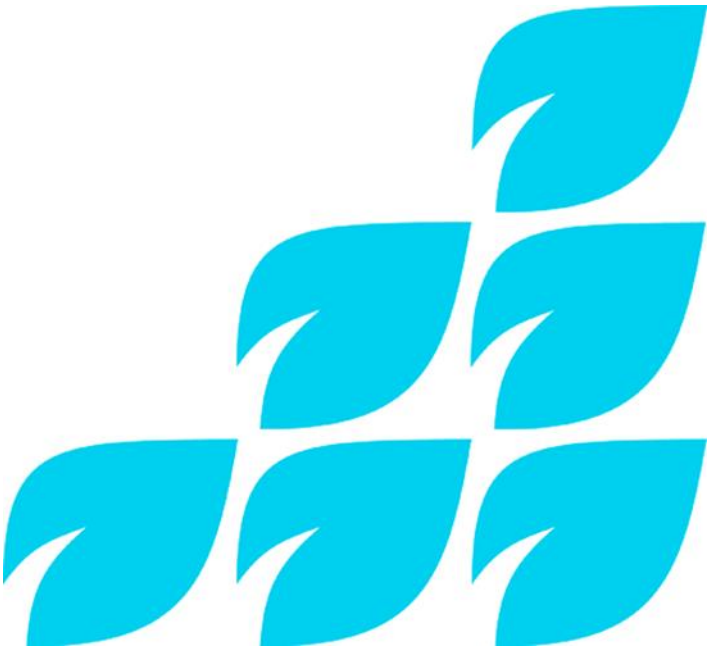
BDA The Association of UK Dietitians

Safe Staffing and Safe Workload Guidance

May 2024



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Executive Summary

Staffing levels in the NHS are a key indicator for patient safety. Key government reports ([1,2,3]) over the last 15 years have highlighted significant failings in this area. NHS Improvement has worked on collecting data around Allied Health Professionals (AHP) staffing levels but much of this relates AHPs as a generic group. This guidance has been commissioned as a successor to the 2017 Safe Staffing Safe Workload Guidance document to provide both qualitative and quantitative information to help address staffing level concerns in clinical dietetic services across the UK across all settings

This document has expanded to include information on alternative means of service delivery, workload, stress and vacancy rates within services, reflecting the changes in working practices over the last 8 years. Newer roles have been included, such as Advanced Clinical Practitioners (ACP) and First Contact Practitioners (FCP). Job planning and practice (clinical) supervision within the workforce have also been reviewed. Service user complexity and the time required for a full dietetic consultation have also been considered.

The NHS published guidance on Job Planning, 'Job planning: the clinical workforce – Allied Health Professionals. A best practice guide, July 2019'([1]) which categorises a professional's workload into two main areas: Direct Clinical Care (DCC) and Supporting Professional Activities (SPA), with two other areas that are used occasionally; Additional Responsibilities and External Duties.

This document recommends that triangulation methods are used to take into account benchmarking figures on activities, capacity, capability, complexity and the safety indicators herein outlined. This combining of information sources enables a more reliable calculation of safe workload and safe staffing to support decision making. The accompanying toolkit and sister document 'Workload Management' ([18]) (to be updated in 2024/25) provide further guidance, together with the BDA 'Influencing Action Pack' can help to 'make the case' when increased staffing needs are identified. There will also be further guidance on Complexity to come in 2024 following a pilot study across the UK.

Introduction

This document focuses on the issue of safe workload and safe staffing levels within dietetic services. NHS staffing remains under scrutiny both internally and externally of the NHS.

The enquiry ([2]) into the Mid-Staffordshire NHS Foundation Trust and subsequent high-profile reports including that by Bruce Keogh ([3]) highlighted the risk to patients of not having the right staff with the right skills at the right time. This led to the 2013 National Quality Board (NQB) guidance ([4]) which set out expectations of commissioners and providers when managing local decisions around staffing to keep patients safe. The NQB recognises that staffing principles ring true across AHPs and the multi-professional workforce is included in the 2016 document' supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time' ([5]). The Model Health System is a data driven improvement tool to enable NHS health system and trusts to benchmark quality and productivity and identify opportunities for improvement so teams can continuously improve patient care. To aid this the NHS produced 'NHS developing workforce safeguards' 'in 2018. Ref ([6])

In 2023 the Health and Care Professions Council (HCPC) has 11006 registered Dietitians who have a professional duty to provide high quality, safe and effective care. Within the NHS, provider boards are accountable for ensuring that their organisations have the right culture, leadership and skills in place for safe, sustainable and productive staffing. In any healthcare provider service, there should be frameworks in place that incorporate a systematic approach to reporting and investigating safety incidents, including considering staff capacity and capability and act on issues identified. Within such frameworks, dietetic staff at all levels have a role in contributing to safe, effective responsive staffing levels. Dietetic managers and team leaders should nurture a culture that is supportive of peers including junior staff who raise concerns about workload or suboptimal staffing levels.

In order to help resolve and support these issues this document is part of a suite of documents to support dietitians and dietetic support workers to work through safe workload and safe staffing challenges in a holistic and pragmatic way.' I suite provides figures and statistics as well as practical tools that are applicable to those working in clinical practice, whether employed by the NHS or elsewhere.

The suite of documents includes:

- *Safe Staffing Safe Workload Guidance 2024*
- *2023 Safe Staffing Safe Workload Project Report*
- *Safe Staffing Safe Workload Toolkit*
- *Workload Management (2017) – to be updated 2024/25*
- *Model and Process for Nutrition and Dietetic Practice (2021)*
- *Complexity Guidance - expected in 2024*

Aim

The purpose of this document is to:

- provide data and resources that can inform and support decision making on safe levels of staffing and activity with BDA members, managers, organisations and commissioners
- analyse workload data and identify the links between excessive workloads, overtime, stress and the impact on the health of BDA members
- obtain initial information from BDA members on the service users' levels of complexity

Objectives

This document intends to:

- report on average workload activities in different settings within the NHS workforce
- ascertain the average number of patient contacts per whole time equivalent of the NHS workforce and provide guidance on what should be considered safe
- identify variations between workload activities and number of patient contacts in different workplace settings and pay bands within the dietetic workforce
- obtain further information regarding job planning, including data on dietetic time spent outside of Direct Clinical Care (DCC)
- provide an understanding of staffing and workload safety concerns
- give guidance on identifying excessive workloads and thus be able to mitigate this and prevent adverse effects on the stress levels and health of the workforce
- describe how capacity, capability and safety indicators need to be considered alongside each other when calculating staffing needs
- signpost to BDA and other supporting documents

Limitations

The methodology, findings and conclusions of this BDA commissioned project were designed to be inclusive of as many NHS employed BDA members as possible. As such, care must be taken when applying the information provided to specialist areas. We would encourage specialist groups, and those not employed by the NHS to utilise a similar methodology to obtain data that is explicit to their speciality; this would enable guidance to be tailored accordingly. Accompanying resources to take this forward are included in the toolkit.

Overview of Current Dietetic Practice (within the NHS)

Dietetic work is undertaken in a wide variety of NHS settings. The range of settings and methods of delivery have increased, partially in response to the Covid 19 pandemic, since the original Safe Staffing Safe Workload document was produced.

Patient /service user focused work is undertaken in settings which include:

- acute: hospital wards and outpatient clinics
- community: community clinics, care homes, hospices, patients' own homes, day care services, schools, or prison services.
- public health
- mental health services: inpatient and outpatient services
- freelance
- home-based and remote working

Many dietetic posts are in the acute, community, primary care or mental health settings; primary care is not NHS employment in England but is in Scotland and Wales. Some dietetic staff work in a combination of acute and community settings within the same day or week. Dietitians are also employed in other NHS settings such as medicines management, public health roles, catering and procurement and may have more strategic job profiles rather than clinical caseloads. Others may include teaching and research within their remits.

Regarding NHS staff, job planning has now re-categorised workplace activities. In addition to direct clinical care (both to individual patients and other important non-patient clinical activities), supporting professional activities are recognised as an integral part of a dietetic workload. These activities include education and training of staff and students, management duties, supervision of others and clinical governance activities. These activities, together with one's own continuing professional development (CPD), appraisals and practice supervision are also key elements of dietetic roles and must be included when reviewing or developing both posts and dietetic services.

The settings in which registered dietitians (RDs) work within the NHS are very varied, methods of service delivery have increased since the 2015 survey and the supporting professional activities undertaken by RDs is well recognised within job planning.

Group education sessions, both in person and virtually, are now widely used as a way of delivering dietetic education and care to a group of patients with the same nutrition and dietetic diagnosis, for example diabetes, weight management and Coeliac disease.

Definitions

Please note: for consistency, throughout this document, we will use the term “patient” to refer to patient, service user or client. We recognise that service user is often the preferred term, however the NHS AHP Job Planning best planning guide ([1]) only uses the term “patients” and therefore we will also, to reduce any confusion. This document also uses the term FTE (full time equivalent) rather than WTE (whole time equivalent).

Workload and caseload need to be defined before addressing the issue of safe workload. The elements of an individual’s workload are defined on the next page as dietetic activities. It is not correct to describe the work of a dietitian only in terms of clinical work. Depending on the pay band and job role of a dietitian, non-clinical work elements can often be equal to or even greater than the clinical caseload.

Caseload

A caseload is the number of patients for which 1.0 FTE dietitian is carrying responsibility at any one point in time. This will include all cases which have been assessed and are under treatment/review and have not been discharged and for which the dietitian has a duty of care. In some situations, there will also be a potential caseload which includes the population of patients for whom the dietitian carries some degree of reviewing responsibility in terms of identification of problems and providing input if required (for example, patients in a Care Home setting) but who are not being treated at the current time. Caseload can be expressed as a number of patients or care episodes, or hours of dietetic time to manage the patient population.

Workload

A professional workload is that work which can be carried out by 1.0 FTE dietitian. In total it comprises a variety of dietetic activities which together constitute the professional dietetic role. In most cases it will include work inherent in a defined clinical situation or caseload.

