A draft health and care workforce strategy for England to 2027

British Dietetic Association Response – 23rd March 2018

Introduction

The British Dietetic Association is grateful for the opportunity to respond to this consultation. We have encouraged our members to take part in the consultation via the online forum. However, we do not believe the online forum can properly cover all the areas we wish to highlight, so have produced this fuller written response.

We have chosen to order our response through the career of a person who becomes, develops and works as a dietitian within the health and care workforce. Wherever possible we have tried to relate our sections to the specific questions raised within the *Facing the Facts, Shaping the Future* consultation paper.

We are keen to continue engaging with the development of this strategy, and would welcome further opportunities to provide input.

Pre-registration Education and Training

- *What measures are needed to secure the staff the system needs for the future; and how can actions already under way be made more effective?*
- *How can we better ensure the health system meets the needs and aspirations of all communities in England?*
- *How can we ensure the system more effectively trains, educates and invests in the new and current workforce?*

Recruiting a diverse workforce

We support the ambition of the strategy to 'push hard to attract the brightest and best young people' and recognise that to enable this to happen, recruitment techniques need to be fully inclusive, multifaceted and started early. Individual professional bodies such as the BDA cannot be expected to drive this themselves, so we believe there needs to be national resources available to support recruitment.

If we are to secure the staff the NHS needs for the future, we need to target young people before they are applying to university. We need schemes and campaigns within schools, which must focus particularly on the promotion of smaller professions in order to ensure they remain attractive as a career path for both male and female students, and from a range of ethnic, cultural and economic backgrounds.

The dietetic workforce remains overwhelmingly (95%) female[1], and as a university educated profession, there is a perception that it is relatively 'middle class'. More needs to be done to make the profession appealing to men, and to ensure that anyone, regardless of socio-economic background, can become a dietitian if they have the skills and desire.

[1] http://www.hpc-uk.org/publications/index.asp?id=1224#publicationSearchResults

Growing the Dietetic profession to meet rising demands

The NHS and HEE need to draw on projections of patient need to inform a strategic approach to workforce planning to ensure that we have the sufficient dietitians for the future. A strategic approach to workforce planning is needed not only for those professions where places are commissioned or where a crisis has developed.

With 4,138 dietitians FTE[2] in the NHS in England and 6,848 in England altogether[3], the number of dietitians per head of population is incredibly small when considering the burden to the NHS of managing long term conditions which have a diet and lifestyle element including diabetes, cancer and dementia. The demand therefore for the skills of the dietetic workforce remains high with GPs in particular and patients themselves, reporting unacceptably long waiting times for consultations.

The experience of our members is that student dietitians are being recruited before they have even graduated, and this is despite the current growth in the number of courses training pre-registration dietitians and the growth in total dietitian numbers. It is clear that we will need to further expand the number of dietitians if we are to keep meeting the needs of the NHS and the wider health and social care workforce, particularly as nutrition and hydration are fundamental aspects of health and social care.

It is vitally important that the impact of recent funding changes to dietetic commissions (including the removal of NHS bursaries) are closely monitored to assess for any negative influence on the ability to recruit. For the first time last year, universities offering dietetic courses were forced to go to clearing to fill places, and although all places were filled, this is a potentially worrying development.

Looking ahead there are significant concerns over attracting young people to consider a career in dietetics. This is particularly challenging for the smaller professions, which struggle to be heard over the larger medical and nursing healthcare professions. The HEIs are working hard to attract students to dietetic courses, but additional support is crucial in order to attract primary and early secondary school students to a career, many of whom will never have considered dietetics as an option

Expanding routes into the profession and encouraging return to practice

Although new courses are coming on stream, there are currently only ten universities across England training dietitians, and the main barriers to admission continue to be the availability of clinical placements, and funding for tuition and living expenses. If we are to grow the profession to meet demand, clinical placements will need to diversify, with appropriate funding provided and steps taken to release dietetic staff from heavy caseloads both in primary and secondary care to support placements.

Currently, entry to dietetics is wholly degree entry via a three or four year full time degree, or two year post graduate course leading to registration. There has been a huge amount of interest in development of the pre-registration apprenticeship as another route into the profession. Many of our invaluable Dietetic support workers are keen to upskill and become qualified practitioners and would welcome the opportunity to undertake an apprenticeship. Unfortunately in its current guise pre-registration apprenticeships will not serve as a solution to the larger workforce recruitment issue, as apprenticeship schemes will only be considered for individual posts which have traditionally been hard to fill, and apprenticeship funding is diverted to the larger healthcare professions.

