BDA The Association of UK Dietitians

Workload Management

Contents

Introduction

The first BDA document focused on caseload safety was produced by the Professional Development Committee of the BDA in March 2001, and in many ways the guidance has not changed. One of the most frequent enquiries to the BDA to this day is still the request for definitive answers to questions on active caseload per specialty/grade. Many dietitians express apprehensions about the safety of their practice as the workload increases beyond that previously expected of them.

The cost of healthcare in the UK continues to rise each year with ever increasing demands on limited resources, made by our patients, clients, employers and indeed each successive government. It has become increasingly important that we look closely at our services and decide how best we can deliver on these demands, safely and effectively.

Concerns over losing dietetic positions due to re-organisation and efficiency measures as services become rationalised are ongoing. These concerns have not changed nor are they likely to in the future. It is perhaps vital now more than at any other time to engage with the public health agenda as dietitians have a key role to play in this. Without considering prevention rather than cure, caseload and capacity issues can never fully be addressed.

The BDA's sister document to this entitled *Safe Workload, Safe Staffing* outlines what is meant by both a workload and a caseload and defines the dietetic activities which, make up a professional role. It provides data and benchmarks as well as tools to help assess capacity and capability for a given situation.

This *Workload Management Guidance* brings together advice from a professional ethical standpoint and an employment relations standpoint. It is by its very nature difficult and contentious to address safe workload from the point of view of the patient, the service, the employee (health professional), and the manager, but all aspects are inextricably linked. All parties have a responsibility to address workload – the dietitian, the manager and the employer – each with their own roles and responsibilities. We have tried to reflect all sides and have identified these as far as possible.

This paper will not by any means address every member's individual circumstances including grade, case complexity, specialty, domain etc. It does, however aim to describe the key features of a workload and provide guidance on the elements which should be considered when assessing any individuals workload. It also aims to provide some assurance as to the legal stand point before deciding whether to take further action or not.

Duty of care

Duty of care basically describes a personal responsibility to service users to practice safely and effectively. The difficulty lies in assessing when practice moves from being safe to unsafe. This assessment is complex and multifactorial in nature, but if done right, will help to focus on what action can and should be taken to re-establish safe and effective dietetic care.

Assessing Workload

Assessment of workload should never be undertaken in isolation, but in conjunction with the team leader/line manager and each will have their own role in the process. The boundaries, not surprisingly, cannot clearly be defined, but as long as individuals know what is expected from them at the outset, then this should not affect progress with the process.

There are five key aspects to consider when assessing safe caseload:

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

1. Benchmarking

In clinical practice benchmark measures can be used as guidance and can be developed as a tool for clinical governance within the healthcare professions.

As stated previously, the question of active caseload per specialty/grade is one of the most frequently asked questions received at the BDA, but is also one of the hardest to answer. No two services or patient populations are ever going to be the same. For example a clinical community caseload in the Highlands of Scotland is going to look very different to the clinical community caseload in Tower Hamlets, London. The BDA *Safe Workload, Safe Staffing* document provides some general benchmarks for the profession as a whole. Some BDA Specialist Groups have surveyed within their specialty and published more explicit benchmarking figures. It is worth noting that some of these benchmarks are older than others and this must be taken into account when using the figures. It is the responsibility of all dietitians to keep up-to-date with current practice in their specialty.

In 1996, The NHS Benchmarking Network was established (www.nhsbenchmarking.nhs.uk). It is a national organisation set up to help understand the wide variation in demand, capacity and outcomes evident within the NHS and define what good looks like. The network supports providers to deliver optimal services within resource constraints, whilst also allowing commissioners to achieve the best balance from available commissioning resources. There are various projects which the network has set up to fill gaps in existing national data, and these include staffing and capacity in dietetics.

Benchmark figures on their own do not describe a safe caseload, but by using the following guidance, it is hoped that members can make a more informed, and personally relevant, assessment of their workload.

