal dietitians are an important member of the renal multi-disciplinary team (MDT) including young adult/transition services and renal diabetes services. Business cases should therefore include for provision of dietetic care within these services and ideally have 0.2WTE as time dedicated per clinic.
- Specialist renal dietitians should be involved in the care of young people and transitions services. The time required to provide this service is difficult to quantify and dependent on their stage of CKD, but should be considered within staffing requirements. Children who transition to adult services may require more dietetic input (i.e. artificially fed) for the first 3-6 months of transition (for example two hours in the first month; one hour in first six months).

Rationale

6.1 MDT attendance

Data from the departmental survey showed that renal Dietitians were required to attend a variety of MDT meetings across all modalities as shown in table 6.1
Some departments could not complete all sections of the survey, and these included satellite dialysis units and those without the specific renal service listed.

Table 6.1 – Frequency of attendance at multi-disciplinary meetings per month (total n 40 renal units).

Multi-disciplinary team meeting	Mean	Range	Median	IQR	Skipped or reported as non-applicable
MDT- wards	5	0-28	4	8	3
MDT meetings – CKD stage 4/5 (not on RRT)	3	0-14	2	8	2
MDT meetings – HD	6	0.5-17	5	4	0
MDT meetings – PD	1	0-4	1	4	3
MDT meetings – Transplant	1	0-10	0	0.2	7
Total meetings combined per month	16	-	12	-	-

In addition to the list above, dietitians reported attendance at a range of other MDT meetings.

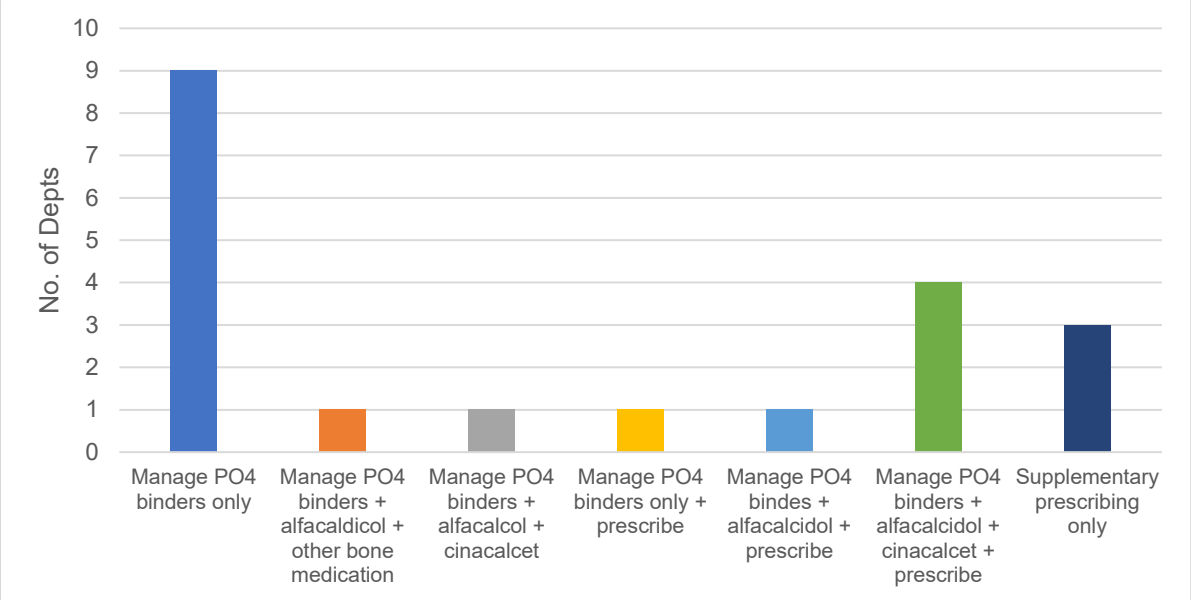
Reported attendance at other MDT meetings included:

- Dialysis work stream meetings
- Inpatient work stream meetings.
- Supportive care meetings attended occasionally
- Young adult meetings attended occasionally
- Etelcalcetide meeting - once per month
- Failing transplant MDT - once per week
- Parathyroidectomy MDT meetings - every other month
- Inpatients HD issues meeting - weekly
- Renal business MDT once per month
- Clinical governance meeting - monthly
- Monthly renal MDT meeting (non-patient-related)
- Renal governance MDT - bi-monthly

6.2 CKD-Mineral bone disease (MBD)

Many renal dietitians perform extended roles and have a significant role in the management of renal bone disease. Since 2018, renal dietitians were awarded the right to train to become supplementary prescribers (SP). Of the 41 responses within the departmental survey, 19 units (46%) reported an active role in managing phosphate binders and or supplementary prescribing. The breakdown of this activity is depicted in figure 6.1. Ten departments took the lead in managing phosphate (PO_4) binders with some of these departments also managing other medications linked to the management of CKD-MBD. In addition, six departments also reported to have at least one team member qualified as a supplementary prescriber (figure 6.1). A further three departments reported to have at least one team member qualified as a supplementary prescriber but did not stipulate which drugs they prescribe.

Figure 6.1 – Renal dietetic involvement in CKD-MBD (n=20).

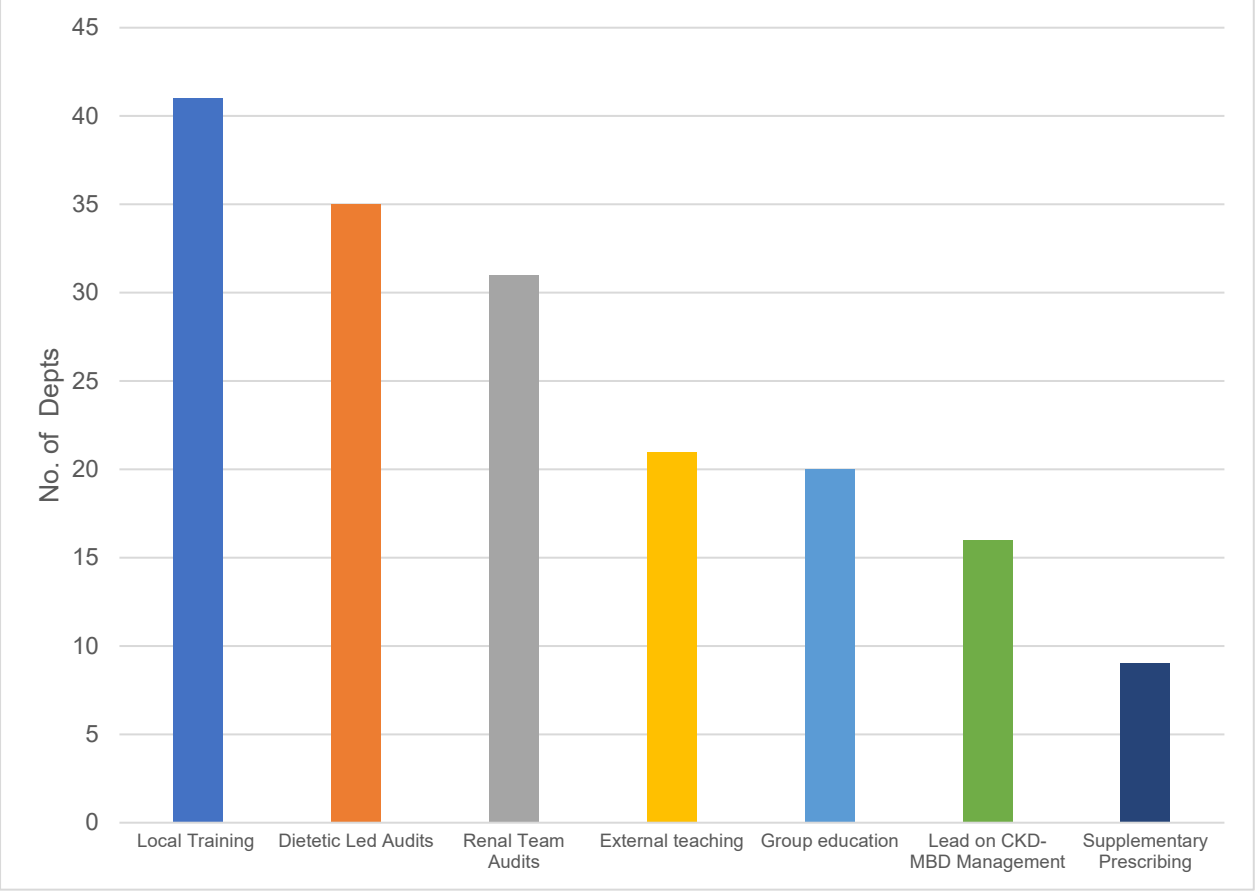


6.3 Additional activities carried out by renal dietitians

There is a wide range of additional activities carried out by renal dietitians. These can be broadly grouped into two types of activity: extended scope clinical practice such as supplementary prescribing and leading on mineral bone disease management, and non-clinical activities such as audit and teaching. These additional dietetic activities are important considerations when assessing renal dietetic staffing levels. Many additional activities are not part of direct clinical care yet essential for supporting safe patient care. Dietetic prescribing and group work activities are currently evolving within dietetics, with the potential for an increasing number of departments undertaking these activities in future years. All the activities reported are essential in supporting patient care, enabling teams to practice safely and provide support to the wider multi-professional team.

The departmental workforce survey demonstrated the range of additional activities that renal dietitians are currently involved in (see figure 6.2). All renal dietetic departments reported to provide local training to other dietitians and health care professionals within their own Trust to aim to improve patient care and safety. Participation in audit work (dietetic or as part of the wider renal team) was reported by 34 (81%) departments. Twenty-six departments (59%) provided additional free text information on further activities carried out as part of their service including student training (7 departments), and resource development (7 departments).

Figure 6.2. Additional activities carried out by renal dietitians as reported by departments (n=40).



6.4. Transitioning and young adult services

The departmental survey showed that though some renal units provided services for young adults, not all of these received renal dietetic input. 22 (52%) of dietetic departments reported to have a transition service, but of these only 8 (36%) reported providing a renal dietetic service.