Returners to practice (RTP) schemes are being used, but sparingly, as the limiting factor is again the same as pre-registration students and availability of clinical placements. Support will be required for smaller professions to access funding for RTP schemes, and again to free up clinician time to supervise RTP.

---

[2] https://digital.nhs.uk/catalogue/PUB30240

[3] http://www.hpc-uk.org/assets/documents/10005135Registrants-by-gender-England-July-2016.pdf

Post-registration development

- *What more can be done to ensure all staff, starting from the lowest paid, see a valid and attractive career in the NHS, with identifiable paths and multiple points of entry and choice?*
- *Do you have any comments on how we can ensure that our NHS staff make the greatest possible difference to delivering excellent care for people in England?*

Initial support and preceptorship

New entrants to the professions and NHS careers are novice professionals who require structured support and development to fulfil their potential to become fully capable, autonomous and specialist practitioners, before later becoming advanced practitioners.

A search for 'HEE preceptorship' brings many examples of preceptorship frameworks from HEE regions, mostly focused on nursing. It is encouraging that these frameworks exist, but feedback from dietetic services indicates that service pressures and a lack of focus in the organisations on supporting these early career staff means that delivery of patient care overtakes all other considerations. We would argue that this is false economy. New staff under pressure do not deliver the best care.

The introduction to 'Capital Nurse Preceptorship Framework'[4] describes why preceptorship programs are necessary and the organisational requirements to make it effective. This is not the experience of other professionals at similar stages of their careers. We call for all entry level professionals to be supported through a preceptorship programme in their first one to two years in the workforce. These professionals are responsible for delivering clinical care for a large percentage of their working time. They are often unable to be released for necessary development time.

In the medical profession there are fully described and supported competency frameworks and training programmes in place. While early career doctors deliver a large percentage of clinical care; they are also supported to learn and develop on the job. There is an expectation of mentorship, time to reflect, education sessions and the opportunity to carry out wider activities that support their development into fully capable practitioners. Other professionals are in a similar position and should be similarly supported.

Defined career pathways and ongoing development

Medical staff have defined career pathways and supported learning and development. Progress and achievement in other professions in much more ad hoc. With the publication of the Advanced Clinical Practice Framework[5] the variation in recognition of advanced practice will be reduced, and this is to be welcomed.

We also welcome the requirement for Masters level study covering all four pillars or a robust process for the recognition of equivalent development and experience. We expect that all staff with the potential to achieve advanced practice roles will be able to access funding and release from service to allow them to study at this level. Our understanding from our members is that these are both factors in determining whether someone is supported to access CPD.

We recognise that some professions such as the medical profession have to contribute their own time and finance to their career development. We are not suggesting that the NHS should find all the resources necessary, but there needs to be systems and funds in place to ensure equitable access to development, across all professions and to ensure that advanced practice is not only the preserve of those who can personally contribute. Part time staff, those with other responsibilities, with restricted disposable incomes or with high levels of debt from pre-registration education should not be disadvantaged.

---

[4] https://www.hee.nhs.uk/sites/default/files/documents/CapitalNurse%20Preceptorship%20Framework.pdf
[5] https://hee.nhs.uk/sites/default/files/documents/Multi-professional%20framework%20for%20advanced%20clinical%20practice%20in%20England.pdf

CPD is a requirement for all registered health professionals. As the HCPC states 'Continuing professional development (CPD) is the way in which registrants continue to learn and develop throughout their careers so they keep their skills and knowledge up to date and are able to practice safely and effectively'. A range of activities are included in CPD definitions and are important in developing and maintaining capability at all levels. In particular we see that there is a requirement to be able to access personal skills development including leadership, innovation, creativity, digital skills, and entrepreneurship. These creative skills are necessary to drive developments in health and care for patient and public good. We call for all professionals to be able to fairly access the resources necessary.

Retaining staff and work challenges

- *What more can be done to ensure all staff, starting from the lowest paid, see a valid and attractive career in the NHS, with identifiable paths and multiple points of entry and choice?*
- *What does being a modern, model employer mean to you and how can we ensure the NHS meets those ambitions?*

Workplace pressures, feeling valued and increasing flexibility

To encourage individuals in to AHP roles, career progression, variety and opportunity is essential. We welcome the proposal for an AHP national workforce plan and would hope that this includes practical advice that can assist dietetic managers in their workforce management. Opportunities to participate in HEE pilots around returning to practice or deep dives into workforce issues would be embraced by our members.

