About the BDA

The British Dietetic Association (BDA) is the professional body representing dietitians in the United Kingdom. The organisation represents the professional, educational, public and workplace interests of its members and protects their working rights. Founded in 1936, it is one of the oldest and most experienced dietetic organisations in the world.

Membership is open to qualified dietitians working in dietetics and/or nutrition and related areas. The BDA represents the whole of the dietetic workforce including public health and clinical practitioners, researchers, industry employees, educators, support workers and students. The BDA currently has over 8,500 members.

Deciding appropriate numbers of training places for health and social care workers

Uncontrolled and unplanned training numbers

The number of people entering the Allied Health Professions (AHP) is not currently controlled and is largely determined by supply and demand factors within the university sector. As it is, Scotland is doing better than the rest of the UK, training a higher number of dietitians per head of population, with three excellent universities providing dietetic programmes. However, these positions are not commissioned and therefore there are no guarantees of the ongoing provision of these courses or of the number of dietitians currently trained. This is demonstrated by the fact that as of next year, there will only be one centre (QMU) offering post graduate dietetic training, a loss of around ten places. We should not be complacent and continuing support for these courses is needed.

If the Scottish Government was to play a greater role in commissioning posts, investment in robust workload measurement and prediction tools would be required to generate valid comparable data that underpins any predictions for workforce needs. Whilst the vast majority of dietitians in Scotland are employed by the NHS, it is not the sole employer. Any workforce prediction tools must be based on all employers’ needs and not restrict numbers to NHS employees only.

There is also, as is reflected across the UK, serious pressure on training placements. Finding sufficient high-quality placements is difficult when the staff that are expected to work with students are themselves under a great deal of workplace pressure. This problem will only be resolved if we expand the workforce in the way discussed below.

Expansion needed

Despite training more dietitians per head of population than the rest of the UK, Scotland continues to have very few dietitians working within health and care services. In the NHS, there are only 1.4 dietitians for every 10,000 people; 762 across the whole of the Scotland. There is a wide range of roles that dietitians can and should be performing across the NHS and wider health and social sector, especially

1 Glasgow Caledonian University, Queen Margaret University and Robert Gordon University.
given the fact that nutrition is fundamental to so much else in health. We firmly believe there to be considerable scope to expand the dietetic workforce in Scotland.

Nutrition is a key factor in a great many of the preventable non-communicable diseases (including cardiovascular diseases, cancer, obesity and diabetes). Malnutrition – both over and under nutrition - is placing great strain on the NHS and care services in Scotland. The Government’s draft Diet, Activity and Healthy Weight Strategy sets out an ambition to tackle pre-diabetes, diabetes and obesity, and dietitians clearly have a key role to play in that.

We should be growing the role of dietitians within the primary and community care sectors. Provision of sufficient dietitians has potential to reduce primary care pressures and improve effectiveness. This could be a broad remit; including provision of education and prevention activities. Dietitians can redesign clinical pathways for conditions such as IBD or Coeliac Disease, which can otherwise be time consuming for GPs. Dietitians can also play a greater role in streamlining prescribing processes for nutritional borderline substances and related products, which are often amongst the costliest prescribing categories.

This approach needs to fit with wider plans for transformation of general practice, primary care and community health services. It must not be about transfer of workload from hospital to community but a true collaboration between clinical teams. Those in primary and secondary care can develop solutions together that best meet the needs of the local population, whilst managing workloads across NHS systems or between health and social care, valuing the contribution of all staff.

The Active and Independent Living Programme (AILP)\(^2\) has a vision for highly skilled multidisciplinary teams, which should include dietitians, delivering care within locality clusters. AILP also places great emphasis on expanding prevention and early intervention. However, if the Scottish Government wishes to give people “quick access to appropriate AHP services to prevent something minor becoming major” and ensure they are “able to access AHP services outside office hours”, they are going to need to significantly expand the dietetic and wider AHP workforce to service this desire.

**Data**

The recently agreed Allied Health Professionals Operational Measures Dataset\(^3\) will, once fully rolled out and implemented, provide consistent information on activity i.e. numbers of referrals, episodes of care and contacts. This will be useful in identifying variation and potential pressures between different parts of the health service in Scotland. However, these data are limited to describing activity without the ability to demonstrate the outcome for individuals or populations, making it difficult to identify what opportunities there are for doing things differently.

The BDA Scotland Board believes that more extensive work is needed to determine optimal pathways for care (which we believe will include a wider use of dietitians), so that we can then calculate what the optimal workforce numbers are to meet these more effective models.