19 (45%) of renal dietetic departments reported having a young adult service, with 12 dietetic departments (63%) providing a dietetic service. No departments reported leading the transition clinics or young adult service. Most dietetic departments provided ad-hoc or bleep cover to both transition and young adult services (table 6.2).

Table 6.2 – Summary of departments who reported having a Transition service (n=22) and Young Adult Services (n=19).

Service	No. of depts	No of patients	Range	Dietetic Depts with service provision	Time Spent (if reported*)
Transition Service	22 (52%)	234 total Mean = 11	8-90	8 (36%)	0.1WTE or less
Young Adult Service	19 (45%)	818 Mean = 43	10-145	12 (63%))	0.1WTE or less

*Data from 4 units only

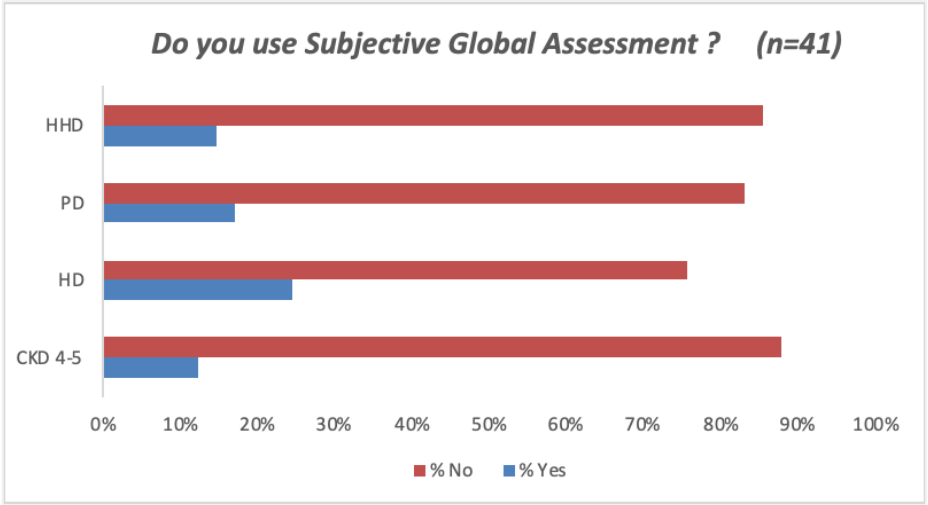
6.5. Renal and Diabetes services

Of 41 renal units, 15 reported to have a renal diabetes service, but only 4 reported to provide a renal dietetic service to Renal Diabetes. Three departments reported to have dietetic-led renal diabetes clinics.

6.6. Subject Global Assessment (SGA)

Ten units out of 41 units reported the use of SGA with HD patients. Only five units reported using SGAs with patients with CKD stage 4-5, figure 6.4.

Figure 6.4 Subject Global Assessment (SGA) usage.



Section 7 - Safe staffing levels

Recommendations:

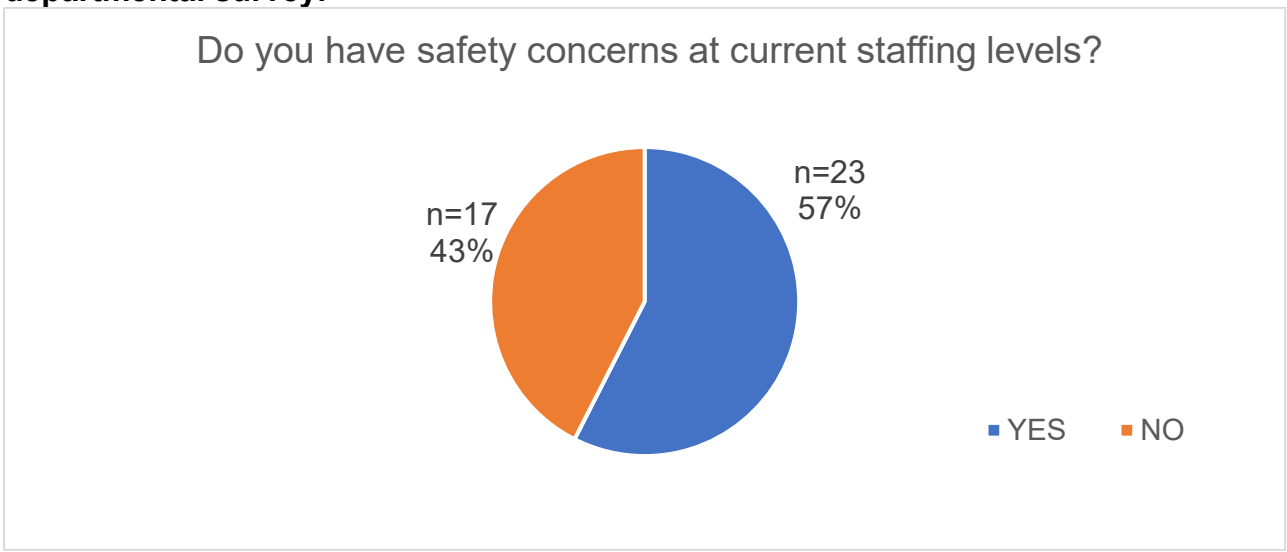
- The individual survey showed that out of 211 renal dietitians 59% felt their current workload was either not safe or not ideal. The departmental survey undertaken at the same time, showed that, out of 40 units, 57% reported that they had safety concerns. As over half the departmental and individual respondents had some safety concerns, this should be taken into account when making recommendations, as current practice is not likely to reflect a 'gold standard'.
- As well as time spent with individual patients, recorded as contacts, most renal dietitians are involved in a wide range of workplace activities, many of which are not a recognised part of patient activity yet are essential in supporting patient care and enabling teams to practice safely. This includes work that is deemed to be an extended scope of practice. These additional activities should be considered in all renal dietetic workforce and recruitment planning.
- Due to difficulties with recruitment problems and high staff turnover, it is recommended that renal rotations or attachments should be provided to enable training for short term back fill opportunities or recruitment options, rather than relying on inexperienced staff to fill in the gaps.

7.1 Safety concerns reported by renal dietetic departments and individuals

Both the departmental and individual workforce surveys provided data that indicated that there were some concerns regarding staffing levels within renal dietetics.

Renal Dietetic Departmental Survey
When asked if they had safety concerns at their current staffing levels, 57% (n=23) responded that they had safety concerns at their current staffing levels and 43% (n=17) reported no concern. Figures 7.1, 7.2 and Table 7.1.

Figure 7.1 Responses to question regarding safety concerns in the departmental survey.



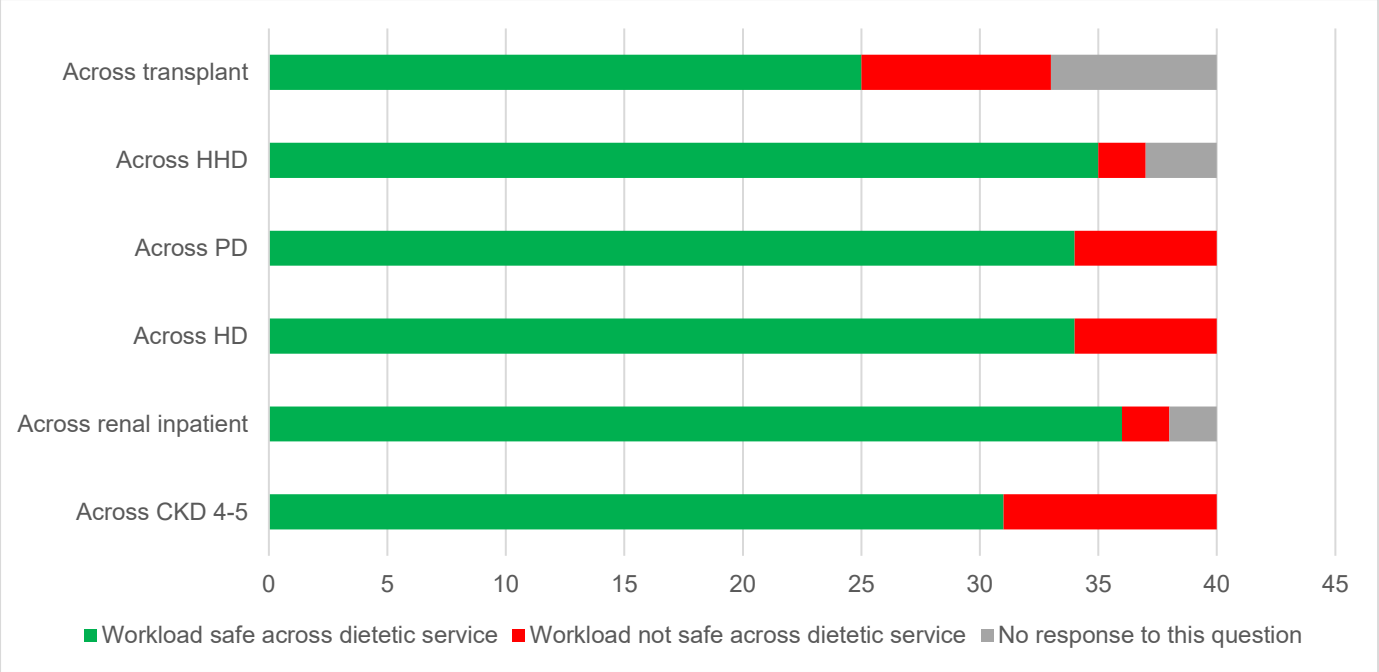
Below are the main themes which emerged from this survey. Some of these affected patients, some dietetic staff and some the wider MDT (Table 7.1).

Table 7.1 Themes which emerged from the department survey.