However, feedback from our members suggests there are many good opportunities or ideas are left behind because dietitians are not allowed or enabled to innovate. There is too much pressure to deliver on current care and pressure to deliver a specific number of consultations / patients. This lack of thinking time can lead to sub-optimal care being delivered in changing environments, and missed opportunities for improvement.

In 2015, the BDA surveyed its member who were NHS employed. Findings showed that 43% of the dietetic workforce felt their workload was unsafe and 9 out of 10 workers were working over and above their contracted hours. This unpaid overtime was in general spent doing patient related documentation. The most frequently occurring concerns when a Dietitians felt their workload was unsafe were:

- Patients not being seen in a timely manner 18.7%
- Lack of opportunity for CPD 13.6%
- Unable to fully complete documentation 8%
- Poor health at work 7.3%
- Low staff morale 7%
- Reduced opportunities for MDT working 6.4%
- Poor patient experience 6.4%

A survey issued to Dietitians who have left the NHS highlighted factors which contributed to them leaving the NHS:

- Too much admin and paper work, not enough time to see patients
- Lack of senior clinical roles (without people management element)
- Discontent with pay structure and lack of recognition and award for hard work/ achievement/ longevity post top of band.
- Lack of investment in employees (in terms of support for professional development).
- Lack of support to be creative and innovative.

As a predominantly female profession, issues surrounding maternity leave and flexible working upon return are particularly important. Our own analysis shows that amongst our own membership as many as 5% per year may take maternity leave. We are told by those at HEE who are facilitating the AHP return to practice scheme that the average AHP leaving the NHS has 9 years of clinical experience and has

worked to an average of a band 6. That is a lot of expertise to lose. Ensuring dietitians are supported to return to work and have the flexibility to work in a way that supports them but still makes use of their skills to support good quality care. Otherwise we risk losing experience and valuable members of the profession for longer or even permanently when they choose to have children.

Better understanding and communicating with the dietetic workforce

It is vital that health and social care services understand and are responsive to the needs of all parts of their workforces, and that they have means of communicating with them.

The NHS is also currently unable to identify and target its Dietitian and AHP employees with information or e-zines. There is no central contact list of AHP leads let alone the AHP workforce - although we understand that an AHP lead list is being brought together. In the digital world being able to tailor information to particular members of staff could help spread the word about key initiatives, pieces of work or strategies without relying on the top down approach with may be fragmented and inconsistent. Overall the NHS needs to map out its workforce better to improve communications and ultimately increase and improve engagement – allowing staff to have an opportunity to share their voice.

Currently the NHS staff survey only has the option for Physiotherapists to select their specific profession while all other AHPs have to select the generic term “AHPs”. The smaller professions are the most at risk professions so the better the intelligence the more able to assist with issues. If information from the NHS survey was gleaned specific to RDs then the BDA would be able to work with the NHS to help overcome challenges the workforce is facing.

Reducing duplication of effort, and collaborating more effectively

Our members have highlighted that there feels that there is competition between Trusts. We know that there is duplication of work across trust such as the development of patient resources or developing service evaluation and audit tools. Even Trusts that have developed IT resources such as patient record templates can be reluctant to share because of the time and funding that has been invested. This is a barrier to improving services and is inefficient. It is difficult for NHS staff from different regions to network with each other and share good practice. Whilst the BDA helps as best as it can from a dietetic perspective digital platforms to bring expertise together from different locations would be very beneficial.

The concept of a multi-disciplinary team is well established. However, the inclusivity of all relevant professions to the care of the patient in MDT’s is not always visible. We recognise the opportunity for dietitians to play a much more critical and central role in such MDT’s and would request that this is reflected in any future strategy document.

Whilst positive impacts of MDT working can be realised from structuring services under AHP leads, some BDA members feel that having an AHP manager in the absence of a dietetic lead can also have detrimental effects for example due to lack of insight to profession specific issues such as (widening) scope of practice or training and development opportunities. It is felt there is a need for professional champions of each profession at local level. This is particularly of concern where small dietetic departments are fragmented across different teams or hospital sites.