2. Practice Supervision

Dietitians should regularly reflect on their skills, knowledge and experience to meet the required person specification, and thereby competence to undertake the workload. This is by no means a reflection on the individual personally, but more a review of the role itself, alongside expectations of the team perhaps, and any other additional responsibilities which may have changed over time.

Time management skills or decision making skills are also both qualities that can be addressed, but are often avoided because to do so could be perceived as admitting a personal shortcoming. In supervision sessions it is important that some focus is made on reflecting on the role, expectations, caseload, opportunities for training and education, and overall to put issues into perspective. This should be based on the most recent appraisal, personal development plan and action for continual professional development.

Practice supervision and reflection should not be used as a management tool to assess capability.

3. Good Practice

This can be identified through local/national standards and professional clinical guidelines, NICE/SIGN guidelines, quality improvement groups, professional consensus, HCPC Standards of Conduct Performance and Ethics, HCPC Standards of Proficiency and BDA Code of Professional Conduct.

Local standards based on national standards, referral protocols, should all exist in some form to support procedures for working. Use of any information and access to it is also of importance. The systematic recording of workload activity (including any changes) along with audit data collected, will provide an evidence base.

4. Job Description/Contract of Employment

Before beginning to assess workload, dietitians should take the time to look over their specific job description and contract of employment. All employees should have their own copy of this (although an additional copy can be requested from the Human Resources Department).

This should be checked for compatibility with the work actually undertaken. Does the job need to be re-evaluated? Are there activities which have been picked up over the years for one reason or another which are not in the job description? If so, consideration should be given to whether these are still necessary. Any decision to stop undertaking a particular activity should be discussed with the line manager first. The line manager may simply be able to remove the task or delegate them elsewhere more appropriately. It may be that a business case is needed for additional departmental staffing/resources.

5. Risk Assessment

Risk can be defined as the probability that a specific adverse event will occur in a specific time period or as a result of a specific situation. This is addressed in greater detail in the next section.

Risk Assessment

Clinical risk assessment helps to identify the degree of harm which could arise from any given activity or intervention. This is very different from personal risk assessment for the individual dietitian. This assessment will establish whether the individual employee is themselves working in a safe and healthy environment. These two aspects are considered separately. Employee risk assessment is addressed in *Toolkit One*.

Clinical Risk Assessment

Safe is defined in the context of this paper as being the ability to provide a service which will ensure patient care is delivered, which meets local and national standards and minimises the potential to do **harm**. This applies to any dietitian whether they work within or outside of the NHS, whether in the field of clinical or preventive practice.

The National Patient Safety Agency has previously described four aspects of harm and these are still relevant. Often in the healthcare setting these levels provide the basis behind frameworks for incident reporting in a world where improving safety culture through openness is high on the agenda.

No harm is where an impact has been prevented – any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving NHS-funded care.

- **Low:** any patient safety incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving NHS-funded care.

- **Moderate:** any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care.

- **Severe:** any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care.

- **Death:** any patient safety incident that directly resulted in the death of one or more persons receiving NHS-funded care.

Most health interventions have the potential to do harm and a major aspect of assessing safe workload is recognising the level of harm which may arise from dietetic interventions. Above all it will be the judgment of the individual dietitian which will ultimately decide whether an activity or intervention is safe or not.

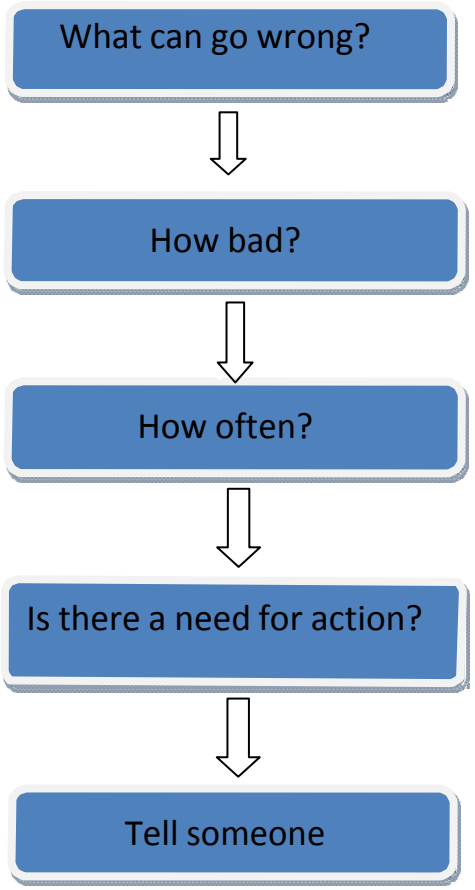
It is important to gather the evidence of unsafe practice, for example recording and reporting clinical incidents which illustrate where things go wrong.