Safety concerns		
Affecting patients	**Affecting dietetic staff**	**Affecting the MDT**
adverse impact on clinical outcomes	concerns regarding workload	reduced opportunity for MDT working
patients not seen in a timely manner	too much clinical work to manage properly	failing meeting audits/standards
poor patient experience/satisfaction	too much clinical work to manage properly	Failing to dedicate tie in service development and research
unable to fully complete documentation	reduced opportunities to develop self (CPD)	
Suboptimal dietetic care	low staff morale	
Inequality in service provided	insufficient opportunities for practice supervision or appraisals	
Unable to cover specific areas (transplant services were often not covered)	Insufficient funding and recruitment issues	

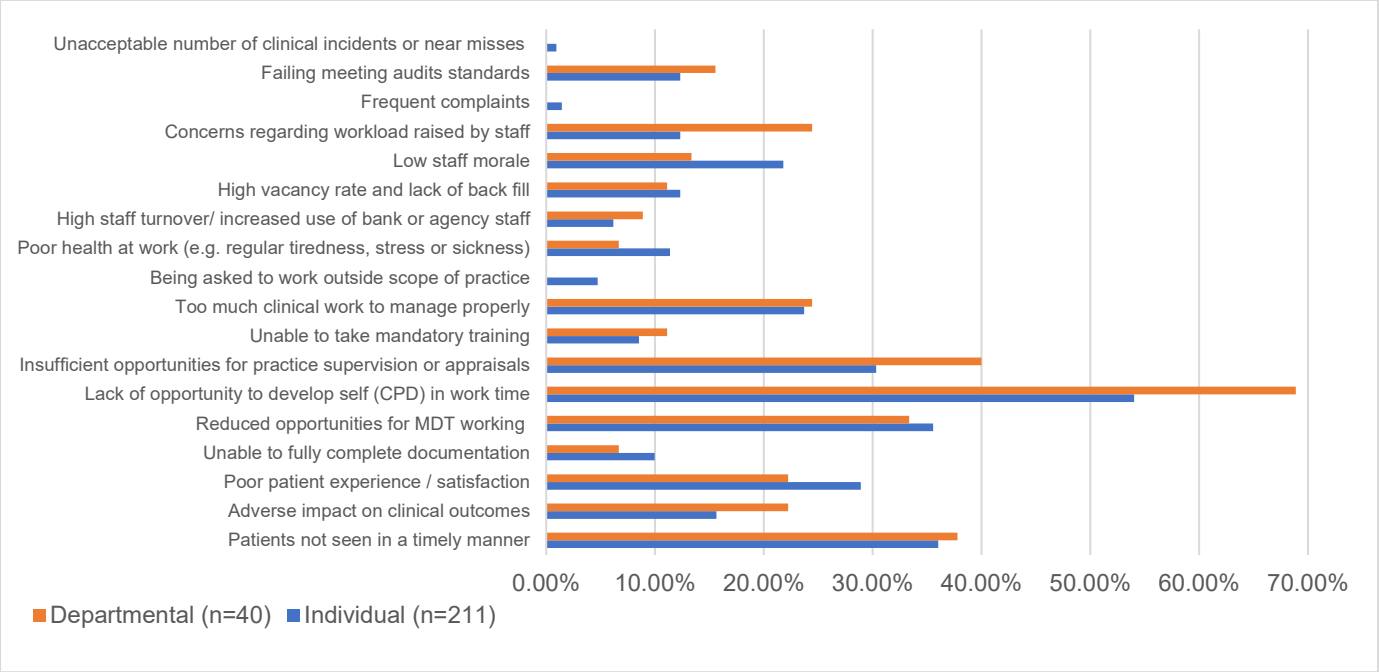
When asked specifically about dietetic staff workload safety the biggest concern was in the transplant services followed by pre dialysis services (table 7.2).

Figure 7.2 Staff workload safety concerns reported across the different renal services.



Both the departments and individuals were asked which were their main safety concerns. It was interesting to note that there were similar findings in both surveys (see figure 7.3).

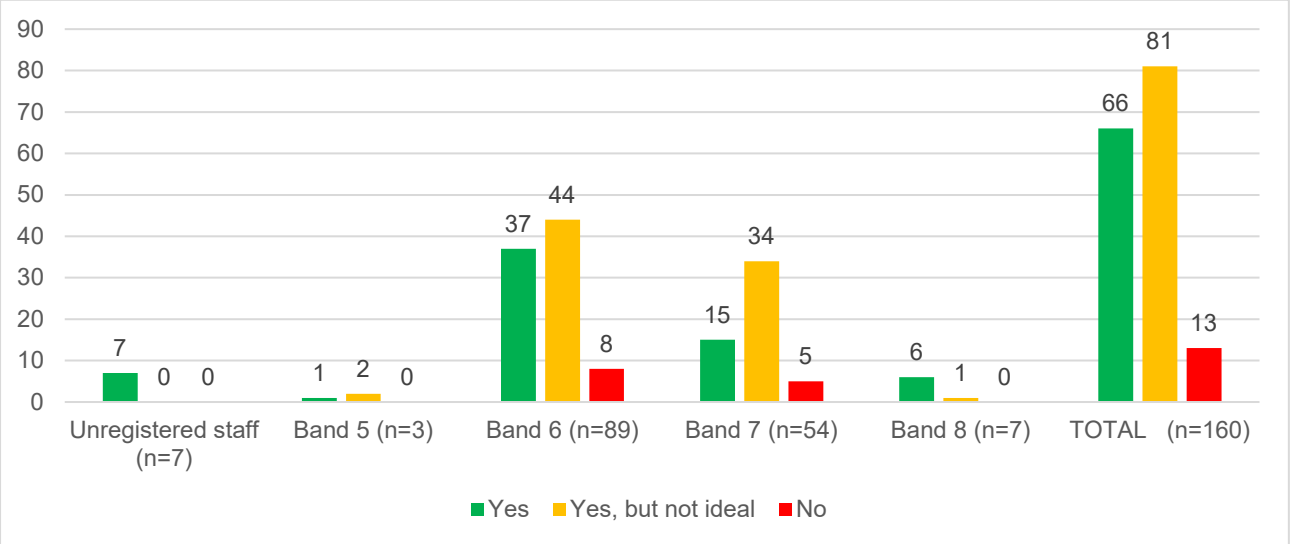
Figure 7.3. Percentage of respondents main safety concerns from both the departmental and individual surveys.



Individual workload safety survey

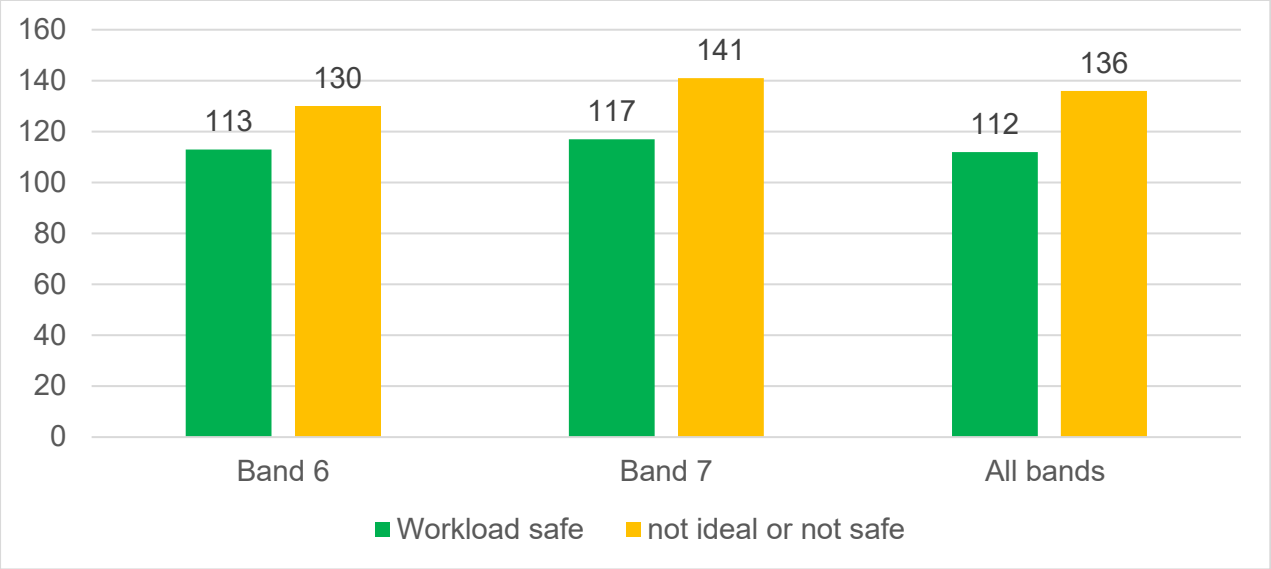
In the individual survey, respondents were asked if they felt their current workload was safe. 160 out of 211 responded to this question. 41% (n=66) responded 'yes', 51% (n=81) responded 'yes but not ideal' and 8% responded 'no' (n=13). Figure 7.4 provides the responses in total and by pay Band.

Figure 7.4 Perception of own workload safety by Banding from Individual survey.



The mean number of patient contacts seen per month per WTE renal dietitian was collected and compared with their workload safety responses. Figure 7.5 shows that the number of monthly contacts was higher in Bands 6 and 7 for those staff who felt that their workload was either ‘not ideal’ or ‘not safe’. This may indicate that a safe number of monthly contacts may be between 100 and 120 for a typical caseload. There are many other activities expected from a renal dietitian and focusing solely on the number of contacts is not a helpful metric.

Figure 7.5. Workload safety and mean number of contacts seen per WTE dietitian, per month.



All departments who responded provided information on the additional roles of the renal dietitian which are not a recognised part of patient activity, yet essential in supporting patient care and enabling teams to practice safely. These include (list is not exhaustive):

- Multidisciplinary (MDT) team work including MDT meetings,
- Planning and provision of group education for patients with kidney disease, including online
- training to other dietitians and health professionals
- CKD-MBD leading role with over 35% reported leading on phosphate binder management with 22% of departments undertaking supplementary prescribing
- student training and resource development
- Lead role in joint clinics including transition clinics
- Audits and resource development work
- Time for professional development

As well as individual patient contacts, most renal dietitians are involved in a wide range of workplace activities, many of which are not a recognised part of patient activity yet are essential in supporting patient care and enabling teams to practice safely. This includes work that is deemed to be an extended scope of practice.
These additional activities should be considered in all renal dietetic workforce and recruitment planning.