Dietetic activities and job plans

These have been re-categorised to match the Job Planning Activity Classification for AHPs ([1])

- ‘Direct Clinical Care’ (DCC) which is divided into two main areas
- individual patients’ attributable (IPA) DCC (all the time spent with individuals and all the associated activities required for that patient (including typing up notes, writing GP letters etc.) Individual patient contacts may be face to face or remotely via telephone or video consultation
- non-individual patient attributable (non-IPA) DCC such as MDT meetings, communication with other health care professionals, developing resource materials for patients

- Supporting Professional Activities (SPA) such as clinical service management, staff training, student training, CPD, practice supervision, clinical governance activities, department meetings and appraisals
- additional responsibilities (ANR) which are usually Trust wide appointed roles
- external Duties (ED) are externally funded e.g. education, teaching, research
- travel; for example, between sites or home visits is included as a separate section within each of the areas given above

see appendix 1.1 for activity and plan flow chart

Patient contacts

Defined simply as a direct patient contact is a contact between a healthcare professional and a patient including proxy contact which is between a healthcare professional and another person on behalf of a patient e.g., parent, carer.

In practice, a patient contact may be defined as the package of dietetic care for that individual per session or appointment which would include all relevant aspects of time associated for that individual per session - either in a one to one or in a group setting. The setting may be face to face or via remote delivery. The length of time expected for a patient contact needs to be sufficient to allow for data collection, dietetic assessment and intervention, liaison with relevant health care professionals and subsequent writing up in notes including electronic documentation. A contact may be categorised as an initial /new contact (the first contact between the patient and the dietetic service) or a review /follow-up contact (all subsequent contacts for that same referral or episode of care).

Workload safety

Assessing when practice moves from safe to unsafe is a complex and subjective process with multiple factors to consider. Under the HCPC Standards of Proficiency, dietitians are required by law to manage their own workload and resources and practice safely and effectively. They have a duty as HCPC registrants under the Standards of Conduct Performance and Ethics ([17]) to manage risk and report concerns about safety.

The following are key components of such an assessment and are explained in more detail in the BDA document ‘Workload Management’ (2017) ([18]) which will be updated in 2024/25.

1. benchmarking
2. practice supervision
3. good practice
4. job description/contract of employment
5. risk assessment
6. complexity

New to the assessment of workload safety is patient complexity. A patient complexity tool has been developed and has been used in the 2023 Safe Staffing, Safe Workload survey for the first time.

Reference to workload safety in the remainder of this document is based on the perceptions of individual clinicians rather than verified entities that have been assessed based on the components above. Nonetheless, there is a significant value in clinician concerns that can be indicative of system failure with potential impact on patient safety.

Whilst this document reports on workload activities and perceptions of safety, the sister document 'Workload Management' ([18]) provides direction on how to address the problem of a workload that has been assessed as unsafe and provides guidance on protecting the staff member from having to manage an unsafe caseload. To this end the workload management guidance provides advice from a professional, ethical and employment relations standpoint.

A further BDA endorsed document providing guidance on estimating patient complexity which should help with placing dietetic staff with the correct skill set and clinical time allocation to undertake their caseload safely, is expected to be published in 2024 following validation throughout the UK in a variety of different clinical settings.

Patient Complexity

There are several definitions of patient complexity; though a "complex patient" is commonly defined as patients with complex care needs requiring more time and effort than the average patient. Patient complexity is important in delivering safe caseload management. Complexity is based on patient's' needs and intervention types, rather than how difficult the dietitian personally found the task. For example, differing bands of dietitians and assistants working in specialist areas are likely to feel more competent to assess more complex patients in that specific area compared with other colleagues.

Approach:

Questionnaire Development

The initial safe staffing questionnaire was developed and circulated in 2015. All dietitians and dietetic support workers employed by the NHS in the UK were invited to complete this questionnaire which was circulated via web link. There were 933 respondents representing 17% of the NHS dietetic profession.

This questionnaire was used as the basis for the 2023 version. As before, it was advertised online by BDA and was available to complete via a web link for 6 weeks between April and May 2023.

There have been several updates and additions to the original questionnaire, reflecting recent changes in the NHS such as job planning and current workplace safety concerns.

Below are the main changes:

- updated definitions for workplace activities to reflect Job Planning definitions and including new activities e.g. supplementary prescribers

Additional questions on the following:

- average time spent with individual patients
- patient Complexity
- home based and remote working, online working and consultations
- practice supervision
- advancing Roles in Dietetics
- vacancies
- workload safety – including questions on workload stress and vacancy rate and updated wording on workload safety concerns (taken from “workforce burnout in the NHS” (House of Commons report 2021) and “Safe and effective staffing” (RCN 2017and 2022) ([8,9,11,12])

Average time spent with individual patients

In order to provide further detail regarding the time required for direct clinical care, it is important to estimate the time required for dietetic consultations as well as the number of contacts. Adding the level of patient complexity is also likely to be helpful to determine the safe number of contacts.
Hence this section was added to provide some data regarding the average (mean) time spent per new (or review) patient for a face-to-face consultation.

The following information was provided in the questionnaire to clarify the aspects of a dietetic consultation to be included when estimating the average time spent per new (or review) face to face dietetic consultation. Separate categories of inpatient, outpatient and home visit were provided. Please note that travel time was not included.

- before seeing the patient - read up relevant previous entries/referral/letter etc.

- dietetic consultation and intervention with patient/carer
- writing up consultation details in all notes (medical/nursing/dietetic etc) and/ or electronic record
- miscellaneous (letters, phone calls, allocation of ONS or enteral feed etc)

Please note that online or phone consultations were not covered in this question.

Patient Complexity

Questions on patient complexity have been added in order to provide further details regarding individual patients seen in addition to time spent.

For this survey, we have used the 'Dietetic Complexity Tool' which was developed at St George's Hospital, London; it is being piloted in several NHS Trusts in the UK and will be validated for use within all four nations.

It has ten different domains to calculate an end score for 'very high, high, medium and 'ow' complexity levels and can be used for patients in both acute and community settings.

It should be able to help job planning by determining the number of patients who can be safely seen per day and to allocate caseloads within a teams mixed banding of staff. The Tool will also assist in supporting business cases, in education and disseminating understanding of the variety of work undertaken by dietitians.

The Complexity Tool (as used in the 2023 survey) is found in the appendix. Once validated, you should be able to use it in your clinical practice as the final version will be on the BDA website.

Home based and remote working, online working and consultations

Homebased working is contractual in location. Working from home would be casual with the employee's base being a hospital site or similar. Remote working can be done anywhere away from the contractual base.

In its long-term plan, the NHS planned to fundamentally redesign outpatient services (Ref NHS Long Term Plan (2019) ([10]), stating that the traditional model of service was outdated and unsustainable. The plans included a redesign of services. so that patients would be able to avoid up to a third of face-to-face outpatient visits over the next five years. However, the Covid-19 Pandemic accelerated this change, so this section has been added to provide a baseline for dietitians, rather than to provide any recommendations at this stage.

Practice Supervision

Practice Supervision is a process of professional support and learning and assists Dietitians to meet HCPC standards and the BDA Code of Conduct. Supervision is defined as a process of professional support and learning, undertaken through a range of activities, which enables individuals to develop knowledge and competence,

assume responsibility for their own practice and enhance service-user protection, quality and safety of care, adapted from www.dhsspsni.gov.uk. ([16])

Due to the role that practice supervision can play in ensuring patient safety it was deemed essential to include in this piece of work to better understand if there was a relationship between practice supervision and levels of reported stress and overwork.

Advancing Roles in Dietetics

These roles include Advanced Clinical Practitioners, First Contact Practitioners and Consultant Dietitians, more details of which can be found from page 29 onwards.

Vacancies

Based on BDA intelligence gathering, we recognise that vacancies are a current issue.

Questions surrounding vacancies were included in the survey to get an overview of the national situation and consider what impact this has on the dietetic workforce. Many organisations are reporting recruitment issues across a range of bandings.

Workload safety

The NHS Staff Survey has suggested that an unacceptably high proportion of NHS staff experience negative impacts as a result of stress in the workplace and that the proportion of staff suffering from stress is on an upward trend. The 2022 survey found that 45% of respondents (covering AHPs, healthcare scientists and scientific and technical staff) reported feeling unwell as a result of work-related stress in the last 12 months, and this remains above pre-pandemic levels. The Covid-19 pandemic had increased workforce pressures exponentially and 92% of trusts told NHS Providers they had concerns about staff wellbeing, stress and burnout following the pandemic. ([12])

Chronic excessive workload has been identified as a key factor of burnout and staff shortages were identified as “the most important factor in determining chronic excessive workload”. ([7])

As a result of these findings, additional questions on workforce safety were added to the questionnaire. These were asked towards the end of the survey so as not to affect the responses to the previous questions.

They were asked to indicate their level of agreement with the following statements using a Likert scale.

a) I feel that I have enough time to provide the level of care I would like
b) I feel that I am providing the quality of care that I should be providing for patients / service users
c) I am happy with the skill mix within our dietetic team
d) We have sufficient number of staff within our dietetic team
e) I feel that my current workload is safe

They were also asked if their workload was excessive, if they had felt unwell due to work-related stress within the last 12 months and if they felt that their work-related stress was episodic or chronic to reflect those questions in the NHS staff survey. They were also asked if they felt they have the freedom to speak up if you see things going wrong.

Workload concerns

They were asked "if you have any concerns regarding your workload, what are your main concerns?" and were able to select up to 6 main concerns from 20 options given below.

The NICE Safe Staffing Guidance for Nursing in Acute wards described 'safe nursing indicators' and 'red flags' as considerations to indicate unsafe staffing levels ([13,19]). These principles were used when developing the list of dietetic safety concerns for the initial questionnaire. The 2023 survey kept the original list with only minor adjustments to update the wording and the addition of one new category "Insufficient time to spend with students on their clinical placements".

See updated list below.