All NHS organisations will have a *Clinical Risk Strategy* and also a Clinical Risk Manager. Dietitians should be aware of the risk management structure, reporting mechanisms, strategy and policies within their organisation.

Risk management is a component part of clinical governance and aims to improve patient safety by using the following approach:

- identifying what might go wrong (risk assessment)
- determining the chances of, and the impact of, things going wrong
- monitoring adverse events
- minimising the chances of them happening (or their impact)
- learning from what has gone wrong.

This can be done by asking a few simple questions illustrated below:



Roles and Responsibilities

Before addressing individual roles, it is important to stress that it is the role of everyone in the dietetic team to have an awareness of the context within which they work including – number of staff; key stakeholders; other AHP services; budgets; local & national policy; and political drivers to name a few. The depth to which dietitians know and understand this context will, of course, depend on the level of the post.

1. The Role of the Dietetic Manager in Managing Workload

Managers have a duty of care to investigate if staff raise concerns about workload – this may include undertaking workplace risk assessments and occupational health assessments. Organisations have different structures for strategic and operational accountability and management. Commonly, the dietetic manager has the overall responsibility for the provision of the service where one or more dietitians are employed. However, it is not uncommon, where no dietetic manager exists, that some of these (if not all) functions will be undertaken by a line manager, e.g. therapy manager, section manager in conjunction with a professional lead/team leader. Within the management function there is an overall responsibility to plan, organise, motivate and deliver a defined level of service. The rapidly changing NHS and business environment requires flexible staff, but changes in workload, caseload and scope of practice need to be negotiated with individual dietitians. Managers have a key role in driving any action plan. Caseload issues must be resolved by consulting with the key staff involved.

The following points must be addressed:

- **Planning**: decide the dietetic objectives or goals and how to meet them, this may be through strategic and/or business planning.
- **Organisation:** determine dietetic activities and allocate responsibilities undertaken in conjunction with other members of the dietetic or multidisciplinary team.
- **Motivation & development:** meet the social, psychological, professional and development needs of staff in the fulfilment of their goals.
- **Delivery:** monitor and evaluate activities and provide feedback mechanisms to the team members.

(i) Planning the Service

Ensure the staffing levels meet the expectations of stakeholders/customers and the needs of service level agreements. Variation in work patterns and activity can often be foreseen and included in the annual business plan. Plans should be in place to cope with annual leave, a quantified level of sickness absence, clinical supervision, staff turnover and study leave. All staff should be fully informed of this and contingency agreed. Arrange to meet key individuals (e.g. team managers, professional manager, key clinicians), inform them and take advice on how best to alleviate the situation.

Managers will need to consider several options in addressing safe caseload for example, is the current wave of demand for the service seasonal and best confronted by working flexible hours for a short period, or does it require the funding of overtime hours? Is this an indicator of long term demand, which needs to be monitored more carefully, and a needs assessment carried out involving others?

(ii) Organisation

All staff need to be orientated to their duties in order that they fully understand the responsibilities and expectations placed on them. If staff have to carry out other additional duties normally performed by someone else in the department, shadowing is an excellent method of training. Dietitians, who have a responsibility for students-in-training, must be capable and confident of supervising students, and have adequate time, without compromising other duties within their remit. The clinical dietetic trainer must be involved in assessing this risk.