The responses indicate that both short and long-term workforce planning are used within renal dietetic teams across the UK. There are, however, significant short term workforce issues.
These are mainly addressed by using junior and/or inexperienced dietetic staff to 'fill' the gaps. Comments received from the surveys indicate that this has a subsequent knock-on effect on the existing renal dietetic team members to provide training and support to facilitate this.

There is suboptimal renal dietetic care for patients with CKD due to insufficient renal dietetic funding overall or to certain areas such as CKD 4-5 clinics or renal diabetic clinics. The results from the surveys show that there are lack of opportunities within dietetic departments for speciality rotations or attachments.

The high turnover of Band 6 renal dietitians was also mentioned as a workforce issue. Some units highlighted that it is very difficult to recruit when only small amounts of funding are made available for workforce provision. There are also dietetic recruitment problems also in some geographical localities.

Conclusion

The individual workforce survey showed that out of 211 renal dietitians 59% felt their current workload was either not safe or not ideal.
The departmental survey undertaken at the same time, showed that 57% of departments also had safety concerns.

As over half the departmental and individual respondents had some safety concerns, this should be considered when making recommendations, as current practice is not likely to reflect a 'gold standard'.

As well as time spent with individual patients, recorded as contacts, most renal dietitians are involved in a wide range of workplace activities, many of which are not a recognised part of patient activity yet are essential in supporting patient care and enabling teams to practice safely. This includes work that is deemed to be an extended scope of practice.
These additional activities should be considered in all renal dietetic workforce and recruitment planning.

Due to difficulties with recruitment problems and high staff turnover; it is recommended that renal rotations or attachments should be provided to enable training for short term back fill opportunities or recruitment options, rather than relying on inexperienced staff to fill in the gaps.

Section 8 - Results from the individual survey

The individual survey was much shorter than the departmental survey and focused on time spent in workplace activities, to help with job planning as well as number of patients seen. They were also asked if they felt that their workload was safe as discussed in section 7.

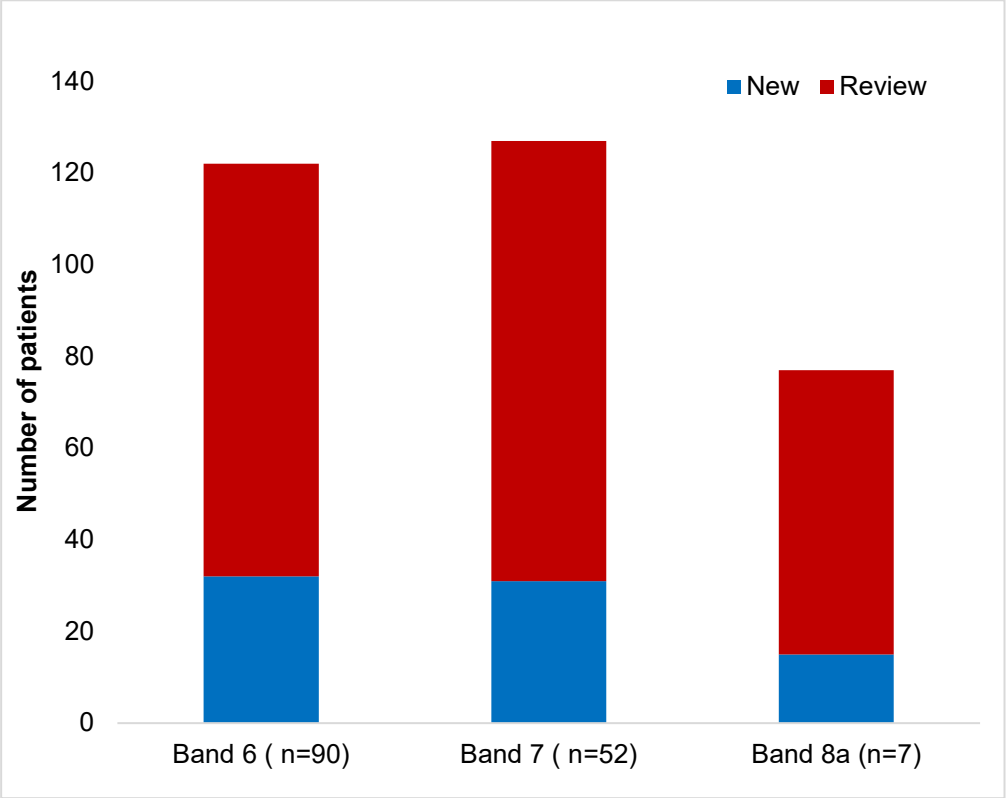
8.1 Number of Patient Contacts

From the data obtained from the individual survey, the mean number of patient contacts per WTE per month for registered dietitians are provided in table 8.1 and figure 8.1. This data includes both inpatients and outpatients.

Table 8.1 Number of patient contacts per WTE dietitian per month.

Band	Number of Respondents	Mean New Patient Contacts/WTE /month	Mean Review patient Contacts/WTE/ month	Total contacts/WTE /month
6	90	32	90	122
7	52	31	96	127
8a	7	15	62	78

Figure 8.1 Mean number of new and review patients seen per WTE per month.



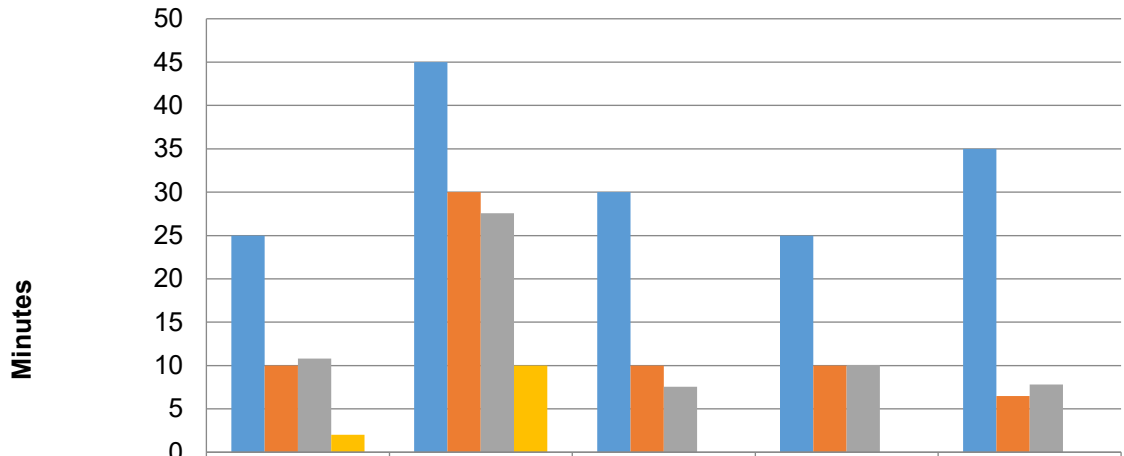
8.2 Length of time spent per individual patient contact

Four further questions were designed to obtain further information regarding the tasks required for each patient contact and the mean length of time required for a single patient contact.

8.2.a. New patients

Assuming the dietitian has approximately 60 minutes to see a new patient, we asked how would they feel that time would usually be allocated for the consultation (in minutes, figure 8.2).

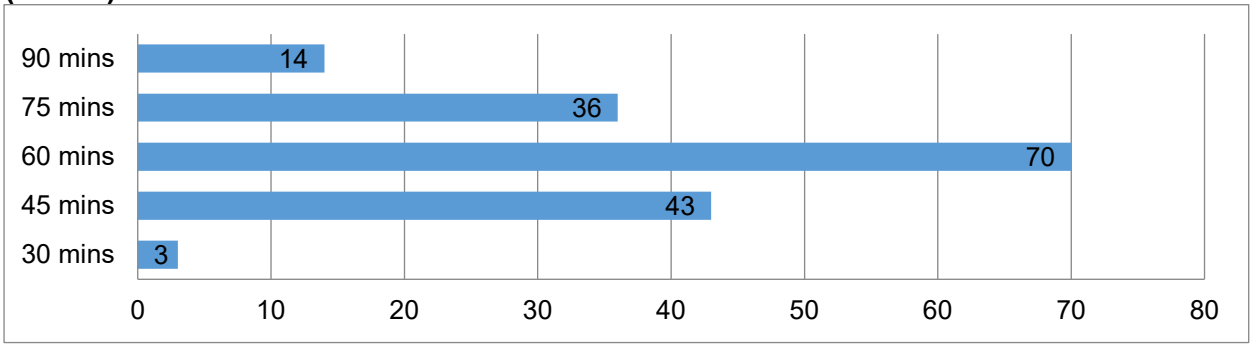
Figure 8.2 Time allocation for a 60mins consultation of a new renal patient by Band 5 to Band 8b renal dietitian (n=163).



	Before seeing the patientRead up relevant previous entries/referral/letter…etc	Face-to-face contact with patient/carer	Writing up consultation details in all notes (medical/nursing/dietetic …etc)	Typing up electronic record	Miscellaneous (typing up Px letter, phone calls, allocation ONS or feed …etc)
maximum (minutes)	25	45	30	25	35
median (minutes)	10	30	10	10	6.5
mean (minutes)	10.79	27.56	7.54	10.06	7.83
minimum (minutes)	2	10	0	0	0

Figure 8.2 showed the mean, median, maximum and minimal time allocated for different tasks within 60 minutes of seeing a new renal patient by the renal dietitian. The respondents (n=166) were asked how much time do they spend for each new renal patient, 42.2% chose 60 minutes per new renal patient (8.4%, n=14) spending up to 90 minutes for each new renal patient (figure 8.3).