Dietetic Safety Concerns
Patients not seen in a timely manner
Adverse impact on patients' clinical outcomes
Poor patient experience/ satisfaction
Reduced opportunities for MDT working (e.g. missing phone calls/ meetings/ case conferences)
Too much clinical work to manage properly
Being asked to work outside scope of practice
Unable to fully complete patient related documentation
Lack of opportunity to develop self (CPD) in worktime
Insufficient time for practice/clinical supervision or appraisals
Struggle to find time to undertake mandatory training
Insufficient time to spend with students on their clinical placements NEW
Lack of opportunity for service development
Poor health at work (e.g. regular tiredness, stress or sickness)
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 to meet Audit Standards
Unacceptable number of clinical incidents or near misses
Other (please specify)

Findings

Demographics

A total of 783 BDA members responded to the survey, although not all answered every question.

Members from all regions across the four home nations of the UK participated and a wide range of areas of work were represented. The NHS is the largest employer of Dietitians in the UK.

97% of respondents worked directly for the NHS, including 15 dietetic support workers, and the remaining 3% worked for a private company or freelance delivering NHS services.

75% of the HCPC registered Dietitians in 2023 work for NHS England.
Historically around 90% of HCPC registered Dietitians have been BDA members.

73% of respondents worked wholly or partially in acute hospitals and 38% worked wholly or partially in community settings.15% worked in mental health services, 13% in primary care, 9% in public health and 10% were freelance all or part of the time. 58% worked in more than one place setting e.g. acute and community.

72% worked with adults, 20% with paediatrics and 8% covered both age ranges.

32 respondents worked as Advanced Clinical Practitioners and 3 as consultants (4.5% in total of the respondents).

Most respondents were Band 6 and above (median – Band 7). 5% were Band 5 and 2% were Dietetic Support Workers. (*See appendix 2.1*)

55% had worked for more than 10 years; only 8% were 0 – 2 years. (*See appendix 2.2)*

94% of respondents were in permanent posts, with 57% working full time. 13% had two posts.

Dietitians from all the BDA specialist groups were represented with the largest single group being Parenteral and Enteral Nutrition, followed by Paediatrics, Gastroenterology, Diabetes, Oncology, Critical Care, Older people, Mental health and then the remaining groups.

Most dietitians were Band 6 or above, with 5% working as a Band 5 and only 1% being Dietetic Support Workers (Band 3 or 4, n=15).

The majority of dietitians had been practising for more than 3 years, with only 8% of respondents (n=65) having worked for 0-2 years.

57% of dietitians were employed full time
Most respondents (94%) were in a permanent post.

100 respondents (13%) also had a secondary post e.g. teaching and freelance

Workplace Activities and Job Plans

The NHS document published in July 2019 'Job Planning the clinical workforce – Allied Health Professionals; A best practice guide' ([1]) defines this as a prospective, professional agreement describing each employee's duties, responsibilities, accountabilities and objectives. It describes how an employee's working time will be used according to the specific categories of direct clinical care (DCC), specified supporting professional activities (SPA) and other activities such as additional NHS responsibilities (ANR) and externally funded duties (EFD).

All NHS employees ***should*** have a job plan which needs to be reviewed on a regular basis, e.g., annually, to reflect changes in working practice.

871 respondents replied to the question on job planning. 37% reported having an up-to-date job plan, 30% had an out dated one, and 33% did not have a job plan at all.

The breakdown of the data shows that the greatest amount of time spent by all bands up to and including 8a was DCC. As banding levels increase clinical service management, clinical governance and trust wide roles take up more of the individual's time as DCC reduces. Of interest, those with current Job plans spent an average of 70% of their time in DCC, those with out-of-date job plans spent 75% and those with no job plan spent 69% DCC time.

All bands up to and including 8b were involved with student training, CPD time ranged from around 4 – 6% of work time, and admin time varied from 4 – 12%,(band 3 and 4 being the highest). The majority of supplementary prescribers were in band 8a roles.

See appendix and 3.1 and 3.2 for charts

Direct Clinical Care

Worktime spent on DCC increased for unqualified staff as their pay band increased, and peaked at band 5 level at the qualified dietetic entry point. Thereafter, DCC decreased as the proportion of supporting professional activities (SPA) increased.

The BDA Workload Management Toolkit (2017) recommended the following amounts of time for bandings as guidance:

Band 5 = 85%, Band 6 = 75%, Band 7 = 65%, Band 8a= 40%, Band 8b suggested 25% and Bands 8c and above up to 10%.

Note; the BDA's figures are between 5 and 15% lower than the example provided in the NHS Job Planning the clinical workforce: allied health professionals best practice guide (2019) ([1]) which covers guidance for all the AHP professions as a group. Generally, the recommended percentage DCC is lower for dietitians in view of the wide range of other activities within their job plans.

From the data in this survey, the actual percentage DCC currently being delivered by bands 5 to 8b is similar to the guidance of 2017, though the mean percentage DCC for band 6,7 and 8a was higher than this recommendation.

The survey results indicate DCC as a percentage of workload being, on average, 72% for bands 3 and 4, 84% for band 5, 79% for band 6, 70% for band 7, 46% for band 8a, 26% for band 8b and 9% for bands 8c to 9.

Note: For those band 8as working in more clinical roles, we would expect a higher % DCC than those who have mainly management roles and would be expected to have between 20-25% DCC. The expected range for DCC for the more clinical roles would be expected to be between 30-50%. Note: those 8as who felt their workloads were excessive had a mean percentage DCC of 56%, *see appendix 3.3 for more.*

When looking at the mean percentage DCC in the different workplace settings (and the proportion that is individual patient attributable and that which is not it is interesting to note that the percentage of non-IPA DCC is broadly similar across all settings (between 10 and 15% of all workplace activities). However, the mean total percentage DCC was highest in both the acute setting and freelance (over 80%).

When looking at the mean percentage DCC in the different workplace settings, it is interesting to note that the percentage of non-IPA DCC is broadly similar across all settings (between 10 and 15% of all workplace activities). However, the mean total percentage DCC was highest in both the acute setting and freelance (over 80%).

Note: due to changes in the definitions for patient activities compared with the 2015 survey, only IPA DCC is counted for patient contacts. However, non-IPA DCC time is extremely valuable as this is required for MDT meetings, ward or board rounds as well as other non- clinical activities. *See appendix 3.4 for more.*

Individual patient contacts

Respondents answered questions regarding the mean number of new and review individual patient attributable contacts that they had in a typical working week. This was further analysed in relation to their responses to questions regarding whether their workloads were deemed to be safe or excessive and if they had suffered from work related stress causing ill health in the last 12months.

The total number of respondents “to these questions was 308. Most respondents worked in the acute sector with a significant number working in the community. The greatest proportion of respondents were specialist dietitians, working at band 6 or band 7 level, *see appendix 4.1 and 4.2 for more details.*

Time spent with individual patients

When asked how much time would be required to see a new patient including all aspects of a dietetic consultation, respondents could choose from the following blocks of time 0-15 minutes, 16-30 minutes, 31-45 minutes, 46-60 minutes, 61-75 minutes, 76-90 minutes and free text for any other time periods

The most frequent choice for time spent for new contacts was 76 – 90 mins for Home Visits, and 46 – 60 minutes for both Inpatients and Outpatients. For review contacts the figures were 46-60 mins for Home Visits and 31 – 45 minutes both for Outpatients and for Inpatients, *see appendix 5.1 and 5.2 for more details*

Mean number of contacts per month per FTE and time spent per contact.

The number of responses to this question was 396.

67% of new consultations fell within the 3 brackets from 16 – 60 mins and 65% of the reviews fell within the 3 brackets from 16 – 60 mins.

Unsurprisingly, more patients were seen when the time spent per contact was lower. For example, when patients only required between 16 and 45 minutes, the total number of contacts was approximately 120 per month. When the time spent was between 61 and 90 minutes, the number of patients seen was approximately 90-95 per month, *see appendix 5.3 for more details.*

Group sessions

10% of respondents delivered group education sessions. The number of sessions per month varied, with 60% delivering once a month and the remainder between twice and nine times per month.

Group size varied from one attendee up to 20 individuals. 47% respondents reported an average of 4 – 6 patients per group.

The assessment of complexity for group education sessions came out slightly different from inpatient and outpatient individual contacts, with fewer high/very high complexity numbers (29% vs 48%), more medium complexity (42% vs 34%) and more low complexity (29% vs 15%). *See appendix 6.1 and 6.2 for more details.*

Patient Complexity

433 responded to the question requesting their views regarding the complexity tool. Respondents were very positive when asking about their views of the complexity tool.

The majority of responders strongly agreed or agreed that the tool was relevant for their area of clinical practice, that it would be useful to help with calculations for safe staffing and they would incorporate it into day-to-day work. Only 8% agreed that they already had a complexity tool that they used. *See appendix 7.1.*

Results regarding percentage patient complexity: estimates by dietitians

There were 410 responses to the question: “Considering the new patients you see each week, what percentage of new patients would you estimate are high/very high, medium or low complexity, according to the definitions from the complexity tool?”

The same question was also asked of patient reviews (413 responses) and of those attending group sessions (91 responses). For individual patients, most respondents stated that they had a high proportion of individuals who had a high or very high complexity (48% for new and 47% reviews), a moderate number with medium complexity (37% for new and 39% reviews) with very few having a low complexity level (15% for new and 14% for reviews).

Group sessions

With regard to group sessions, 29% of patients were deemed to have a high or very high complexity level, 42% medium complexity and 29% low complexity.

Complexity in different workplace settings

A separate question was asked regarding the length of time spent per individual patient seen and the complexity of these patients for three different workplace settings: inpatients, outpatients and home visits.

For new patients:

Home visits

For new patients, 66% were estimated to have a high or very high complexity level, and 34% medium complexity. For review patients, 51% were estimated to have a high or very high complexity level, 43% medium complexity and 6% low complexity.

Out patients

For new patients, 50% were estimated to have a high or very high complexity, 46% medium complexity and 4% low complexity. For review patients, 49% were estimated to have a high or very high complexity level, 48% medium complexity and 3% low complexity.