(iii) Motivation and Development

Leadership is an important factor to provide empathy while acting on issues of unsafe practice. Personal development plans and continuing professional development (CPD)/training must be addressed throughout the business plan cycle. While formally setting objectives and discussing CPD, these areas should be revisited as and when appropriate.

(iv) Delivering the Service

If staff raise concerns about managing their workload, the manager has a responsibility to investigate and provide support to help resolve the situation. If the workload is found to be genuinely unmanageable, the manager needs to consider whether the workload can be redistributed, or whether part of the service should be withdrawn. They are also responsible for escalating concerns to senior managers within their organisation. Carrying out a workload audit is helpful, not only in terms of caseload but also in identifying how dietitians are spending their time. Effective time management is vital.

2. The Role of the Dietitian in Managing Workload

A dietitian must:

- Participate in any orientation or supervision provided for all, mutually agreed, new duties.
- Attend departmental meetings and voice opinion. Contribute to the discussion.
- Identify the service level expected and formalise this with management into performance targets with a review date. Until there is a baseline of the standard of service anticipated, there can be no real argument. (Some posts necessarily require innovation and the duties are not prescriptive but the post holder has to agree this at recruitment or when a change is agreed).
- Report to senior staff before compromising the service to below local standards. A reasonable measure of adaptability, flexibility and a willingness to respond to local needs will be expected.
- Help to gather evidence for any workload review.
- Consider and suggest different ways of delivering the service.

Challenging Workload Issues

There will be occasions when despite every effort being made to rectify the issues which have led to concerns about workload, a more formal approach may be required to address them.

The advice for challenging concerns about individual workload (be they a dietetic assistant, entry level dietitian or a manager) will be different to challenging an unsafe service caseload. Managers may have legitimate concerns that if a particular aspect of the service cannot be provided safely, then it may need to be withdrawn completely resulting in potential redundancy and redeployment. It is not within the scope of this paper to address a process for managers who need to address workload of the whole department/team or a particular aspect of the service. Managers will need to seek separate advice for this.

The steps and checklist we have described here are for the individual practitioner to challenge their own caseload.

1. Step One – informal Discussion

Discuss your concerns informally with your line manager or department manager and agree an action plan to address these. Either ask the manager to document the outcome of your discussion in writing or document it yourself.

2. Step Two – BDA Support

The local BDA Trade Union Representative or a BDA Policy Officer should be contacted for assistance and support, they will be able to give direction on how to find the right information to help with a specific problem, for example the employer's local policies, BDA Trade Union best practice and BDA Trade Union advice leaflets, BDA practice guidance and clinical guidelines. There is also information readily available on the BDA's Professional and Trade Union web pages.

3. Step Three – Gather the Evidence *(see also Toolkit 3)*

All the evidence in support of the specific issue should be collected together, including the employers expected clinical and performance standards, along with reasons why they cannot be met. Policies and protocols that risk being breached should also be included.

It is helpful to document details of waiting times, activities that cannot be completed, overtime being worked regularly, potential risks to patients and any impact on outcomes. Use incident reporting where appropriate. Ask for advice on how to prioritise your work with competing demands on your time and also what information you need to collect to support your case for excessive caseload.

Detail faulty, unsafe and inadequate equipment and highlight any lack of facilities. Staff shortages due to long-term sick or maternity leave should be included and also any recent risk assessments or staff surveys that support the case.

4. Step Four – Course of Action

The next step is to bring together all the information gathered and investigate all the options. Management support, together with collaborative working and communication will be crucial in deciding on and following through with any course of action. There is a joint responsibility to resolve issues, wherever possible, informally together with your immediate manager or their manager should the issue be about them or their actions.

- Being able to say 'no' nicely is a skill that needs to develop from the beginning of training, but is not easy. However, the responsibility for restricting services is ultimately the decision for the service manager/team leader.
- Show the reality of the situation, provide statistics, explain the problems, and communicate any actions in response to the situation.
- Gain support from those who can influence e.g. consultant, ward nurse, team leaders.