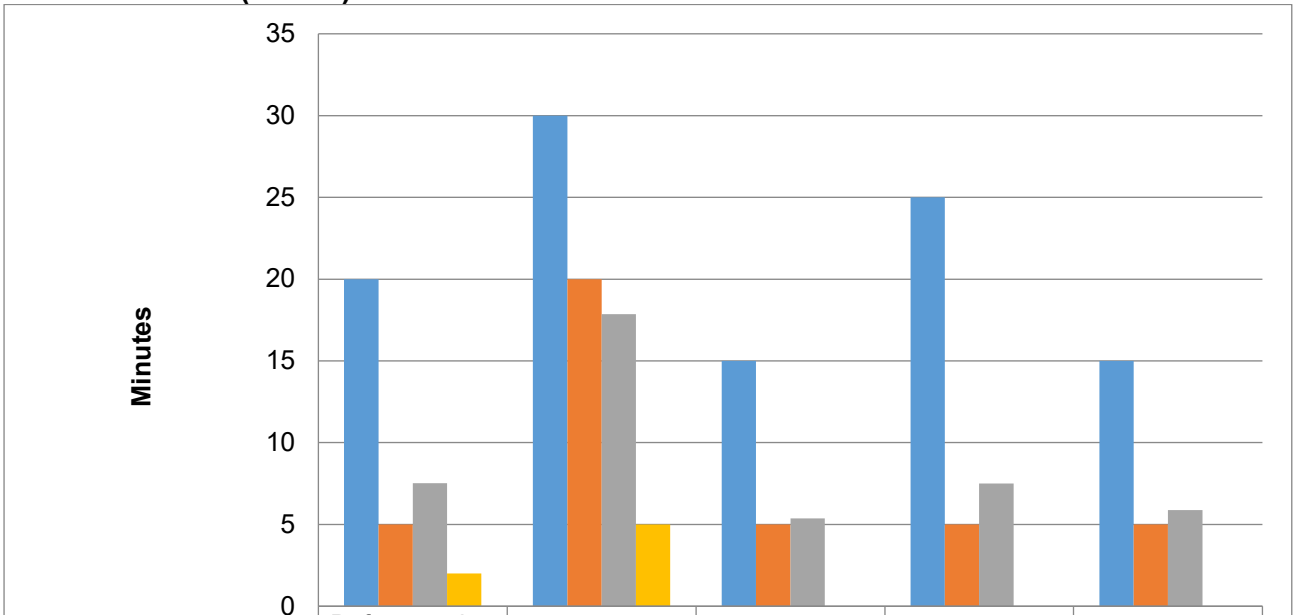
Figure 8.3 Time spent per new renal patient and number of respondents (n=166).



8.2.b Review patients

Assuming the dietitian would have approximately 40 minutes to see a review patient, we asked how they would feel that time would usually be allocated for the consultation (in minutes, Figure 8.4).

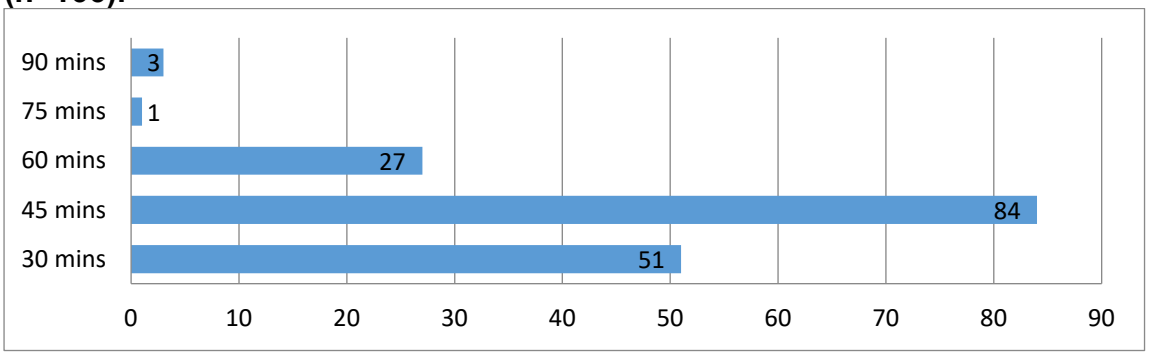
Figure 8.4. Time distribution for a 40 minutes review slot by Band 5 to Band 8b renal dietitians (n=166).



	Before seeing the patientRead up relevant previous entries/referral/letter…etc	Face-to-face contact with patient/carer	Writing up consultation details in all notes (medical/nursing/dietetic …etc)	Typing up electronic record	Miscellaneous (typing up Px letter, phone calls, allocation ONS or feed …etc)
maximum (minutes)	20	30	15	25	15
median (minutes)	5	20	5	5	5
mean (minutes)	7.53	17.85	5.37	7.5	5.88
minimal (minutes)	2	5	0	0	0

For review cases, half of the respondents (50.6%, n=84) spent 45 minutes but some (1.8%, n=3) spent up to 90 minutes (figure 8.4).

Figure 8.4 Time spent per review renal patient and number of respondents (n=166).



8.3 Estimates of individual patient attributable time

Calculations were then made to estimate the percentage time spent on individual patient attributable direct patient care. Please note this percentage is taken from individual patient contacts and does not include the other (MDT focussed) aspects of direct clinical care.
The calculations were based on the data taken from the mean number of new and review patients/WTE/month for Bands 6, 7 and 8a, the most frequent response for the length of time required for both a new patient (60 minutes) and a review patient consultation (45 minutes) adjusting for the mean number of working days/month.

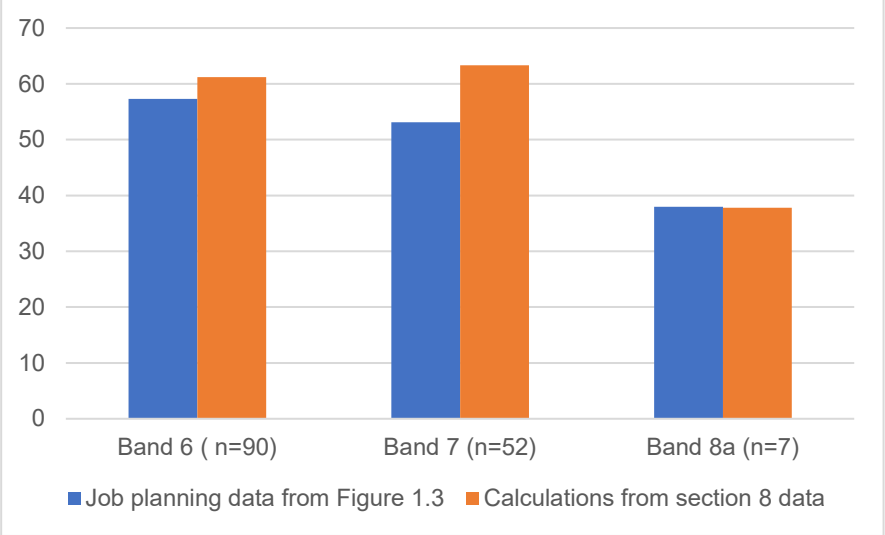
The results showed similarities to the data from figure 1.3 regarding percentage of time spent in different workplace activities which are shown in table 8.2 and figure 8.5.

Table 8.2 Table to show comparison between estimate of time spent in the provision of individual patient attributable DCC.

Band	Number of responses	Job planning data for individual patient attributable direct clinical care (Figure 1.3)	Calculation of time (minutes) spent with individual patients (Section 8 data)
6	90	57.3	61.2
7	52	53.1	63.3
8a	7	38	37.8

The estimate from the calculation above provides a higher percentage of time spent providing individual patient attributable direct clinical care. This is most likely to mean that Band 6s and Band 7s dietitians in reality spent less than 60 minutes per new patient or 45 minutes for a patient review.
The job planning data matched the calculations for Band 8as. Overall, the respondents may have given a time frame for the length of time they would like to spend with a patient, whereas in reality, the length of time spent may have been shorter.

Figure 8.5. Estimates of Individual Patient Attributable Direct Clinical Care from Individual Survey using data from figure 1.3, section 1 and table 8.2, section 8.



Conclusion

There was a rich source of data from the individual survey, particularly from the AFC Band 6 and Band 7 dietetic workforce. This showed that a high percentage of contracted hours were in direct clinical care, most of this being individual patient attributable care, but time spent working as part of the renal MDT was also significant.

Despite high levels of clinical commitments, the mean length of time spent per individual patient is significant and matches recommendations in the BRS Multi-Professional Workforce Guidance.

Section 9 - Digital Technology

The inclusion of digital technology in the healthcare setting is a key driver from HM Government and The NHS (HM Government & NHS 2020; NHS England). The RNG Workforce planning Group acknowledge that the survey was carried out prior to COVID19, when it became evident that digital technology would be integrated into renal dietetic practice over the UK. Digital technology can be of enormous benefit to many aspects of patient care and best practice is being configured within dietetics. Modes of digital technology available to dietitians include video consultations, patient education via websites, video and mobile applications (Dawson et al 2021). The health literacy and the socio-economic background of our patients should not be overlooked (Dawson et al 2021). The RNG Workforce planning Group will include digital technology in renal dietetic practice in future workforce planning surveys.

Section 10 - Guidelines recommending the services of a Specialist Renal Dietitian

National Guidelines

Guidelines	Comments
NHS England, 2015, In Centre Haemodialysis https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/01/a06-serv-spec-haemodialysis-ichd.pdf	• Average provision of dietetic service on a quarterly basis in unstable patients. • Monthly for those with a poor appetite or significant weight loss. • Stable on dialysis 6 monthly reviews.
NHS England, 2017, Kidney Transplant services https://www.england.nhs.uk/wp-content/uploads/2017/05/service-spec-adult-kidney-transplant-service.pdf	• Optimum delivery of the agreed pathways requires effective working relationships with the following services and organisations – Renal Dietitians. • No guidance on time.
NHS England, 2015, Haemodialysis Renal Failure at Home https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/02/a06-s-f-dafb-serv-spec.pdf	• Recommendation for Renal Dietitians to be part of the MDT.
NHS England, 2015, Chronic kidney disease in adults assessment and management https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/01/a06-spec-renal-asses-ad.pdf	• Recommendation for Renal Dietitians to be part of the MDT.
NICE, 2018, Renal replacement therapy and conservative management https://www.nice.org.uk/guidance/ng107/resources/renal-replacement-therapy-and-conservative-management-pdf-66141542991301	• Offer an assessment by a specialist renal dietitian to people starting dialysis or conservative management.
Intensive Care Society - Guidelines for the provision of intensive care services, 2019 https://www.ficm.ac.uk/sites/default/files/gpics-v2-final2019.pdf	• A staffing of 0.05-0.1 WTE per Critical care bed. This level is expected for advanced clinical practice.