Inpatients

For new patients, 72% were estimated to have high or very high complexity, 27% medium complexity and 1% low complexity. For review patients, 53% high or very high complexity level, 44% medium complexity and 3% low complexity.

Across all three workplace settings, the percentage of new patients with a high or very high complexity was 50% or more. The percentage of review patients with a high or very high complexity level was lower for home visits and inpatients but there was little change in the outpatient setting.

Discussion

The results from the complexity tool[1] can only be used as a preliminary guide as the tool is currently undergoing a validation study. It is worth noting that we recognise the NHS is under considerable financial strain and some departments might only be able to see the higher complexity patients due to staffing levels.

Once validated, if the tool is used, all dietitians must rate the patients only on what appears in the domains to produce the overall score of complexity. It is worth remembering that patient complexity is not defined by the dietitian's personal interpretation but is based upon an assessment using the validated complexity tool.

[1] Please note: this complexity tool should not be used in its current form until approved by the BDA and uploaded to the BDA website as both the content and complexity total score limits could change following the validation study.

- This section of questions was to ascertain the following:
- the percentage of contracted hours worked from home
- the percentage of individual consultations that took place when they worked from home (online or phone consultations)

A separate question was asked to ascertain the following: “What proportion of patients received either an online or phone consultation rather than a face-to-face consultation?”

There were 525 responses to the questions on home-based working, of which 72% spent at least some of their time working from home. Of these, 35% spent between 1 and 10% of their contracted hours working from home, 19% spent between and 11 and 20% and 12% between 21 and 30% of their contracted hours. Interestingly, 20% of respondents spent more than half of their time working from home.

It is important to consider the following when interpreting the results:

- time spent working from home included both patient consultation time (DCC) as well as all other SPA or ANR activities
- the questionnaire did not ask if respondents contractual employment was to work from home or whether working from home was a casual agreement. From the responses, only a small minority (4%) indicated that they–undertook 91 - 100% of their work from home; these respondents are most likely to be Dietitians with a contractual agreement to work from home. *See appendix 8.1 for more details.*

64% of all respondents to this section had at least some individual patient consultations working from home; though for nearly half of these respondents, this was for between 1 and 10% of their consultations; a very small proportion. For those who had some patient consultations when working from home, only 20%, had at least half of all consultations when working from home, *see appendix 8.2 for more details.*

Proportion of online and phone consultations

This section of questions asked where individual patients were seen; the choices were inpatient, outpatient, home visit or online or phone consultation

Note that 335 respondents had some individual consultations when working from home, though for about half of these, this was ≤10% of all their consultations.

There were a further 190 responses to the question regarding the location which indicated that most of these consultations were not held at home.

Most of these online or phone consultations were likely to have taken place in an NHS setting e.g. clinic room or dietetic office.

Overall, 20% of new and 22% of review patient consultations were held either online or by phone, though most of these did not take place from home but in other workplace settings.

Only 5% of new patients and 4% of review patients received a home visit. *See appendix 8.3 and 8.4 for more details.*

Perceptions of Workload Safety

Dietitians' perceptions of their working environments produced interesting data. The following points highlight some of the principal findings:

- 55% felt their current workload to be unsafe
- 48% felt there were insufficient staff members in their teams
- 48% felt the skill mix in their teams was not correct
- 42% stated they felt unable to provide the quality of care they felt that they should deliver
- 21% did not have sufficient time to provide the level of service that they would like to deliver77% felt that their workload was excessive with only 23% who felt that it was not excessive

It was interesting to note that a greater percentage of staff felt that their workload was excessive than those who felt it was unsafe. However, if you include those who were "undecided" then only 25% of respondents felt that their workload was safe, a similar percentage to those who said that they did not have an excessive workload. Though these questions are very similar; the term "excessive workload" is used with greater frequency to describe the workload of NHS staff compared with the term "unsafe workload", *see appendix 9.1 and 9.2 for more details.*

Overtime

Survey respondents indicated that 78% worked overtime. Of this cohort working overtime, 83% were providing between 10% and 20% over and above their contracted hours. More than 50% of this overtime worked was spent on catching up with patient related administration.

Only 5% received payment for their work, 32% were unpaid, 34% received time off in lieu (TOIL) and 29% had a combination of TOIL and unpaid overtime. A common theme is that it is very difficult/impossible to take TOIL owing to heavy workloads. Of those who received payment, this may be dependent on whether there is any funding left in the departmental budget at the end of the financial year.

Of the 5% who received payment for overtime worked above their contracted hours, if these payments are via a bank or agency agreement, then under NHS AfC terms and conditions this is not considered as overtime. This may affect some of the responses from the 5% of respondents who indicated that they received payment for additional hours worked, *see appendix 10.1 and 10.2 for more details.*

Vacancies

Questions including vacancies was included in the survey to get an overview of the national situation and consider what impact this has on the dietetic workforce. Many organisations are reporting recruitment issues across a range of bandings.

A snapshot of NHS vacancies advertised in September 2023 revealed a range of titles and requirements for the band 6 and band 7 roles advertised (the largest proportion of survey respondents).[2]

Band 6 roles were generally described as 'specialist', 'senior' or 'experienced' dietetic roles. Band 7 roles titles varied widely from 'Band 7 Dietitian', 'Specialist Eating Disorders/Gastro/Diabetes etc Dietitian', 'Senior Specialist Dietitian', 'Senior Specialist/Team or Operational Lead Dietitian', or 'Advanced Dietitian'.

Band 8a roles were deputy director or clinical lead dietetic positions.

Band 8b roles were deputy head of therapies or consultant level positions.

The requirements for knowledge and experience varied hugely for the band 7 roles. Some, correctly, stipulated essential evidence of Level 7 (Masters) or equivalent post graduate training via courses/certificate/diploma, some listed this as desirable whilst others had no such requirement stipulated.

Experience requirements varied from no requirement specified, experience being desirable rather than essential, an unspecified length of experience in a particular specialty to a year of experience in the speciality.

Regarding the 6 'Advanced Dietitian' band 7 roles advertised, 4 correctly specified masters level or equivalent training but 2 had no requirement stipulated

The 8a and 8b roles advertised all correctly had Masters level or equivalent qualifications or currently being undertaken.

Those reporting vacant positions reported anything from zero to 20 positions becoming vacant within the year. The majority was between 1 and4 posts, the median figure being 3.

Respondents reported that as a percentage of the team/department, these vacancies represented up to 60% of their workforce. For most services, this equated to between 10% and 30% of their establishment being unfilled at any time of the year, *see appendix 11.1 and 11.2 for more details.*

Clearly these vacancies have an impact on service delivery; managers would be required to look at recruiting temporary staff depending on their organisation's financial situation, reductions in service delivery if vacancies were multiple or prolonged, and staff would be under considerable pressure to attempt to cover

[2] No details were requested on the bandings of vacant positions or length of vacancy.

additional workloads. Workplace stress therefore increases - which in turn could lead to ill health and 'burn out' amongst some of the workforce.

A question was also asked to see if recruiting managers were making alterations to the vacant positions in order to improve recruitment possibilities. Nearly a quarter of respondents did not know. 25% did not alter the roles, 21% readvertised at a lower band with preceptorship, 13% changed to a lower band with skill mix alterations within the team, 11% readvertised at a higher band with increased responsibilities and 7% readvertised at a higher band without altering the job specification at all, *see appendix 11.3 for more details.*

Work place concerns

There were 429 responses to the question: "If you have any concerns regarding your workload, what are your main concerns? Please select up to 6 concerns from the list below"

The top 6 concerns were:

- lack of opportunity to develop self (CPD) in work time
- patients not seen in a timely manner
- lack of opportunity for service development
- reduced opportunity for MDT working
- too much clinical work to manage properly
- high vacancy rate and lack of backfill

See appendix 12.1 for full details.

All of these were chosen by at least 30% of respondents as were low staff morale and poor patient experience/satisfaction.

Other comments were highlighted: 3respondents wanted to choose all items. Only 3% of respondents added a new concern that was not already listed. These were as follows:

- difficulty recruiting staff
- working extra hours to get everything done
- non-dietetic members of MDT provide nutrition advice instead of Dietitian
- delays in getting things done
- inadequate delegation to support workers

None of these workload concerns were surprising given the responses provided earlier in this document regarding current workload.

Workload and work-related stress

A total of 490 respondents provided data on their workloads and whether they were perceived to be excessive. 77% of the respondents stated their workloads were excessive.

There were a small number of responses from public health, more from primary care and mental health and the highest number from community and acute hospital settings.

Large numbers of dietitians reported excessive workloads, which would correlate with the overtime worked by such a large percentage of respondents. Acute hospitals reported 80% with excessive workloads, community 79%, mental health Services 58%, primary care 54% and public health 33%

The greatest number of staff feeling their workloads were excessive were from the acute sector. Please note that: freelance in this context relates to those working in the NHS and therefore are most likely to be working as a locum, this may explain the high percentage stating that their workload is excessive.

A positive comment was that 83% of respondents felt that they had the freedom to speak out if they felt that things were going wrong – and thus be proactive in improving the work situation. *See appendix 13.1 for more details.*

The figures for those who reported a stressful workplace, the responses for episodic and chronic stress in the workplace were not dissimilar (32% of all respondents stated their work-related stress was episodic and 29% stated it was chronic, while 29% did not have work-related stress). This indicates just under a third of the workforce feel that they are continually working under stressful conditions.

There were 429 respondents to the question relating to workload stress and feeling unwell due to work related stress in the last 12 months. The responses demonstrate a clear link between excessive workloads and being unwell due to work related stress. Of those with an excessive workload, 62% felt unwell due to work related stress, which still left 38% who did not feel unwell in the last 12 months. In contrast, those who stated their workload was not excessive, only 35% felt unwell due to work related stress while 65% did not.