5. Step Five – Formal Action

If all informal routes to resolving caseload issues have been explored and exhausted, then consult with the BDA Trade Union Representative, as there will almost certainly be a requirement for their support from this point on. It is important to seek advice from the BDA Trade Union at an early stage to prevent any unnecessary escalation. It is always possible that a local representative or National Employment Relations Officer could negotiate a solution without recourse to formal action. The BDA Trade Union Representative will be able to assist in the compilation and setting out of any concerns in writing. The scale of the issue needs to be determined, along with identifying all those affected by the problem.

Where there is a concern about a duty of care not being met, you need to ensure that your concerns are not simply due to a difference in professional opinion, as this could result in possible “false claims”, and will be viewed very seriously. The BDA Trade Union can advise on this.

Consideration should be given to the whether the issue is an individual matter or a collective issue. If it is a collective issue, the matter needs to be discussed with colleagues, as they will be equally responsible and accountable. They must be kept in the picture with regards to progress and activity via staff meetings or Trade Union newsletters, again the BDA Trade Union Representative will be able to assist with the dissemination of this information. In the event of a collective issue, it is important that the local rep and/or the National Employment Relations Officer is informed as there may be trust wide implications or reasons which should be raised at the Joint Negotiating Committee.

Concerns must be put in writing to the relevant manager and (unless local policy requires the completion of a pro forma) this should be put into a formal letter. The information should be clear, detailing the concerns, and accompanied with any supporting evidence. Although there doesn’t need to be a huge amount of detail, there should be reference to any possible breaches of protocol, codes of practice or employers’ policies, whilst highlighting the risks to both patients and staff.

It is important to consider what outcomes would be acceptable, and management will be expected to respond in writing to the concern listing what tasks can be carried out safely, and what cannot. Management will also need to outline any intended interim measures e.g. increase staff/share workload or tasks.

Local policies will outline any timescales to be followed in terms of the manager’s response. A follow up letter may be necessary, requesting a response as a matter of urgency before escalating the matter to the next tier of management.

Once there is a response to the letter of concern, there should be a letter confirming the expected process. This should make clear the timescales of meetings and any discussion. From this point on all correspondence including any proposals must be kept confidential.

If after following these steps, concerns have not been addressed adequately, then local TU Representatives should contact the BDA Trade Union Office for further support.

The BDA Trade Union provides the same level of representation for all of its members and is mindful that managers can also be members who may request from time to time advice or representation.

In the likelihood of any conflict of interest, all parties will be provided with their own representative and will in all instances be afforded equal representation.

Conclusion

This document provides no definitive answers to workload management. Each situation is unique, but one can learn through experience, the support of others and recognising a situation before it spirals out of control. There is never a quick solution to workload issues, but as far as possible, the dialogue between employee and manager should be kept open.

Ensuring a defined level of service e.g. referral criteria, local standards and protocols, is the beginning. Working with others to develop care pathways can provide outcomes which make caseload management more predictable. Keeping the BDA informed of any benchmark data available will help build the national picture for a given specialty. Workload management is part of dietetic practice and workload management is part of the quality service we would all expect to deliver (and as individuals receive) in healthcare today.

Toolkit One – Work Related Stress & Personal Risk Assessment

Work related stress is different to pressure. Some degree of pressure on a regular basis is not harmful as it can be motivating, and this in turn can help us perform better. There is no doubt that constantly high caseload demands can lead to pressure and it is hoped that through management support, together with collaborative working and action planning, this pressure can be reduced to an acceptable level. However, although most jobs will have an element of pressure, it is important not to become immersed in pressure over prolonged periods of time. Pressure turns to stress when individuals experience too much pressure without the opportunity to recover.

The Health and Safety Executive definition of stress is ‘the adverse reaction a person has to excessive pressure or other types of demand placed upon them’.

Stress affects people in different ways and at different times, it is usually caused by a combination of factors that is going on in both our personal and our working lives. Often just being aware of all the factors causing stress can help. Simple measures can be taken to alleviate or reduce the level or frequency of stress. If there is no improvement or the stress factors cannot easily be managed, it is important that this is brought to the attention of management and professional advice sought.