British Renal Society - A Multi-professional Renal Workforce Plan for Adults and Children with Kidney Disease, 2020 https://britishrenal.org/wp-content/uploads/2020/10/FINAL-WFP-OCT-2020.pdf	• Workforce recommendations for Specialist renal dietitians who hold central responsibility for nutritional assessment and dietary therapy in the prevention and management of CKD and in more advanced stages of AKI.
Think Kidneys, 2021, Nutritional Considerations in Adult Patients with Acute Kidney Injury https://www.thinkkidneys.nhs.uk/aki/wp-content/uploads/sites/2/2021/03/Nutrition-Guide-2021.pdf	• Renal Dietetics is an integral part in the management of AKI.
The Renal Association, 2019, Clinical Practice Guideline on Haemodialysis https://renal.org/sites/renal.org/files/FINAL-HD-Guideline.pdf	• The guideline aims to provide guidance on how to look after patients and how to run dialysis units, and provides standards which units should in general aim to achieve.
The Renal Association, 2019, Clinical practice guideline on under-nutrition in chronic kidney disease https://bmcnephrol.biomedcentral.com/track/pdf/10.1186/s12882-019-1530-8.pdf	• Review of existing recommendations on nutrition and kidney failure.
British Dietetic Association, 2016, Safe Staffing, Safe Working Guidance https://www.bda.uk.com/uploads/assets/53c343b0-c925-4513-a5d6d08b9b24ba2a/Safe-Staffing-Workload-Guidance.pdf	• Recommendations for Dietetic staffing levels in the UK.
NHS , 2017, Multi-professional framework for advanced clinical practice in England https://www.hee.nhs.uk/sites/default/files/documents/Multi-professional%20framework%20for%20advanced%20clinical%20practice%20in%20England.pdf	• Key principles for planning the workforce and governance of Advanced clinical practitioners.

NICE 2021 Chronic Kidney Disease: assessment and management. https://www.nice.org.uk/guidance/ng203/resources/chronic-kidney-disease-assessment-and-management-pdf-66143713055173	• Offer dietary advice about potassium, phosphate, calorie and salt intake appropriate to the severity of CKD. • if dietary intervention is agreed, provide it alongside education, detailed dietary assessment and supervision to ensure malnutrition is prevented. • A specialist renal dietitian, supported by healthcare professionals with the necessary skills and competencies, should carry out a dietary assessment and give individualised information and advice on dietary phosphate management.

International Guidelines

Guidelines	Comments
Workforce Recommendations for Renal Dietitians in Australia and New Zealand, 2018 https://dietitiansaustralia.org.au/wp-content/uploads/2018/11/Renal-Dietitians-Workforce-Recommendations.pdf	• Developed by The Australian and New Zealand Renal Dietitians Workforce Planning Group • Recommended a minimum of 2.25 hours per inpatient per admission • See guideline for outpatient calculations and recommendations for new and existing patients.
ESPEN, 2021, Clinical nutrition in hospitalized patients with acute or chronic kidney disease https://www.espen.org/files/ESPEN-Guidelines/ESPEN-guideline-on-clinical-nutrition-in-hospitalized-patients-with-acute-or-chronic-kidney-disease.pdf	• The guideline focuses on nutrition in AKI and CKD in hospitalized patients. This includes those on the nephrology/renal wards, medicine and surgical wards, and ICU.

ASPEN, 2010, Clinical Guidelines: Nutrition Support in Adult Acute and Chronic Renal Failure https://aspenjournals.onlinelibrary.wiley.com/doi/pdf/10.1177/0148607110374577	• The guideline focuses on nutrition in AKI and CKD.
An Evidenced-Based Demand Management Toolkit for Dietetic Services. A Framework for Effective & Efficient Dietetic Services, Renal, 2017, Queensland Health https://www.health.qld.gov.au/__data/assets/pdf_file/0024/668022/feeds-renal.pdf	• CKD stages and frequency of dietetic intervention at each stage of CKD and AKI.
EBPG Guideline on Nutrition, 2007 *Nephrology Dialysis Transplantation, v 22, Pages ii45–ii87* https://academic.oup.com/ndt/article/22/suppl_2/ii45/1871238	• Guidance on malnutrition in people with kidney disease.
Evidence Based Practice Guidelines for the Nutritional Management of Chronic Kidney Disease, 2006, Dietitians Association of Australia https://onlinelibrary.wiley.com/doi/epdf/10.1111/j.1747-0080.2006.00100.x	• Summary of evidence based guidelines related to the dietetic management of adult patients with CKD.
National Kidney Foundation & Academy of Nutrition and Dietetics, 2019, Clinical practice guideline for nutrition in chronic kidney disease: update https://www.kidney.org/sites/default/files/Nutrition_GL%2BSubmission_101719_Public_Review_Copy.pdf	• Guideline on nutrition in CKD.

Future recommendation

- Review the surveys based on the comments collected in appendix 3.

- Aim to repeat the survey in the next 5-10 years, including the advancement of virtual technologies such as Patients know best and Attend Anywhere are likely to see an increase in contacts with these patient groups.

- Associate future surveys with patient reported experience measurements (PREMS).

- Liaise with UKRR for future collaboration regarding relevant data collection and analysis.

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UK Renal registry, UKKR (2018). Adults on renal replacement therapy (RRT) in the UK at the end of 2018 Available at: https://renal.org/sites/renal.org/files/22nd_UKRR_ANNUAL_REPORT_Ch2.pdf

UKKA (2019) Clinical Practice Guidelines Acute Kidney injury. https://ukkidney.org/sites/renal.org/files/FINAL-AKI-Guideline.pdf

Appendices

Appendix 1

Renal Dietetic Departmental Survey 2019

The Renal Nutrition Group aims to update the previous workforce guidelines (BRS-RNG 2002). The first step is to identify the current renal dietetic workforce in the UK, by completing this survey (split into 5 sections). This can only be achieved with your participation.

Each survey needs to be completed by the lead renal dietitian representing all the renal dietetic workforce within each renal unit, comprising of main unit and associated satellite units/clinics. In order to avoid duplication we only need 1 survey per team/dietetic renal service provider (for example if you are the sole dietitian working in a private satellite unit, we would be grateful if you could complete this).

Definitions
NP = new patient; FUP = follow up; VC = video conference; WTE = whole time equivalent (1 WTE= 37.5hours/week = 10 sessions. Note: 1 session = half a day = 3.75 hours)**. Please do not use any local or other abbreviations.**

Patient related activities
Job plans describe how working time is divided up according to specific categories. All patient related activity is categorised as direct clinical care (DCC). DCC includes both individual patient attributable care (split into direct and indirect intervention with a specific patient) and non individual patient attributable care (e.g. MDT meetings).

Individual patient attributable DCC
Any intervention that relates to a specific person's clinical care provided by the renal dietetic service. One direct patient contact = one direct contact with a patient or their representative – usually face-to-face and including all the associated activities e.g. note writing. These associated activities (mostly indirect activity) include interpretation of blood results, anthropometric measurements, estimating requirements / feeding regimens, dietary analysis, communicating with other HCPs to gather information to formulate dietetic plan, dietetic documentation, GP letters. Contact method includes face-to-face, telephone, email, skype and video conferences. This includes both individual and group education.
The length of time taken for one direct patient contact includes all the associated activities required for that contact (and not only the face to face time). In this document the word "contact" refers to one direct patient contact.

Non individual patient attributable DCC
Other patient focused activities that do not involve direct communication with the patient or their representative do not count as patient contacts. This includes MDT meetings. It also includes telephone conversations or emails with other care professionals and all other patient related documentation.

PLEASE EXPAND TABLES AS NEEDED ACCORDING TO YOUR SERVICE PROVISION. It is estimated to take 45 minutes (depending how easy is to get the information required)

If you require further clarification for answering the questions please contact x

1) ABOUT YOUR RENAL DIETETIC TEAM:

1.1 Introduction

Your Name: Role: Name of the unit:
Email address: Contact telephone number:

Is your renal dietetic service:
NHS based/funded YES NO Private based/funded YES NO

1.2. Staff Numbers

1.2.1. Please provide the total numbers of WTE dietetic staff within your renal dietetic team, by Banding (including renal and non-renal workload)

	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8b
WTE								

1.2.2 Please provide the number of WTE (per week) available for direct renal clinical work only (excluding time spent on other duties e.g. general roles, non-renal specific departmental work, staff supervision, etc.) accordingly to what your service currently provides. We understand these will be best estimates.

	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8b
Renal Inpatient								
Outpatients clinics CKD 1-5								
Outpatients clinics CKD 4-5								
Outpatients clinics transplant								
HD main unit								
HD satellite								
HD home								
PD								
Others (please state/expand the table)								

1.2.3 Do you have any administration support? YES NO. if yes specific WTE

Band 1	Band 2	Band 3	Band 4

1.2.4 Do you use of casual workers or Locum? YES NO

2) INPATIENTS RENAL SERVICES:

2.1 Please complete the table below.

Inpatient services	**Total number of renal beds**	**Covered by dietitian WTE**		**Covered by non-dietitian (dietetic assistant, technician, support workers)**	
		Band	**WTE**	**Band**	**WTE**
Total No of beds on renal ward (excluding HDU/ICU)					
No of renal HDU beds (if any)					
No of renal ICU beds (if any)					

Do you have any nutrition apprentices in your team? YES NO. (If yes what is their role?.....)