Career progression and developing leaders

- *What more can be done to ensure all staff, starting from the lowest paid, see a valid and attractive career in the NHS, with identifiable paths and multiple points of entry and choice?*

Advanced and Leadership roles

All practitioners require clinical or practice development to generate depth and breadth of expertise in the specialties in which they work. This is important for the quality of clinical care, patient outcomes and patient satisfaction with care. Advanced and consultant level posts are important in ensuring that the systems are in place and applied to support the practice of those in more junior roles and maintain a high quality of practice.

We know from feedback from patient groups that patients with specific conditions require health professionals with in depth understanding of their condition and the impact on their health. If they are treated by less experienced staff they can receive suboptimal care and this can impact on their outcomes.

We agree that 'strong leadership is essential for high performing teams' and welcomes the input of Skills for Health in the production of leadership visions. However, when it comes to senior roles we are concerned that these are still very medical and nursing in focus and this does not capitalise on the unique skills of dietitians and our AHP colleagues. For example, we understand there to be only one Chief Clinical Information Officer who is an AHP, yet every single AHP processes clinical information which is fundamental to patient care. Opportunities at director level are limited and unlike in Wales, specific AHP director posts are rare.

Key leadership and strategic roles within trusts such as Director of Nursing or Caldicott Guardian should be open to non-medical and nursing staff such as dietitians and other AHPs. Not only because of the skills and expertise that dietitians can bring but also for the added benefit of providing role models for band 6 and 7 dietitians to stay working within the NHS for a career they feel has aspirations for the future.

Research and academia

There is evidence that research active health organisations deliver higher standards of care. We would therefore encourage investment and support for the development of clinical academic roles. These will encourage clinicians with research specialty and interest to continue with clinical practice and research and improve patient care.

As it stands, we hear from members that opportunities to participate in research varies between employers. We echo the CAPHR's response to this consultation;

> *"More opportunities for more healthcare professionals to engage in research activity as an integral part of their job roles and career development must be progressed. Inequities in opportunities across the professions need to be addressed, recognising the value of engagement in research for enhancing patient care, service improvement and workforce development".*

The NIHR programme has been excellent in helping clinicians to develop research skills and to complete and publish clinically meaningful research.

These roles have benefits in the education sector as well. We regularly hear from student dietitians that when a lecturer or teacher retains a clinical role they can offer an important and different perspective which improves their learning experience. We again agree with the CAHPR response:

> *"More AHPs need to be enabled to engage in research activity while retaining a clinical role, with current challenges to this addressed and best practice built upon, and the benefits of this recognised and realised - for service delivery, staff development, recruitment and retention and the research completed"*

Additional concerns

Separate to our consultation response, the BDA has a number of specific concerns regarding the draft workforce strategy and strategy consultation process thus far. These are outlined below.

Data

We are concerned that the vacancy rate data for dietitians is not a true reflection of vacancies as we understand them from other statistics and feedback from our own members. While we appreciate this is simply a 'snapshot', we would not want this to create the impression there are not pressures and problems filling dietetic posts. Indeed the figures given do not appear to align with vacancy rate statistics

published by NHS Digital. For the month of March 2017 for example, they would seem to indicate a vacancy rate of 4%, not 1.1%[6]. We would welcome further information on the source of this data.

Even then, we do not believe vacancy rates sufficiently encompass the pressures faced by dietetic departments, where short staffing due to maternity leave, sickness or holiday time place teams under greater pressure. We often receive feedback from members that frontline services are only kept functioning because key administrative tasks are missed or undertaken at home in their own time.

Consultation process

While we appreciate that Health Education England, NHS England and others have endeavoured to engage on this strategy in an open way, but we are concerned that only very limited numbers of staff have been able to engage in such an important piece of work. We also believe that the online forum was not a particularly appropriate forum for professional bodies to make extended and detailed responses.

Thus far the online forum has had limited engagement in the grand scheme of the scale of the NHS workforce in England, certainly less than 0.5% of total workforce of over 1.1 million. This is a much smaller proportion than was managed by the similar *AHPs Into Action* online workshop held in 2016/17.

While we acknowledge that there have been local meetings at which the strategy has been discussed, these are again limited in terms of the number of people able to attend and many members of NHS staff will either not have been able or felt unable to attend if they had wanted to.

[6] https://digital.nhs.uk/catalogue/PUB30196

5th Floor, Charles House, 148/9 Great Charles Street Queensway, Birmingham B3 3HT
Tel: 0121 200 8080 email: info@bda.uk.com

bda.uk.com