Clearly, there are many in the dietetic workforce who, despite working with excessive workloads, are resilient and have coping strategies so that they do not suffer from work stress-related illness. *See appendix 13.2 and 13.3 for more details.*

Overtime

The results from 429 respondents (*see appendix 13.4 for more details)* unsurprisingly demonstrated that for those who have an excessive workload, regularly work overtime and report work related stress, the numbers reporting workplace ill health due to stress are the highest – both in terms of numbers per se and percentage suffering ill health. Understandably, there is a direct correlation between those who report an excessive workload and working overtime.

There was a small group of respondents with a manageable workload who did not work overtime, yet still felt unwell due to work related stress This could be attributed to being new in post, recent promotion so finding their new role challenging or being short staffed in the department. A similar number stated their workloads were not excessive but they were working overtime and they also reported work related illness

due to stress. Again, similar scenarios to the first group could be contributing to the stress but the additional overtime working is likely to be an additional factor.

For the small group of respondents who reported an excessive workload but were not working overtime the group was evenly split between those who suffered work related stress illness and those who did not.

The largest group of respondents were those who had excessive workloads and worked overtime. This group also had the highest percentage of staff reporting ill health due to work related stress (63%).

Those working overtime to manage their excessive workloads accounted for more than two thirds of the workforce surveyed, and 63% of this group reported ill health due to work related stress. Including those who did not report excessive workloads but who also suffered work related stress, this translates into 56% of the respondents.

From the range of workplace scenarios, whether practitioners had excessive workloads or not, worked overtime or not, some suffered work related ill health due to stress and others did not. These variations can be attributable in part to the individuals' resilience and what coping strategies they may have in place. Examples of strategies for coping with stress and building resilience include good time management, working 'smarter', taking breaks during the working day, ensuring holiday entitlement is taken, talking to someone you trust (personal or professional), looking after your wellbeing (good diet, physical activity, sleep, relaxation, avoiding unhealthy habits like excess alcohol, smoking, recreational drugs, and focusing on life outside of work are all actions that can help. (see reference: "workforce stress and the supporting organisation" HEE and "what to do if you are struggling with stress" NHS Scotland NHS Inform) ([14,15])

Determining the safe number of Individual Patient Contacts

a) Workload and time spent with Individual Patients

433 people answered these questions. Those questions regarding how much time respondents were allocated per new and review contact in the different workplace settings, and how much time is spent per contact in relation to whether or not the respondent feels their workload is excessive or not, produced surprisingly similar results.

Regarding whether or not respondents felt that their workloads were excessive, 97 (23%) felt their workloads were safe and 324 (77%) felt their workloads were excessive.

Regarding the time spent per patient, there was no consistent pattern to indicate that dietitians spent less time, on average, per patient seen for those who considered their workloads to be excessive from the others, *see appendix 14.1 and 14.2 for more details.*

Outpatient Clinics

There was also a question relating to the outpatient clinic time allocated for individual appointments in outpatients/ community which was “Do you feel that the time allocated for dietetic assessment, treatment and related admin is sufficient?”

369 people answered this question, of which 43% responded that they felt the clinic time allocated was sufficient while a greater proportion, 57% felt the time allocated was insufficient.

Discussion

Dietitians appear generally to spend an appropriate amount of time per patient for new and review consultations unrelated to their workload. The difficulty appears to be when asked to take on a greater number of patients than they can see safely. This additional work which many undertake often means working overtime.

b) Workload and number of individual patient contacts

As discussed earlier, respondents answered questions regarding the mean number of new and review individual patient attributable contacts that they had in a typical working month. This was further analysed in relation to their responses to questions regarding whether their workloads were deemed to be safe, excessive and if it was excessive, was this episodic or chronic and if they had felt unwell due to work related stress within the last 12 months

As stated previously, the total number of respondents to these questions was 308.Most respondents worked in the acute sector with a significant number working in the community. The greatest proportion of respondents were specialist dietitians, working at band 6 or band 7 level.

As the total number of contacts/month/FTE increased, staff perception of a safe workload diminished. Generally, when the number of contacts was less than 90 per month workload was deemed safe. Once the number of contacts reached 110 or more per month, dietitians reported that their workload felt unsafe (*see appendix 14.3 for more details)*

Dietitians who reported that workload was manageable had an average of 82 contacts/month/FTE and those who stated their workloads were excessive had an average of 115 contacts per month. The number of contacts per month/FTE are clearly closely linked in terms of manageable and safe workloads (82 – 90 contacts/month/FTE) and likewise the excessive and unsafe workloads (110 – 115 contacts/month/FTE)[3]. S*ee appendix 14.4 and 14.5 for more details.*

Clearly, those respondents with fewer total contacts (average 82/ month/FTE) felt that their workload was not deemed to be excessive.

Those respondents with an excessive workload but not unwell due to work related stress reported an average of 106 contacts / month / FTE.

[3] Please note, the vast majority of respondents were band 6 and above and many were specialist dietitians working in the acute setting. The safe number of contacts was found to be lower in the community setting than in the acute setting.

Those respondents with an excessive workload which resulted in feeling unwell due to work related stress had an average of 120 contacts / month / FTE[4].

For those dietitians that work in the acute sector

A caseload requiring up to 90 contacts /month/FTE would indicate a safe caseload with the staff member unlikely to be suffering work related stress.

On average, higher caseloads requiring approximately 100-110 contacts / month / FTE mean that the Dietitian is more likely to be feeling that their workload is excessive, but this may not have a detrimental effect on their health.

Once caseloads are on average 120 contacts / month / FTE then there is a higher probability of the Dietitian reporting ill health due to work related stress.[5]

For those that work in the community, the corresponding figures are

A safe caseload would be likely to be on average 70 contacts per month per FTE

Higher caseloads requiring on average approximately 85 contacts / month / FTE mean that the Dietitian is more likely to be feeling that their workload is excessive

An excessive caseload is likely to be more than 100 contacts per month/FTE. [6]

For those that work in Mental Health

The mean number of new patient contacts per month per FTE was 12 and 47 reviews, giving a total of 59 contacts per month. There were 20 respondents to this question and unsurprisingly there was no significant difference between a safe and an excessive workload with these low numbers.

For those that work in primary care

Again, numbers were low; 19 respondents. However, there was a difference between a safe and an excessive workload – the safe number is likely to be similar to that for community dietitians.

For those that work in Paediatrics

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[4] Please note: these figures are for dietitians only as there were insufficient responses from support workers to obtain sufficient data. Most responses were for band 6 dietitians, so safe contact numbers may well be lower for newly qualified band 5 dietitians. By far, the largest response was from the acute hospital sector and hence, these recommendations are likely to be the most robust.

[5] Please note, as a high proportion of respondents worked in the acute sector, these figures are likely to be lower in other workplace settings.

[6] Please note: there will be variables in the working environment which will affect the safe numbers of patients that can be seen.

This survey was not designed to provide specific guidance for specialist groups, but it is of interest to note that the mean number of monthly contacts was 106 for those who stated that their workload was excessive and 78 contacts if it was not excessive, which is similar to the data for both community and primary care dietitians.

In Summary[7]

Setting	Mean Safe number of contacts/ month/FTE	Mean Excessive number of contacts/month/FTE
Acute	90	120
Community/primary care	70	100
Paediatrics	70	100

Additional factors to consider

Lower monthly contacts would also be expected in the following scenarios:

- for those staff where the New to follow up ratio is higher than 1:1.5
- where travel time is high e.g. staff undertaking home visits
- where caseload contains a high proportion of high or very highly complex patients
- where caseload contains patients requiring a significant additional time commitment e.g. education on carbohydrate counting in diabetes
- where the job plan contains a significantly high proportion of SPAs relative to time allocated for DCC such as band 8as with a clinical caseload
- for those newly qualified or new to post

Calculating safe contact numbers for your workplace setting

See calculation for estimating the number of contacts using job planning information and the data from this survey. (see separate document/link)

Practice supervision

Practice supervision is a process of professional support and learning, undertaken through a range of activities, which enables individuals to develop knowledge and competence, assume responsibility for their own practice and enhance service user protection, quality and safety of care (BDA: adapted from www.dhsspsni.gov.uk) ([16])

Practice supervision should be included within working practices and is important for all bands. It is a key component to supporting dietitians to meet HCPC standards.

There were 426 respondents to these questions. 269 (63%) received practice supervision but 157 did not (37%). For those who had practice supervision, the most

[7] Please note that these figures are based on a full working month and do not include any time for absences such as annual leave, training or sick leave. An average of 20% absence is often used. Hence an annual expected number of contacts would be (Xx12) x0.8 where X is the monthly number of contacts.

frequent time interval was 6 – 8 weeks (42%), followed by monthly (34%) and three monthly (9%), *see appendix 15.1 for more details.*

Those who stated that they did not currently receive any practice supervision were asked for their comments. A selection of their comments that reflect common themes include

- due to service pressures, clinical supervision is often cancelled or moved
- no time for any supervision in the day due to staff shortages
- not in job plan
- often cancelled due to hospital pressures
- specialist area no other RD understands it
- rarely happens unless I ask

The survey also looked at supervision and stress levels amongst respondents to try and ascertain whether having regular supervision helped to manage work place stress and ill health.

For those who reported no work-related stress leading to ill health, 65% had supervision and 35% did not. Of those who reported ill health due to work related stress a smaller number, 60%, had supervision and larger number, 40%, did not receive supervision. This could indicate that regular supervision may have a beneficial role in helping to reduce workplace stress induced ill health as this supervision may help in identifying and rectifying stressful work conditions.

From the responses obtained, 35% had a supervisor in the same dietetic clinical area, another 35% had their Dietetic line manager as supervisor and 30% had another HCP as their clinical/practice supervisor. This is indicative of the fact that some band 7s and a significant number of Band 8s report upwards to another HCP rather than a dietitian.

Regarding the dietetic line manager as practice supervisor, the BDA recommends that a practice supervisor should ideally not be their line manager if the workforce can accommodate it.