2.2 Inpatients outliers

Average number of renal dietetic outliers (excluding critical care):
Estimated number of referrals per week: …….
Is this input provided by (tick as many as applicable):

- A renal dietitian
- A non renal dietitian who has completed specific renal competencies
- A general dietitian without renal competencies plus supervision from a renal dietitian
- A general dietitian without renal competencies with no renal dietitian supervision
- Others, please specify …

2.3 Screening for referrals

Do you use a screening tool for inpatients? Yes No
If yes, please state: MUST, in house developed, INUT, others

How are inpatients referred to the dietitian or identified that require a dietitian?
Please place tick only 1:

Patient referred by using a screening tool only (no triaged by dietitian)	
Patients triaged by dietitian only (no screening tool, for example self-screening and/or attending ward round)	
Both methods stated above	
Others: please specify	

3) CKD outpatients and DIALYSIS

3.1 Complete each box NP = New patient FUP = Follow Up

	Stage 1- 5 CKD	**Stage 4 -5 CKD**	**Outpatients conservative management**
Total number of patients (including those not under the dietetic services: you may need to ask the managers of your unit for this information)			
Total number of NP seen in a year by the dietetic services (please state if no service is provided)			
Total number of FUP seen in a year by the dietetic services (please state if no service is provided)			
Total number of renal dietetic contact per year			
How often do you see these patients ?	➢ 0-3 months ➢ 3-5months ➢ 6 months ➢ annually	➢ 0-3 months ➢ 3-5months ➢ 6 months ➢ Annually	➢ 0-3 months ➢ 3-5months ➢ 6 months ➢ annually
DIALYSIS PATIENTS	**Peritoneal Dialysis**	**Home Haemodialysis**	**Main Centre Haemodialysis**
Total number of patients (including those not under the dietetic services: you may need to ask the managers of your unit for this information)			
Total number of NP (to the dialysis modality) seen in a year by the dietetic services (please state if no service is provided)			This include the total number of new HD patient per year (including satellite)
Total number of FUP seen in a year by the dietetic services (please state if no service is provided)			
Total number of renal dietetic contacts per year			

How often do you see these patients?	➢ 0-3 months ➢ 3-5months ➢ 6 months ➢ annually	➢ 0-3 months ➢ 3-5months ➢ 6 months ➢ Annually	➢ 0-3 months ➢ 3-5months ➢ 6 months ➢ annually

SATELLITE UNIT HAEMODIALYSIS UNITS Please complete for each satellite unit	**Name of satellite unit:**	**Name of satellite unit:**	**Name of satellite unit:**
Total number of patients (including those not under the dietetic services: you may need to ask the managers of your unit for this information)			
Total number of NP (to the dialysis modality) seen in a year by the dietetic services (please state if no service is provided)			
Total number of FUP seen in a year by the dietetic services (please state if no service is provided)			
Total number of renal dietetic contact per year			
How often do you see these patients?	➢ 0-3 months ➢ 3-5months ➢ 6 months ➢ annually	➢ 0-3 months ➢ 3-5months ➢ 6 months ➢ Annually	➢ 0-3 months ➢ 3-5months ➢ 6 months ➢ annually

3.2 Do you do SGA? Yes No. If yes in which setting? (tick as many as apply

- CKD 4-5
- HD
- PD
- HHD

3.3. Please add here any additional description of your service. (For examples, are your clinic consultant/nurse led or do you provide dietetic led clinics? Or anything that you think is relevant linked to workforce)

4) TRANSPLANT

4.1 Is your renal unit a Transplant Centre (does your centre perform the surgery)? Yes / No

4.2 Complete the table below

Total number of new TX per year (if you are a Tx centre)		
Total number of patients with a functioning transplant in your renal service (even if not seen/under a renal dietitian, including those not under the dietetic services: you may need to ask the managers of your unit for this information) **excluding new Tx**		
Total number of NP seen in a year by the renal dietetic service (if you are a centre) Please state if service is not provided		
Are these NP seen while they are on the ward? (if you are a centre)	**Yes / No**	
Total number of FUP seen in a year by the dietetic services Please state if service is not provided		
Total number of patients contacts per year (renal dietitian contacts)		
How often are these patients seen:	**0-12 months post Tx** ➢ 0-3 months ➢ 3-5months ➢ 6 months ➢ Annually ➢ No dietetic input	**After 12 months** ➢ 0-3 months ➢ 3-5months ➢ 6 months ➢ Annually ➢ No dietetic input

4.3 Is your renal unit a Transplant Centre for kidney -pancreas transplantation? If yes complete the following box (if no go to section 5)

Total number of new SKP per year (if you are a Tx centre)	
Add any comments that they are not captured in section 4.2	

5) MDT ATTENDANCE, ADDITIONAL ACTIVITES AND OTHER SERVICES

5.1 MDT attendance

Multi-disciplinary Team Meeting Attendance	**Number per month**
MDT meetings – CKD stage 4/5 (not on RRT)	
MDT meetings – HD	
MDT meetings – PD	
MDT meetings – Transplant	
Other – please specify	

5.2 Activities

Additional activities	**Please tick where applicable**
Involvement in dietetic led audits	
Involvement in renal unit audits	
Advanced Role – Supplementary Prescribing	

Lead on CKD-MBD Management:	
- Amending binders (either local agreement, PGD, local)	
- Amending alfa (either local agreement, PGD, local)	
- Amending cinacalcet (either local agreement, PGD, local)	
- Other	
Education and teaching (Universities, outside hospital)	
Local Training (in -house)	
Group education for patients	
Lead roles in transition clinics	
Lead roles in other areas: please specify	
What other activities do you carry out as part of your renal dietetic service?	

5.3. Other services

5.3.1 Does your renal service (even if these patients are not seen by the renal dietitian) provides a transition service for 16-18 year olds? Yes/ No
Number of patients …….
If yes, does you renal dietetic team provide a service? Yes /no
If yes, how much time WTE renal dietetic do you spend per month in this area?
Transition service ……. WTE/month

5.3.2 Does your renal service (even if these patients are not seen by the renal dietitian) provides a young adult service? Yes/ No
Number of patients …….
If yes, does you renal dietetic service provide a service? Yes /no
If yes, how much time WTE renal dietetic do you spend per month in this area?
Young adult service ……. WTE/month

5.3.3 Does your renal service (even if these patients are not seen by the renal dietitian) provides a joint diabetes and renal clinic? Yes/ No
If yes, does your renal dietetic service provide a service? Yes /no
If yes, how much time WTE renal dietetic do you spend per month in this area?
Joint diabetes and renal clinic ……. WTE/month

5.3.4 Do you provide a dietetic led renal clinic (pt will come to see you only, not as part of the MDT /nurse or consultant led clinic)? Yes /No

STAFF WORKLOAD

6.1 Do you feel that your renal dietetic service has any of the following safety concerns at your current staffing levels?

If so, please select your main concerns from any of the lists below. Tick those that are most applicable to your service (up to 10)

Patient Concerns		**Personal Concerns**	
Patients not seen in a timely manner		Reduced opportunities to develop self (CPD) in work time	
Adverse impact on clinical outcomes		Insufficient opportunities for practice supervision or appraisals	
Poor patient experience/ satisfaction		Unable to take mandatory training	
Unable to fully complete documentation		Too much clinical work to manage properly	
Reduced opportunities for MDT working (e.g. missing phone calls/ meetings/ case conferences)		Being asked to work outside scope of practice	
		Poor health at work (e.g. regular tiredness, stress or sickness, working unpaid overtime)	
Staff Concerns		**Other**	
High staff turnover/ increased use of bank or agency staff		Frequent complaints	
High vacancy rate and lack of back fill		Failing meeting audits standards	
Low staff morale		Unacceptable number of clinical incidents or near misses	
Concerns regarding workload raised by staff		Being asked to work outside scope of practice	

6.2 Safe staffing levels.

Across the all renal dietetic team, do you feel your staff's workload is safe?	Yes / No
Add comments, including what % increase in renal dietetic staff do you feel you would need.	
Do you feel your staff's caseload is safe but not ideal?	Yes /No
If yes, why? (please add comments)	
Across the CKD 4-5 renal dietetic service, do you feel your staff's workload is safe?	Yes /No
Across the inpatient renal dietetic service, do you feel your staff's workload is safe?	Yes /No
Across the HD renal dietetic service, do you feel your staff's workload is safe?	Yes /No
Across the PD renal dietetic service, do you feel your staff's workload is safe?	Yes /No
Across the HHD renal dietetic service, do you feel your staff's workload is safe?	Yes /No
Across the transplant renal dietetic service do you feel your staff's workload is safe?	Yes /No

Appendix 2

Insert individual survey adapted from the safe caseload and safe staffing questionnaire that was developed by the BDA in 2015, in recognition of the need for an evidenced based resource to support workforce planning and local decision making.

BDA RNG Workload Individual Survey

The Renal Nutrition Group aims to update the previous workforce guidelines (BRS-RNG 2002). They are circulating a questionnaire to the lead renal dietitian within each renal unit in the UK to identify the current renal dietetic workforce.

This short questionnaire has been designed to be completed by individual renal dietitians and dietetic assistants to complement the main workforce survey.

It has been adapted from the safe caseload and safe staffing questionnaire that was developed by the BDA in 2015, in recognition of the need for an evidenced based resource to support workforce planning and local decision making.
Thank you for taking the time to complete this short survey. It should take up to 20 minutes to complete.
You will be required to give information about your current workload and the amount of time you spend carrying out patient related activity and non-patient related activities. You will also be asked about how many new and follow-up direct contacts you have each week in both one-one and group settings. You may wish to reflect on this before completing the questionnaire**.**

Definitions
Job plans describe how working time is divided up according to specific categories. All patient related activity is categorised as direct clinical care (DCC). DCC includes both individual patient attributable care (including both direct and indirect intervention with a specific patient) and non individual patient attributable care (e.g. MDT meetings).