**Barriers to a successful recruitment and retention strategy**

**Opportunity and flexibility**

To keep AHPs in the health and social care sector, career progression, variety and opportunity are essential. However, feedback from our members suggests many good opportunities or ideas are left behind because dietitians are not allowed or enabled to redesign, innovate or optimize usage of eHealth and digital opportunities. There is too much pressure to deliver based on current models of care and to deliver a specific number of consultations. This lack of thinking time can lead to sub-optimal care being delivered in changing environments, sub-standard systems and processes and missed opportunities for improvement.

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Opportunities to progress require there to be sufficient senior roles, in a range of settings, for dietitians to aspire to. This should include both more specialist clinical roles and more senior management jobs. Where senior roles already exist, they need to be open to all those with appropriate skills. Often, despite being technically open to AHPs, in reality senior roles above a certain level become the preserve of either medics or nurses.

As a predominantly female profession, issues surrounding maternity leave and flexible working upon return are particularly important. Women are also more likely to have caring responsibilities. Our own analysis of Scottish data show that amongst our own membership as many as 5% per year may take maternity leave. We must ensure 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 or need to assume caring responsibilities.

**Feeling valued**

It is vital that dietitians and indeed all health and social care staff feel valued in their roles. Ongoing pay restraint has no doubt impacted on this for some of our members, and the BDA feels strongly that pay should be equitable across the UK. For example, should Scotland choose not to introduce the pay award offered in England, it risks demotivating staff and losing people to outside of Scotland.

In 2015, the BDA surveyed its members UK wide who were NHS employed. Findings showed that 43% of the dietetic workforce felt their workload was unsafe and nine out of ten workers were working over and above their contracted hours. This unpaid overtime was in general spent doing patient related documentation. The most frequently cited concerns, when a dietitian 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 UK wide survey by the BDA issued to dietitians who have recently left the NHS highlighted a number of recurring themes:

- 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.

**Workplace health**

Getting nutrition and hydration right is important for health and social care workers, as well as their patients/clients. Health and social care staff face challenges accessing the right food and drink to aid focus and concentration and maintain safety. Shift and lone working, as well as high pressure working environments, also impact on health (both mental and physical) and the capacity to eat and drink sufficiently. Initiatives such as Health Working Lives, the Health Promoting Health Service and the BDA’s Work Ready Programme can utilise the skills of dietitians to improve workforce health and nutrition.

**Brexit**

Approximately 10% of currently registered dietitians in the UK state their nationality as being from another EU country, with the majority of those being from Ireland. This may be artificially increased as Northern Irish dietitians may choose to state their nationality as Irish. A further 10% of registered dietitians in the UK state their nationality as being from another EU country, with the majority of those being from Ireland. This may be artificially increased as Northern Irish dietitians may choose to state their nationality as Irish. A further 10% of registered dietitians in the UK state their nationality as being from another EU country, with the majority of those being from Ireland. This may be artificially increased as Northern Irish dietitians may choose to state their nationality as Irish. A further 10% of registered dietitians in the UK state their nationality as being from another EU country, with the majority of those being from Ireland. This may be artificially increased as Northern Irish dietitians may choose to state their nationality as Irish. A further 10% of registered dietitians in the UK state their nationality as being from another EU country, with the majority of those being from Ireland. This may be artificially increased as Northern Irish dietitians may choose to state their nationality as Irish. A further 10% of registered dietitians in the UK state their nationality as being from another EU country, with the majority of those being from Ireland. This may be artificially increased as Northern Irish dietitians may choose to state their nationality as Irish. A further 10% of registered dietitians in the UK state their nationality as being from another EU country, with the majority of those being from Ireland. This may be artificially increased as Northern Irish dietitians may choose to state their nationality as Irish.

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4 [https://www.bdaworkready.co.uk/](https://www.bdaworkready.co.uk/)
5 [https://www.hcpc-uk.org/assets/documents/1000528FBreakdownofregistrantsnationality.pdf](https://www.hcpc-uk.org/assets/documents/1000528FBreakdownofregistrantsnationality.pdf)
dietitians are from outside of the EU, mostly from Australia, South Africa and Canada. As a consequence, although there may be some limited impact on workforce numbers as a result of Brexit, there is a possibility that current limitations placed on dietitians from outside the EU could be scaled back depending on the immigration policy that the UK decides to pursue after we leave. Current salary caps for workers from outside of the EU adversely affect younger, more recently qualified dietitians.

