Working to develop a dietetic service in line with the Progressing Disability Services Model of Care

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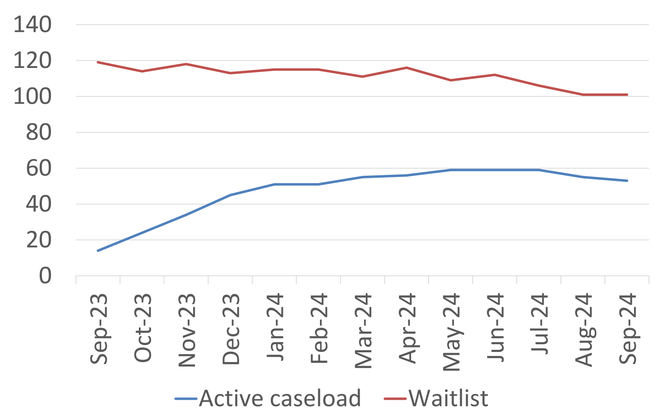
Introduction

- Progressing disability services (PDS) aims to deliver **accessible, equitable, family-centred services** for children with complex needs.
- PDS uses an outcome-focused framework to meet the therapy needs of children using three levels of intervention: universal, targeted and specialist.
- Feeding, eating, drinking and swallowing (FEDS) difficulties are common among children with disabilities. Children with FEDS difficulties are at increased risk of malnutrition. Therefore demand for dietetic services on Children's Disability Network Teams (CDNTs) is high.
- This research aims to assess the performance of the dietetic service (0.5WTE) on the Mullingar CDNT against key principles of PDS to inform service development.

Methods

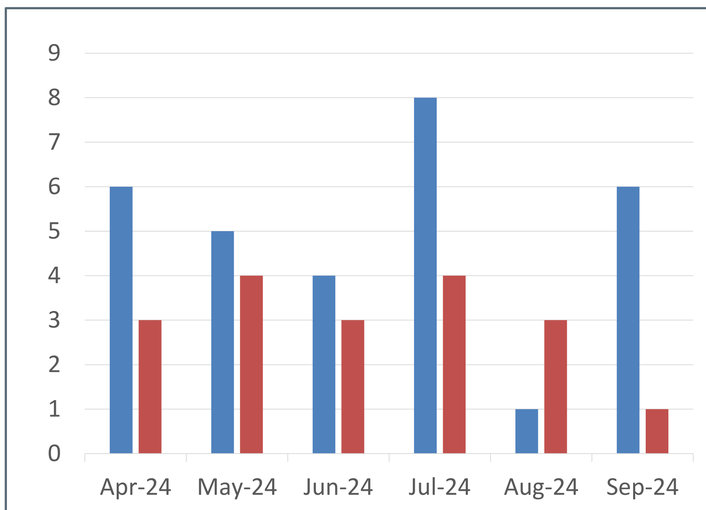
- Information on the dietetic open caseload and waitlist was collected from September 2023 to September 2024.
- Data collected included the number of referrals open and waiting per month by clinical need; the number of new referrals received and new consults seen per month; and waiting times.
- This data was analysed using Microsoft Excel.

Results



- Max capacity = caseload of 55-60 in a 0.5 WTE post
- After 1 year in post, waitlist had reduced by 16%.

Figure 1: Dietetic active caseload and waitlist numbers



- The no. of new referrals received exceeded dietetic capacity for new consults in all but one month.

Figure 2: No. of new referrals received and new consults seen

Figure 3: Waiting list number by priority rating and clinical need

Priority rating	Main clinical need	No.
P1b (n=28)	Poor weight gain	4
	Highly selective eating *	24
P2 (n=54)	Selective eating*	36
	↑weight+comorbidity	6
	Other	12
P3 (n=21)	↑weight, no known comorbidity	17
	Other ?inappropriate historic referrals	4

Priority rating legend:
P1a = home enteral nutrition support + infants <2 years with faltering growth
P1b = Children >2 years with faltering growth/low BMI;
highly selective eaters <10 foods or avoiding ≥2 food groups
P2 = Selective eaters (>10-20 foods); increased weight with comorbidity
P3 = Increased weight with no known comorbidity

Figure 4: No of children waiting >12 months by priority rating

Priority rating	No.
P1a	0
P1b	1
P2	37
P3	13

- The majority of children waiting (55%) were referred with selective eating.
- *There is often insufficient data to differentiate between highly selective (P1b) referrals and milder selective eating (P2)
- Current waiting times to access dietetic services are lengthy; up to 12 months for high priority P1b referrals.

Conclusion

- Providing an **accessible equitable** dietetic service to children attending the Mullingar CDNT within current resources (0.5WTE) appears at the face of it an impossible task. With an ever-growing dietetic waitlist, an evidence-based pathway that aligns with the PDS tiered approach to service provision is needed for children with selective eating.
- The development of a screening tool for use by HCPs to assess the risk of micronutrient deficiencies in relation to the severity of their selective eating would help filter out priority dietetic referrals from milder feeding problems and misperceived feeding problems.
- Even mildly affected children and anxious parents deserve support and intervention. These cases should be directed to universal and targeted supports as first line intervention. This will help reduce waiting times for 1:1 dietetic services for those most in need.