Individual patient attributable direct clinical care
Any intervention that relates to a specific person's clinical care provided by the renal dietetic service. One direct patient contact = one direct contact with a patient or their representative – usually face-to-face and including all the associated activities including note writing. These associated activities (mostly indirect) include interpretation of blood results, anthropometric measurements, estimating requirements / feeding regimens, dietary analysis, communicating with other HCPs to gather information to formulate dietetic plan, dietetic documentation, GP letters. The contact method includes face-to-face, telephone, email, skype and video conferences. This includes both individual and group education.
The length of time taken for one direct patient contact includes all the associated activities required for that contact (and not only the face to face time). In this document the word "contact" refers to one direct patient contact.

Non individual patient attributable DCC
Other patient focused activities that do not involve direct communication with the patient or their representative do not count as patient contacts. This includes MDT meetings. It also includes telephone conversations or emails with other care professionals and all other patient related documentation.

If you work in a split post (eg 0.5 renal and 0.5 diabetes), please complete the questionnaire for the renal section of your post only (in this example 0.5 wte).

BDA RNG Workload Survey for Individual Clinicians 2020

1. Where are you based?
Acute hospital
Satellite Unit
Community

2. Do you mainly work with adults or children?
Adults
Children

3. Is your work mainly with inpatients or outpatients?
Inpatients
Outpatients
Both

4. What pay Band are you employed on?
2
3
4
5
6
7
8a
8b

5. For how many hours are you employed per week within renal dietetics? (please choose nearest)
0.1 W.T.E (3.75 hours)
0.2 W.T.E (7.5 hours)
0.3 W.T.E (11.75 hours)
0.4 W.T.E (15 hours)
0.5 W.T.E (18.75 hours)
0.6 W.T.E (22.5 hours)
0.7 W.T.E (26.25 hours)
0.8 W.T.E (30 hours)
0.9 W.T.E (33.75hours)
1.0 W.T.E (37.5 hours)

6. Does your workload require you to work over and above your contracted hours?
Yes /No

7. If 'yes' is this work paid or unpaid or is the extra work taken as time in lieu?
Paid / Unpaid/ Taken as time in lieu

8. Over the last 6 months, have you needed to use renal working hours to work in other specialities, such as outliers / to cover leave / short of staff in other team ? Yes /No
If yes, how many hours per month?

9. Reminder of definitions for the following:
INDIVIDUAL PATIENT ATTRIBUTABLE DIRECT CLINICAL CARE
(This relates to all the time taken for specific patients' direct clinical care that are usually face to face and all the associated activities required for that contact)

NON INDIVIDUAL PATIENT ATTRIBUTABLE DIRECT CLINICAL CARE
(These activities do not involve direct communication with the patient (and do not count as patient contacts). This includes MDT meetings and telephone conversations or emails with other care professionals0. Of the TOTAL contracted hours that you work, please state what percentage of your time is spent on the following activities on average per week:

- Individual patient attributable direct clinical care
- Non Individual patient attributable direct clinical care
- Management of staff and renal dietetic services
- Training of others (within Trust) including staff and students
- Own Training including CPD, appraisals
- Additional Activities eg Audits, CKD-MBD Management
- Role as Supplementary prescriber
- Education and teaching (externally funded)
- Research (externally funded)

10. Own training. How many renal study days have you attended over the last 12 months? How many contracted hours per month do you have that you can dedicate to your own CPD?

11. Advanced Care Practitioners (ACPs). Do you work as an advanced care practitioner? Yes/No
If so, please summarise your additional roles and responsibilities

12. Professional development. Have you published a research article? Yes-lead author Yes – but not lead author No
Have you given an oral presentation at a renal conference?
Do you have a MSc?
Do you have a PhD?
Any further comments

13. Patient Contacts. The following questions relate to INDIVIDUAL PATIENT ATTRIBUTABLE DIRECT CLINICAL CARE contacts only (includes face-face, email, skype, telephone (as per previous table). Please put a 0 (zero) if you do not see any.

a) **On average... How many patients with kidney disease do you seen in one month in the following categories (exclude any group sessions)**

Inpatient		OP (CKD stages 1-3)		OP (CKD stages 4-5)		HD + HHD		PD		Tx		Tel		Other	
NP	FU	NP	FU	NP	FU	NP	FU	NP	FU	NP	FU	NP	FU	NP	FU

b) Group sessions
How many group sessions do you do per week?
How many patients do you see per group session?

14. How much time do you spend (on average) for each new renal patient contact (both face to face and all associated activities including note writing)?
30 mins
45 mins
60 mins
75 mins
90 mins

15. How much time do you spend (on average) for each follow up renal patient contact (both face to face and all associated activities including note writing)?
30 mins
45 mins
60 mins
75 mins
90 mins

16. Assume you have got approximately 60mins to see a new patient, what do you think the proportion of time allocates within the consultation ?

Before seeing the patient Read up relevant previous entries/referral/letter…etc	
Face-to-face contact with patient/carer	
Writing up consultation details in all notes (medical/nursing/dietetic …etc)	
Typing up electronic record	
Miscellaneous (typing up Px letter, phone calls, allocation ONS or feed …etc)	

17. Assume you have got approximately 40mins to see a review patient, what do you think the proportion of time allocates within the consultation ?

Before seeing the patient Read up relevant previous entries/referral/letter…etc	
Face-to-face contact with patient/carer	
Writing up consultation details in all notes (medical/nursing/dietetic …etc)	
Typing up electronic record	
Miscellaneous (typing up Px letter, phone calls, allocation ONS or feed …etc)	

18. Do you feel that your current workload is safe? Yes/No

19. If no, what are your main concerns? please select up to 3.
Patient concerns
Patients not seen in a timely manner
Adverse impact on clinical outcomes
Poor patient experience/ satisfaction
Unable to fully complete documentation
Reduced opportunities for MDT working (e.g. missing phone calls/ meetings/ case conferences)

Personal concerns
Lack of opportunity to develop self (CPD) in work time
Insufficient opportunities for practice supervision or appraisals
Unable to take mandatory training
Too much clinical work to manage properly
Being asked to work outside scope of practice
Poor health at work (e.g. regular tiredness, stress or sickness)

Service concerns
High staff turnover/ increased use of bank or agency staff
High vacancy rate and lack of back fill
Low staff morale
Concerns regarding workload raised by staff
Frequent complaints
Failing meeting audits standards
Unacceptable number of clinical incidents or near misses

Other (please specify)

Thank you for completing the questionnaire. Please leave any further comments here x.
If you wish to be entered into a prize draw to win an all-expenses paid trip to a future RNG meeting, please leave your email address here.

Appendix 3
Survey Questions Quality/Feedback for future survey.

Questions	Comments
3.1: CKD Out-Patients	
Total number of patients: • CKD 1-3 • CKD 4-5 • Conservative management	Some dietetic department unis are not able to split CKD by stage or by conservative management.
Total number of NP seen in a year by the dietetic services	No issues
Total number of FUP seen in a year by the dietetic services	No issues
Total number of renal dietetic contacts per year	No issues
On average, how often do you see these patients?	No issue
3.2: Dialysis Patients	
Total number of patients	Appeared to be answered well
Total number of NP to the dialysis modality seen in a year by the dietetic services	Some units unable to separate contacts between NP and FUP. Some units only see PD and HHD on referral and so unclear if NP refer to newly commenced PD and HHD patients, or those patients who are referred and seen for the first time.
Total number of FUP seen in a year by the dietetic services	No issues
Total number of renal dietetic contacts per year	Some units only entered Total contacts and left NP and FUP blank, and so when analysing all units together, this figure was not the sum of NP and FUP, but much higher. Some units were unable to separate out some or all dialysis modalities. PD and HHD included in CKD4-5 for 1 unit.
On average, how often do you see these patients?	No issues
	No issues
Do you use SGA and in which setting?	No issues
3.3: Additional comments	Difficult to analyse and group themes. Could have provided tick options for this question such as Estimated, Accurate, Mixed with a Other comments box for free text.

4.0 Transplant	
4.1 Is your renal unit a Transplant Centre?	No issues
4.2 Total number of new transplants per year	No issues
Total number of patients with a functioning transplant	No issues
Total number of NP seen in a year by the renal dietetic service	Some mis-interpretation of this question with three units including new in-patient referrals for patients with existing transplants Would be useful to have asked if units provided a post transplant dietary education service
Are these NP seen while they are on the ward	No issues
Total number of FUP out-patients seen in a year by the dietetic services	One unit included in-pts, but question did specify out-patients. Another excluded NP seen in Out-pts. Would have been useful to ask whether unit has a funded service for out-patient transplant patients
Total number of patient contacts per year	Misinterpreted by at least one unit which provided out-pt review of FUP contacts only and excluded NP transplants seen as in-pts and NP referrrals seen in Out-pts. Therefore, this Q should clarify whether NP, FUP and whether in-pt and out-pt. Some units were unable to separate out Tx pts seen in Out-pt clinics for K+, wt mgmt. or ONS nd so included in CKD 4-5.
On average, how often are these patients seen?	Would be useful to know if these patients are seen as in-patients or out-patients. Units appear to have included in-patients, some of which may be for nutritional support/unstable electrolytes whereas others did not.
4.3 Is your renal units a centre for kidney-pancreas transplantation	No issues
Total number of new SKP per year	No issues
Add any comments not captured in S4.2	For SPK units, would be useful to ask about pre SPK assessment contacts.

Please add comments regarding your patient data for CKD, dialysis and transplanted patients.	This question did not have a number. Would be helpful if all questions were individually numbered. Difficult to analyse free text. Various themes e.g. other TP services offered such as group sessions, patient self referral/opt-in service, MDT work.
General feedback:	Fields allowed numbers and text to be entered. This made analysis very difficult as all text had to be removed and inserted into a cell comment before any analysis could be performed
General feedback:	Would be interesting to know usage of remote consultations such as Patient knows best, Attend Anywhere etc.