1. Management Standards

Tackling work related stress by working with the employer will assist both the employee and the employer by agreeing both workable and realistic ways of tackling the cause. The Health and Safety Executive produced *Management standards and guidelines on work-related stress for employers and employees and their representatives* is available at: http://www.hse.gov.uk/stress/

The *Management Standards* cover six key areas of work design that, if not properly managed, are associated with poor health and wellbeing, lower productivity and increased sickness absence. The six management standards cover the primary sources of stress at work. These are:

1) **Demands** – issues such as caseload, work patterns and the work environment.

2) **Control** – how much say the individual has in the way they do their work.

3) **Support** – encouragement, sponsorship and resources provided by the organisation, line management and colleagues.

4) **Relationships** – promoting positive working to avoid conflict and dealing with unacceptable behaviour.

5) **Role** – people understand their role within the organisation and the organisation ensures that they do not have conflicting roles.

6) **Change** – how organisational change is managed and communicated within the organisation.

The Health and Safety Executive believe that, if present, these standards would reflect a high level of health, wellbeing and organisational performance.

The *Management Standards* will:

1) Demonstrate good practice through a step by step risk assessment.

2) Allow assessment of the current situation using surveys and other techniques.

3) Promote active discussion and working in partnership with employees to help decide on practical improvements that can be made.

4) Help simplify risk assessment for work related stress by:

- Identifying the main risk factors for work related stress.
- Helping employers focus on the underlying causes and their prevention.
- Providing a yardstick by which organisations can gauge their performance in tackling the key causes of stress.

2. The Employee's Role in Managing Stress

Dietitians should:

- Contact their BDA representative to see what role they can play in making the workplace as safe as it can be.
- Attend any training courses arranged by their employer which will help with understanding how to deal with stress.
- Locate and familiarise themselves with employers' local policies and look at them in conjunction with the HSE's risk factors and *Management Standards*.
- Consider volunteering to sit on discussion groups and taking part in risk assessments. Helping to develop effective plans is key to ensuring a positive attitude to workplace wellbeing as well as addressing colleague's health and safety at work. A positive attitude towards health and safety is an effective way of building good working relationships.

(i) The Employer's Responsibility

The employee has a right to have their health and safety at work protected and as such the Health and Safety (Consultation with Employees) Regulations 1996 (8) requires the employer to consult with his/her employees or their representatives on any matter that affects their health or safety at work. This includes a risk assessment and action plan to manage the causes of work-related stress.

(ii) Personal Risk Assessment

This issue is complex and this guidance document only aims to highlight the main points. If a formal risk assessment is to be carried out, then the Management of Health and Safety at Work Regulations 1999 (MHSWR) impose a specific duty on employers to carry out a suitable and sufficient assessment of all risks to the health and safety of employees and others, arising at or from a work activity.

The employer/line manager does not have to carry this out themselves. Regulation 3 of the MHSWR states that a risk assessment must be carried out by a competent person for the purpose of identifying the measures that employers must take in order to comply with their duties under all applicable health and safety legislation.

Who is a competent person? It is the employers' responsibility to ensure that those carrying out assessments are competent to do so. The assessor should have an understanding of the workplace, an ability to make sound judgments and knowledge of the best practicable means to reduce those risks identified.

Competency does not require a particular level of qualification, but may be defined as a combination of knowledge, skills, experience and personal qualities, including the ability to recognise the extent and limitation of one's own competence.

Although an employee must never be pressured into undertaking an assessment, it would be helpful to engage and input to the process, as no one will understand the role better than the individual undertaking it.

It is best practice to have more than one person doing the risk assessment, it may also be useful to have someone with similar competencies, but who does not know the job or area, as they see things that are taken for granted and not seen as a risk or hazard by a regular worker in that area.

A general risk assessment can be carried out which may lead to a more detailed assessment of specific risks.

There may also be a need to look at other regulations within the *Health and Safety at Work Act*.