Advancing Roles in Dietetics

These include Advanced Clinical Practitioners (ACP), First Contact Practitioners (FCP) and Consultant Dietitians

ACPs

Findings from the survey relating to advanced care practitioners are as follows:

- 92% stated their workloads were excessive
- 4% were supplementary prescribers
- 10% of the time was spent on clinical service management tasks (including appraisals)
- 56% of the time was spent on DCC

- workplace settings included Primary Care, Mental Health, Community settings and the largest number (63%) employed in Acute settings.
- bandings: these ranged from 8c to Band 6. The majority were Band 8a (35%) and band 7 (37%)

Advanced Practitioner roles support dietitians in developing their clinical career pathways undertaking roles central to meeting the changing demands by on the NHS. These roles enable practitioners to expand their contribution to healthcare and gain personal job satisfaction. This level of practice supports the retention of experienced clinical staff.

ACPs are experienced practitioners working with a high degree of autonomy and complex decision-making skills, which can include prescribing.

Benefits of Dietetic Advanced Practice roles include developing services where the RD is the first point of contact, leading to fewer appointments, quicker referral times, better patient outcomes and reducing the workload on medical colleagues.

ACPs must work across the Four Pillars of Advanced Practice (practice, evidence-based practice research, facilitated learning and leadership). These professionals work at Masters level or equivalent achieving PG certificates, Diplomas or full Masters degrees i.e., Level 7 in all four Pillars. There is an expected time frame of 18 – 24 months to achieve all these competencies. There are different entry points of entry for this level of practice; entry level with Preceptorship, Enhanced level (Dietitian with an in-depth knowledge), Advanced level (authoritative knowledge, operating at Masters Level) and Consultant (national and/or international leader in their field). Most work at Band 8a and above. trainee ACP/APs may be practising at Band 7 level until all competencies are met. For some ACP/APs this role may be an opportunity to further develop their clinical career to consultant level.

Some RDs have the term ‘Advanced’ in their job titles but may not be working at this level for various reasons. For these cases the job title may need rewording or further training completed to meet the requirements of ACP.

Each of the four nations in the UK has its own National Framework for Advanced Practice which can be accessed on line. The BDA produced guidance documents in 2023, ‘Advanced Practice’ and ‘Manager considering Advanced Practice posts’ which are available on the BDA website.

Of the 23 ACPs who responded to this question in the survey, 30% had completed the relevant training to achieve the required levels of competency in all Four Pillars, and 70% had not.

FCPs

Findings from the survey relating to first contact practitioners are as follows:

- 71% stated their workloads were excessive
- 69% of the time was spent on DCC

- workplace settings included freelance appointments, primary care (50%), Community (25%) and acute settings.
- bandings: these were Band 7 with one ‘outlier’ at band 5.

FCPs work as diagnostic clinicians in Primary Care, and practice at Masters level i.e. band 7 and above. Practitioners are required to have at least 5 years post graduate experience including 3 years in a specialist area before training to become a FCP. When starting training for this role they should be level 7 in clinical practice and some experience within the other 3 Pillars. Qualifications are gained either by completing e learning modules and a portfolio or via an HEI FCP level 7 module.

Of the 9 FCP who responded to this question in the survey, 5 (55%) had completed their training and 4 (45%) had not.

Consultant Dietitians

This is a relatively small group of professionals, in the Band 8 range, who are national and international leaders in their field. They possess higher qualifications including doctoral level in their scope of practice. They make complex judgements as well innovate and lead to advance practice.

- Findings from the survey relating to consultant dietitians are as follows:50% stated their workloads were excessive
- 10% of the time was spent on externally funded education and training
- 10% of the time was spent on additional trust wide appointment roles
- 12% of the time was spent on service management tasks (including appraisals)
- 41% of the time was spent on DCC
- workplace settings were primary care, community and acute (50%) settings.
- bandings: these were equally spread between band 7, 8a, 8b and 8c.

Comparisons between baseline (2015) and current data

Mean percentage DCC in different workplace settings

Comparative data	Year	Acute	Community	Adult	Paediatric	All Responses
Percentage direct clinical care	2023	82	72	72	75	72

The percentage of the DCC or patient related activity were very similar for most workplace settings except for the acute sector, where the %DCC increased markedly.

There were no significant differences between those who said workload was safe (or not excessive) and those who said it was not safe (or excessive) in both the 2015 and 2023 data.

Mean percentage DCC per band

Year	Data	Band 5	Band 6	Band 7	Band 8a
2015	Mean percentage patient related activity	80	78	68	35
2017	BDA guidance	85	75	65	40
2023	Mean percentage DCC	84	79	70	46

All percentage DCC figures in 2023 were higher than the 2015 data and higher than BDA guidance from 2017.

There was little change for bands 6 and 7, though the increase was greater for both bands 5 and 8a in 2023. For the band 8a respondents, this is likely to be due to the fact that a considerable number who responded were in very specialist clinical roles, rather than managerial ones, compared with the 2015 survey respondents.

The BDA would recommend that the mean percentage DCC for band 5 should be updated to 80%. This would facilitate sufficient time for preceptorship and skill and knowledge development. We would also recommend an initial lower level of DCC for those Dietitians moving into a new specialist area, who would also benefit from preceptorship. We also recommend that the percentage DCC will need to be reviewed for higher bands (e.g. ACP, consultant) as some may have a higher DCC worktime than when this guidance was originally created.

Mean length of time per patient contact

In 2015, the estimated mean time spent per patient contact new and review) was approximately 40 minutes. No further details were available regarding length of time per contact in this baseline survey.

In contrast, when asked how much time was spent for a dietetic consultation in 2023, new patient consultations were around 60 minutes and reviews 45 minutes, and often longer.

Safe number of patient contacts

Comparison between mean annual number of contacts per year and perception of workload safety

Comparative data	Year	Acute	Community
Mean annual no of contacts /FTE for those with safe (or not excessive) workload	2015	1498	915
	2023	864	672
Mean number of annual contacts/FTE for those with unsafe (or excessive) workload	2015	1747	1248
	2023	1248	768

There were significantly fewer patients seen in the 2023 survey.

This is likely to be due to the increased length of time spent per patient, reflecting the increasing complexity of patients seen, with less complex patients remaining on "prioritisation or waiting lists" and the increasing requirement for post dietetic intervention paperwork.

Perception of workload safety

Perception of workload safety	2015	2023
Percentage who feels workload is safe	57	25
Percentage undecided		20
Percentage who feels workload is unsafe	43	55
Percentage who feels workload is not excessive		23
Percentage who feels workload is excessive		77

In 2015, 43% felt their workload was unsafe. This figure increased to 55% in 2023 with a further 20% being "undecided" if it was safe or unsafe; this choice was not an option in the 2015 survey.

In 2023, 77% felt their current workload was excessive and 23% felt it was not excessive (n=429). It is interesting to note that most those who said that their workload was safe also said it was "not excessive". However, most of those who stated that their workload was "unsafe" or "undecided" also stated that their workload was excessive. Hence, the term "excessive" is probably a more sensitive marker than the term "unsafe".

Workload Concerns

In the baseline survey, dietitians were asked to choose up to three workload concerns, though they able to choose more. In the 2023 survey, they were able to choose up to six concerns, but this was the maximum they could choose, *see appendix 16.1 for more details*

Despite an increase in the number that could be chosen, it is very clear to see that the percentage of respondents with workload concerns has increased markedly, and that there are similar concerns chosen most often; namely lack of opportunity to develop self in work time, and patients not seen in a timely manner.

Conclusions[8]

Limitations.

[8] Documents are available on the BDA website, under 'Professional Practice', relating to both individual and dietetic scope of practice to help decision making.

At the time of preparing this document, the authors were unable to obtain exact figures for the number of RDs working within the NHS. The HCPC register has 11,006 registrants (September 2023) and the BDA membership for practising RDs is 8524 with an additional 55 working abroad. Therefore, 77% of HCPC registered RDs belong to the BDA. It is likely that registered dietitians working in the private healthcare sector, freelance, academia, industry, media and any other areas are almost certainly BDA members. By deduction, the gap between the HCPC figures and BDA ones (2482 people) is likely to be mostly staff employed within the NHS.

Job planning

A requirement for NHS positions; the survey indicated that 37% respondents had a current Job Plan, 30% had an out-of-date Plan and 30% had no Job Plan at all. Workload activity definitions have been updated to be in line with the NHS Job Planning Guidance ([1]).

Safe Caseloads

The data was analysed to produce guidance for safe caseloads, and safe number of individual patient contacts/month/FTE) for acute and community settings. The figures are provided on page X. The mean safe number of contacts decreased as banding increased due mainly to the increase in SPA activities among the higher bands.

There was a wide variety in the average length of time spent per individual patient, but the most frequent choices were 46-60 minutes for a new patient and 31-45 minutes for a review. The length of time spent per patient is considerably longer than the estimates from the 2015 survey and helps to explain the reduction in the estimated safe number of patient contacts.

Dietetic assessment and intervention

The mean safe number of contacts is lower than the 2015 figures. This is likely to be due to the increased complexity of patients seen, the increased time required to complete both dietetic assessment, intervention and associated documentation as well as a slight change in the definition of both direct clinical care and an individual patient attributable contact.

Practice supervision

Regarding practice supervision, 38% of respondents did not receive supervision on a regular basis.

Workload safety

There were a number of questions on workload safety with some concerning results. A high proportion reported that their workload was excessive (77%), with a further high proportion of respondents (61%) reporting work related stress, both episodic and chronic stress. 78% of respondents worked overtime, the majority delivering between 10% and 20% above their contracted hours. The large group of staff with all of these factors: an excessive workload, working overtime and feeling unwell due

to work related stress was concerning as this was 44% of all the respondents to this section.

Workforce

Workforce concerns covered a range of issues. Of the 20 options provided, the most frequently cited were lack of CPD opportunity in work time on an individual theme, and for service-related issues, patients not seen in a timely manner, too much clinical work to manage properly, lack of opportunity for service development, reduced opportunity for MDT working and the national concern of high vacancy rates and lack of backfill. Some respondents cited their concerns over being asked to work outside their scope of practice.