Fundamentally, the BDA believe strongly that the talented dietitians should be able to work in our health and social care services, regardless of their nationality or country of birth.

Supporting students to enter a career in health or social care
Recruiting the best and most diverse future workforce
Health and social care services in Scotland need to attract the brightest and best young people and must recognise that to enable this, recruitment techniques need to be fully inclusive and multifaceted. New recruits must be engaged early – well before they are thinking of applying to work in health or social care. Individual professional bodies such as the BDA cannot be expected to drive this alone. We believe national resources should be made available to support recruitment for all health and social care professions.

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 students of any gender, and from a range of ethnic, cultural and economic backgrounds.

The dietetic workforce in Scotland remains overwhelmingly (96.5%) female\(^6\), 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.

Maintain and expand financial support
We strongly support the continued provision of free university places for Allied Health Professionals and ongoing support for placement expenses. This should be guaranteed for the future.

However, we believe that it would be positive to expand the support currently made available to student Nurses and Midwives to student Allied Health Professionals. Nursing and Midwifery students studying in Scotland, who meet residency conditions, are eligible for the Nursing and Midwifery Student Bursary of £6,578 per year, plus additional non-income assessed bursaries and allowances. These bursaries are not available to dietitians or other AHPs but would be a major incentive to study dietetics and enter the NHS workforce.

Reducing use of agency staff
The BDA agrees that agency staff are not the most cost-efficient means of providing cover during times of sickness, absence or excess pressure. The simplest way to reduce use of agency staff is to ensure there are sufficient employed staff within health and social care services, who are paid appropriately and feel supported. This may reduce sickness rates and build in resilience, ideally reducing the need for departments to resort to agency staff.

The BDA is supportive of the extended use of staff banks, which are already commonly used for nursing and midwifery staff, and increasingly for Allied Health Professional roles. These offer flexibility both to health and social care services and to staff, while ensuring that services are only charged at equivalent rates to permanent staff. Evidence shows that recent increases in hourly costs of agency nursing and midwifery staff mean the average rate is nearly three times that of bank staff\(^7\).

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\(^7\) [http://www.isdscotland.org/Health-Topics/Workforce/Publications/2017-06-06/2017-06-06-Workforce-Report.pdf](http://www.isdscotland.org/Health-Topics/Workforce/Publications/2017-06-06/2017-06-06-Workforce-Report.pdf)
Demographic impact on future workforce requirements

Ageing population
The ageing population is a particular pressure on our healthcare workforce, as more patients are requiring greater levels of increasingly complex care, for longer. For example, from a dietetic perspective, older people are much more likely to suffer from undernutrition and/or have various co-morbidities such as obesity, diabetes or COPD, that require more interventions. Already, older people make up around 40% of all people with undernutrition, with 10% of those over 65 affected by undernutrition. Over half of all costs to the health service associated with undernutrition are spent on people aged over 65.

As AILP recognises, many of these sorts of conditions can be effectively prevented or tackled “upstream”, and in doing so represent an overall cost saving to the health and social care service. To do so will require investment in dietetic and other AHP services, and workforce planning needs to take account of ageing populations and their impact on health and social care services locally.

Ageing workforce
Of course an ageing population and changes to pension schemes mean that health and social care staff will be working for longer and until they are older. The current dietetic workforce is relatively young, with the bulk of the dietetic workforce aged between 25 and 39 years old. This is probably, in part, a result of recent dietetic workforce expansion.

Nonetheless, changes in the retirement age and a drive to continue working into older age, mean that the health and social care workforce will become older. We know working in your older years is good for your health and therefore we need to be more creative about the types of dietetic jobs we create. Increased support and flexibility are vital to ensure that an older dietetic workforce is recognised as an asset, with skills to be harnessed.

Additional frameworks, regulations or legislation to support the health and social care workforce

Prevention and public health
Obesity, alongside undernutrition and preventable NCDs such as diabetes and cancer are a growing public health problem that place great strain on health and social care services but is in many cases entirely preventable. It is widely recognised that expanding prevention activity and public health interventions can reduce pressures on health and social care services and make good financial sense. This has been recognised as core within AILP, which states that;

“The evidence base for preventative strategies, including many AHP-led interventions, is now growing in key areas such as communication in children and young people, mental wellbeing, physical activity, nutrition, and work and health.”

The government has a key role to play as well, not just in putting in place support and interventions, but also taking steps to create environments which promote good health. As has been recognised in the draft Diet, Activity and Healthy Weight consultation, there are a number of significant steps that the government can and should take to tackle obesity.

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