Patient complexity

Initial findings on patient complexity are provided within this document, with a full guidance document expected in 2024 following validation studies within the UK

Home-based working

Home-based working is a relatively new change to dietetic practice, and supports the NHS Long Term Plan (2019) [10]. 72% of respondents spent some of their time working from home. For a third of these, this was for less than 10% of their time. 64% of respondents had at least some individual patient consultations when working from home; though this was often less than 10% of their consultations. Only 20% had more than half of all consultations working from home. Vacancy rates were looked into as this has a detrimental impact on safe staffing, overtime working and stress levels within departments. The survey showed that vacancies on average were 3 per year within a department, and varied from 10% to 30% of the staffing establishment.

Advancing roles in Dietetics

Over the last 10 years or so there has been an increase in advanced roles of practice in varied workplace settings, both in clinical and operational positions available for dietitians. advanced clinical practitioners, first contact practitioners and consultant dietitian positions have increased career opportunities for experienced dietitians, and this growth should continue in the future. This survey showed that numbers were still low, with only 12 FCPs and 4 Consultant dietitians who responded to the survey, though 37 ACPs responded. Not all FCPs and ACPs had completed the appropriate training.

Safe staffing levels

Guidance for dietitians is given within the document to help calculate safe staffing levels within a team/department with indicators highlighting potential safety issues.

Recommendations

Job planning

Make sure job plans are in place and up to date. This will help to ensure that the job role reflects what is required of the post and make adjustments where needed in response to changing service demands. It also ensures all dietetic workplace activities are timetabled, as well as Direct Clinical Care (DCC).

Referral rates

Monitor referrals and track changes in service demands. Many departments, particularly in acute settings, are reporting large increases in referral rates with staff struggling to cope, hampered by resistance from the organisation to accept the need for increased staffing.

Process implementation

Establish protocols and utilise screening tools for referrals. These processes should be reviewed on a regular basis as they may require modifications depending on demand so that skilled Dietitians are using their expertise efficiently in dealing with the more complex cases.

Range of competencies

Regularly review the skill mix of the department so that the correct level of expertise is in place to meet the demands of the service. Include dietetic support workers within the department; their contribution to the service can be highly beneficial and cost effective.

Complexity and caseloads

The complexity of patients and time required per consultation has increased over the years. This needs to be factored in during job planning to ensure sufficient time is allocated for each dietetic episode of care. In addition, the safe caseload /number of patients that can be seen by a dietitian varies according to a wide range of factors including speciality (which is outside the remit of this survey). Consideration must be given to individual requirements of the post and calculations must be realistic, allowing for planned absences.

Service delivery

Utilise technology and use video consultations, phone calls and emails where appropriate along with conventional face to face consultations. Group education sessions, where appropriate, are an effective use of clinical time.

Be aware that there can be a negative impact of moving to a service relying on remote working as the department may lose ‘visibility’ to senior management within the organisation. This could result in a struggle to make its presence felt, have clinic rooms and office accommodation removed, not be prioritised for investment etc.

Practice supervision

Ensure that staff members have regular practice supervision and annual appraisals. This contributes to the development of the team members (which aids retention), can be an opportunity to identify any issues (and put them right) and support the staff

members with any health issues, including work related stress, by putting in plans to mitigate this. The HCPC states “Our Standards support the case that registrants should be participating in supervision as part of their practise where possible” and their standards of proficiency require registrants to understand the importance of participation in training, supervision and mentoring ([17])

Appropriate banding

Ensure that staff of all bands can feel confident to raise concerns with senior members of the department and that they are working within their scope of practice.

Staff recruitment and retention

Work on the recruitment and retention of staff within a department to help minimise vacancy rates as these are contributing to staff feeling overworked, undertaking considerable amounts of overtime and for some, work related stress results in ill health and can lead to burnout. There is shortage of AHP workers both in the UK and internationally, and the NHS is putting in place plans to increase workforce training to ease the situation.

Be aware that readvertising jobs at a higher banding, rather than offering a preceptorship route, in order to try and recruit to positions whilst not conforming to the necessary requirements for knowledge, skills and experience expected of the higher band, can put the individual registered dietitians and dietetic service in danger should there be a clinical incident as a result of this action.

Contact time

Aim to minimise the amount of overtime worked by team members as the workload should normally be achievable within the contracted hours of the post. Overtime worked should be repaid either financially or as time in lieu. Ensure breaks are taken and holiday entitlement is utilised. Consider requests to alterations to working hours/practice if this helps the post holder’s work life balance and productivity.

Triangulating methods for assessing safe workload

As the survey results have shown, excessive and unsafe workloads have contributed to episodic and chronic work-related stress and subsequent sickness among dietetic staff.

> “Burnout is a widespread reality in today’s NHS and has negative consequences for the mental health of individual staff, impacting on their colleagues and the patients and service users they care for. There are many causes of burnout, but **chronic excessive workload** is a key driver and must be tackled as a priority. This will not happen until the service has the **right number of people, with the right mix of skills** across both the NHS and care system. ([7]) Workforce burnout and resilience in the NHS and social care 2021Government report”

This report states that “It is imperative staff have the opportunity and the confidence to **speak up**. However, this needs to be matched with a culture in which

organisations demonstrate that they are not just listening to, but also acting on, staff feedback.

Improvements to workplace culture have been made, but equally, there is more work to be done. Embedding and facilitating cultures which support **compassionate leadership** must be at the heart of that work."

Below screenshot from 2016 safe staffing, safe workload document Taken from NICE (2014) ([19])

Making Decisions on Staffing – Guiding Principles

How to get the right dietitians, with the right skills, in the right place at the right time

When considering the safe staffing levels, there are five key principles pertinent to all bands of dietetic staff:

- **Focus on patient care**
  - Assessing the needs of individual patients is paramount when making decisions about safe staff requirements. This will vary across workplace setting and specialty.
  - Informed professional judgment should be used to make any final assessment of staff requirements.
- **Accountability for staffing level**
  - The employing organisation should enable staff to take part in programmes that assure the quality of care and standards to maximise effectiveness as well as optimise the productivity of the team.
  - Staff should be involved in developing and maintaining hospital policies and governance about staff requirements, such as escalation policies and contingency plans.
  - There should be collaborative decision making on staff deployment between clinicians and managerial staff.
- **Responsiveness to unplanned changes**
  - The ability to be responsive to unplanned variations in demand or the availability of staff needs to be considered. This would include seasonal shifts in staffing needs.
- **Monitoring the adequacy of staff levels**
  - There should be procedures in place for systematic ongoing monitoring of safety indicators and a review of staff levels at timely intervals such as twice a year or sooner.
- **Promote staff training and education**
  - Provisions should be in place for staff to have the appropriate training necessary to enable them to have the right skills to provide the care required. This will help ensure capability as well as capacity. 13

In 2018, NHSI stated that "Trusts must ensure the three components are used in their safe staffing processes"

Principles of safe staffing

Developing workforce safeguards Supporting providers to deliver high quality care through safe and effective staffing NHS Improvement October 2018

They also recommended the use of the NQB's triangulated approach to staffing decisions

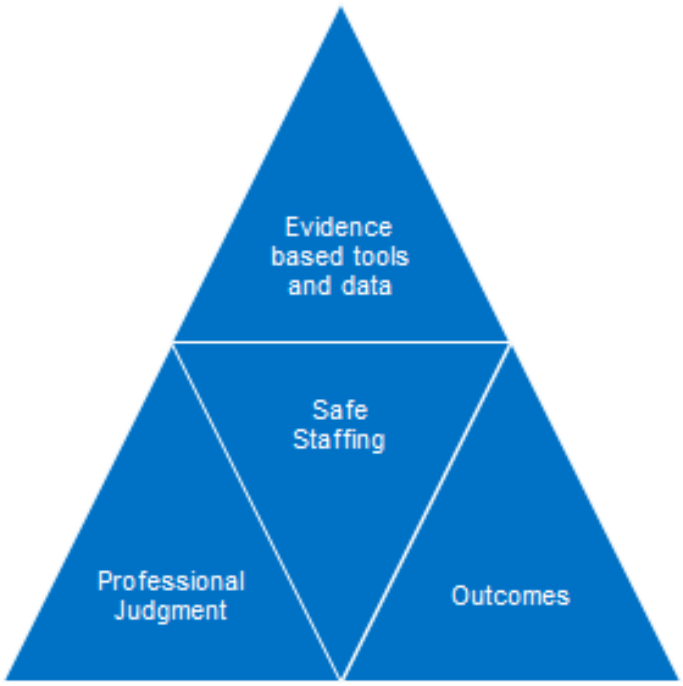

Figure 1: Principles of safe staffing

Figure 2: NHSI three components in safe staffing process

“From now on we will assess trusts’ compliance with the ‘triangulated approach’ to deciding staffing requirements described in NQB’s guidance. This combines evidence-based tools, professional judgement and outcomes to ensure the right staff with the right skills are in the right place at the right time (see supplement). It is based on patients’ needs, acuity, dependency and risks, and trusts should monitor it from ward to board” ([6])

Developing workforce safeguards Supporting providers to deliver high quality care through safe and effective staffing NHS Improvement October 2018

A triangulated approach to assessing Safe Workload and Safe Staffing levels in Dietetics

In 2016, the NQB advocated that the capacity and capability of nursing staff were the main determinants of the quality of care experienced by patients ([6]). It is also the case that the capacity and capability of dietetic staff are the main determinants in the quality of nutritional care experienced by patients. Therefore, in addition to considering workload, the approach taken by NICE and NHS England in having ‘the right skills in the right place’ and monitoring safety indicators, is an approach that is likely to be beneficial to dietetics.

Thus, within each dietetic job plan there should be adequate time and hence sufficient capacity for dietetic staff to see patients safely (allowing for appropriate non-IPA direct clinical care) and there should also be adequate time for education and training to ensure the capability of the workforce.

it is recommended that a range of data incorporating capacity, capability and safety indicators are triangulated in order to achieve a more reliable estimate of safe workload and staffing levels. Patient complexity is another factor likely to influence dietetic capacity.

Conflicting priorities and adjusting the balance of workload activities, particularly to address safety concerns, can be a complex task and may require review of service provision, not just workload management. It is important to think holistically and innovatively when addressing workload safety.

Figure 1. Triangulating data on staff capacity, staff capability alongside data on safety indicators is the recommended approach to obtaining a reliable assessment of the safety of a dietetic workload or safety of staffing level.

Figure 3: From BDA Safe Staffing Guidance (2016), now archived

Capacity

Comparing those who perceived their caseload to be safe to those who perceived their caseload to be unsafe, the following differences were found.

As the total number of contacts/month/FTE increased, staff perception of a safe workload diminished. Generally, when the number of contacts was less than 90 per month workload was deemed safe. Once the number of contacts reached 110 or more per month, Dietitians reported that their workload felt unsafe.

77% felt their current workload was excessive. Most of those also stated that their workload was “unsafe” or “undecided”. Hence, the term “excessive workload” is probably a more sensitive marker than the term “unsafe”.

There were differences in the perception of the safe number of contacts in different work place settings; in particular between the acute and community settings. As found in the previous survey, a greater number of patient contacts per full time equivalent took place in the acute setting together with a greater number of new patients seen.

Setting	Number of contacts per month/FTE dietitian		Number of contacts per /FTE dietitian	
	*Safe/Not**	*Excessive **	*Safe/Not **	*Excessive number dietitian **
Acute	90	120	864	1152
Community	70	100	672	960

* Figures for typical month (does not include any adjustment for absences)

**Already includes the 20% absence calculation

This assumes the time required for both new and review patients is close to the average (60 minutes and 45 minutes respectively) and that the new: follow ratio is no higher than 1:1.5

EXAMPLE

In the acute setting, if we assume that the N:FT ratio is 1:1.5 and that the total number of patients seen per full working month is 90 (per FTE); then the number of new patients will be 36 and reviews would be 54 patients.

Time taken:

36 NEW requires 36 hours (60 minutes per consultation)54 reviews require 40.5 hours (45 minutes per consultation)

Total time required = 76.5 hours

Total working hours = 162.5 hours

Percentage Direct Clinical Care = 70% or113.75 hours

Remove any non-IPA DCC (on average 10-15% of full-time hours) assume this is 12% = 19.5 hours

Therefore, percentage Direct Clinical Care minus non-IPA activity = 113.75-19.5 or 94.25 hours per full working month

Hence this individual should be able to see this number of patients within the time allocated, provided that there are no absences nor additional time already spent such as travel time, access to medical notes or digital records, waiting to see patients e.g. on wards or in clinics and other duties such as clinical administration.

Capability

Markers of the Capability of Dietetic Workforce include the following: amount and frequency of time spent on CPD, practice supervision, competencies achieved, appraisals, patient experience, outcomes of dietetic interventions and evaluation of training provided to other health care professionals.

The range of CPD activities is extensive and includes work-based learning such as:

- BDA Classroom and BDA eLearning via the BDA Learning Zone
- reflective practice, clinical audit or Facebook journal club
- professional activity including active membership of a specialist group
- mentoring or teaching
- formal education from short courses to higher degrees

Link: (Continuing Professional Development (bda.uk.com)

From the evidence regarding safe staffing levels for nursing staff, previous dietetic work and the results from the 2023 safe staffing and safe workload questionnaires, it is likely that a variety of factors contribute towards a safe dietetic workload. It is recommended that a range of data that incorporates capacity, capability and safety indicators is used in order to assess the safety of a dietetic workload.
Both the capacity and the capability of an individual dietetic staff member are important to help ensure the provision of a safe and quality service. Below are tables summarising the most relevant information to capture in order to assess the safety of a dietetic workload.

Capacity assessment of Individual staff member	• Percentage of time spent in workforce activities (e.g. percentage DCC/SPA) • Number of patient contacts per year per FTE • Referral rate and rate of patient turnover • Ratio of new to follow up contacts • Patient complexity mix • Level of work with MDTs • Referral to treatment time
Capacity assessment of team or department	• Percentage of time spent in workplace activities (e.g. DCC/SPA) per individual / team/ pay band • No of patient contacts per year per FTE • Referral rate and rate of patient turnover • Ratio of new to follow up contacts • Referral to treatment time for in and out patients

	• Patient complexity mix • Skill mix • Time required for new and review patients • Service demands in addition to number of referrals • Overall view of capacity and demand • Benchmarking of activity with other departments • Look at trends within department over time • Look at trends within department over time
Supporting resources	• Safe staffing, safe workload questionnaire results • Patient Complexity Tool (once finalised) • Appendix: Workload Activity Split Calculator • BDA Resource: • 'Influencing Action Pack for Dietetics' • Toolkit: calculation to show process for calculating staff requirements • BDA Resource: Caseload Management 2012 • BDA Resource: Caseload Management Toolkit

Capability

The following table summarises the key information required in order to assess the safety of a dietetic workload from a capability perspective,

Capability assessment of Individual staff member	• Skill set and experience • Competencies achieved in specific areas of work • Adherence to best practice and latest clinical guidelines • Frequency and outcome of practice supervision and peer review • Record of training and education received (including mandatory training) • Preceptorship completion • Audit/ service development work completed • Evaluation of training provided to others • Feedback from dietetic peers, AHPs and other HCPs • Patient experience
Capability assessment of team or department	• Adherence to clinical guidelines and latest evidence base • Outcomes achieved due to dietetic interventions • Patient experience metrics • Outcome and frequency of peer review and practice supervision • Education and training record and ongoing programme of development opportunities

	• Feedback from students on clinical placements • Patient experience
Supporting Resources	• BDA Resource: Model and Process for Nutrition and Dietetic Practice • BDA Resource: Standardised language terminology • BDA Resource Practice Supervision • Patient feedback e.g. Friends and Family test

Safety

No data can provide absolute certainty about how safe the care of an individual patient or staff member can be; however, safety indicators can be used to indicate the likelihood of potential problems. NICE described safe nursing indicators and red flags as considerations to indicate unsafe staffing levels. The same system is used here; those indicators with an accompanying red flag should alert dietetic managers that they may need to take immediate action to ensure patient safety.

Patient related indicators	• Timeliness of patient care (including referral to treatment time and unmet need) • Waiting list metrics • Patient experience metrics • Outcomes of dietetic intervention
Dietitian or support worker indicator	• Being asked to work outside scope of practice • Frequency of in date mandatory training • Frequency of in date appraisals • Frequency of workload concerns • Frequency of work-related stress • Staff sickness rate • Frequency of working above contracted hours in order to complete work • Level of working overtime • Frequency of practice supervision • Amount of time provided for supervision of students on their clinical placements • Number of CPD opportunities and number of staff freed up to attend • Number of opportunities for service development • Frequency of training of other HCPs • Level of input to MDT teams
Service-related indicators	• Performance data • Adequacy of in date nutrition related guidelines and policies • Frequency of clinical incidents and near misses

	• Inadequate delegation to support workers • Non-dietetic members of MDT provide nutrition advice instead of Dietitian • Number of staff vacancies • Recruitment and retention rates • Ability to recruit appropriate staff • Level of reliance on temporary staff, bank and agency staff • Departmental level of work-related stress, sickness • Level of staff engagement • Level of staff morale • Frequency of complaints • Feedback from students on clinical placements • Adherence to adequate auditing schedules • Results from peer reviews • Benchmarking data

Summary
With many conflicting priorities, adjusting the balance of workload activities to address safety concerns can be a complex task and may require review of service provision and not just an individual or teams' workload management. It is important to think holistically and innovatively when addressing workload issues, taking into account all the triangulating factors, whilst keeping the impact on patient care at the forefront of one's mind, will enable the most informed decisions to be made in the interest of patient safety.

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Members of working group
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Supplements

Recommended safe staffing levels from BDA specialist groups
Members from specialist groups

During the time this project was carried out, the BDA Specialist Groups were asked if they have any staffing guidelines currently in place to help with establishing safe staffing levels.

The guidance below was received from those groups who were able to provide information.

Cystic Fibrosis Specialist Group

0.5 FTE/75 patients, 1.0 FTE / 150 patients, 2.0 FTE / 250 patients. For paediatric patients with CF the figures are 0.5 FTE/ 75 patients, 1.0 FTE/150 patients and 1.5

FTE / 250 patients. These recommendations were made in 2011. Travel time not factored in.

Critical Care Specialist Group

Recommend 0.05 - 0.1 FTE RD/ critical care bed

Diabetes Specialist Group

The only guidelines are those produced by Diabetes UK who advise 4 x FTE RDs / population of 250,000. ISPAD guidelines recommend 0.5 FTE RD/100 young adults under the age of 19 with Diabetes.

Food Allergy Specialist Group

No guidelines available

Gastroenterology Specialist Group

The only guidelines in place are for OPD appointment slots of 30 minutes each.

Mental Health Specialist Group

Only guidelines are for 0.5 – 1.0 FTE RD per 10 – 12 inpatient beds for people with eating disorders

Neuroscience Specialist Group

For specialist rehabilitation 0.75 – 1.0 FTE RD per district

For long term neuro conditions 2.0 FTE RDs per district

Stroke services 0.15 FTE RDs per 5 inpatient beds for hyperacute and acute stroke units

Obesity Specialist Group

No guidelines

Older People Specialist Group

No specific guidelines, but a proportion of patients do not require 1:1 consultation e.g. care and nursing home settings.

Paediatric Specialist Group

No guidelines

Primary Care Network Dietitians

Only guideline is 30-minute OPD appointment slots

Renal Nutrition Group

Inpatients: 0.05 FTE RD /bed. 0.06 FTE RD/ Renal HDU bed and 0.15 FTE RD / Renal ICU bed.

Outpatients: 60-minute new appointments and 45-minute review appointments.

Dialysis: 4 hours p.a. / patient.

However, 60% Renal RDs express safety concerns at these levels of service.

NB. No responses were received from the other Specialist groups within the BDA.