Toolkit Two – Elements of a Workload – Dietetic Activities

A professional workload is that work which can be dealt with/undertaken by 1.0 WTE dietitian. In total it will comprise all those elements which together constitute the defined activities of a professional dietetic role.

1. Care Contact Time (Patient Focused Activity)

Defined as that time a dietitian spends on work which is directly associated with patients and is made up of direct patient contact and indirect patient activity:

(i) Direct Patient Contact

Usually face-to-face contacts with patient and/or carer/family and including all the related activities such as note writing. Other direct contact methods include telephone, email and skype.

(ii) Indirect Patient Activity

All those tasks that do not involve direct communication with the patient of their representative but are focused on the patient. For example ward rounds, case conferences, MDT meetings, telephone calls, acquiring and collating information, writing letters and case reports, preparing patient information, etc. Also helping to facilitate patient goals for example working with catering/diet kitchen specifically for a given patient.

2. Staff Focused Activity

Such workload elements include:

(i) Teaching and Training of Others within and Externally to the Employer Organisation:

- Health care workers e.g. dietetic peers, AHPs, medics, nurses, social workers, support workers students, diet cooks.
- Those from outside agencies/external bodies e.g. prisons, higher education institutes.
- Student training (dietetic and other students).

(ii) Dietetic Management

Managers of dietetic or therapy services carry combined clinical and strategic/operational managerial responsibility for the work of the service. In a clinical service such as dietetics, the clinical management responsibilities may be delegated to senior staff, and may form a significant proportion of their workload. This part of staff focused activity includes those tasks which require professional knowledge and experience and for which clinical responsibility is reserved.

(iii) Staff Management

- clinical supervision
- leading personal development reviews
- mapping staff to service to ensure efficient and effective use of resources (skill mix)
- monitoring and analysis of staffing levels and workloads
- recruitment and induction of staff
- staff development and training
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3. Service Focused Activity

The higher the grade of dietitian the more types of service focused activity they will be involved in.

(i) Service Management

- service development/redesign related work
- preparing clinical service plans and business proposals
- catering/menu planning activities
- strategy group/committee meetings and related work
- policy development activities
- managing complaints
- compiling reports
- staff returns
- routine budget monitoring
- day-to-day department administration e.g. supplies, ordering, contracts
- personnel matters e.g. sickness/absence monitoring, travel claims
- management of departmental clerical staff
- health and safety
- corporate governance.

(ii) Clinical Governance Related Work

- clinical audit and research
- clinical effectiveness/governance work to further dietetic practice e.g. standard setting, developing risk assessment
- standard monitoring
- monitoring quality and outcomes
- development of multidisciplinary protocols.

4. Self-focused Activities

(i) Professional/Personal Development

- mandatory training
- any continuous professional development activity
- journal clubs
- professional portfolio completion
- shadowing
- receiving clinical supervision
- reflective practice
- receiving appraisal/performance review
- study leave.

(ii) All Other Activities

Work for/on behalf of the profession

This includes work that does not fall into the above categories:

- BDA work e.g. membership of working groups, Boards and Council
- Representation/membership of other bodies e.g. NICE/SIGN guideline development, Parliamentary Cross Party Groups, health department steering groups
- Employment relations work e.g. partnership forums, TUC, and Trade Union Representative

This includes activities such as:

- Travel
- Networking
- Secondment e.g. Professional Executive Committees of PCTs (PECs), Health Boards.

Variable Factors Affecting Workload

In addition to the identified elements of a workload, there may be other variable factors within the locality, which may put considerable pressure on the workload. These are identified below for consideration.

1. Population Served

The specific needs of the local population will differ according to the locality. This may affect the management and provision of services. The identification of specific groups within the population who require specialist levels of skill and competence will affect workload and caseload, for example cultural variability, age profile and social circumstances.

2. Settings

Dietitians provide services in many settings. For example a patient's home, GP practices, acute adult hospitals, rehabilitation facilities, and paediatric hospitals, etc. The setting and the support systems available will not only affect provision of direct treatment, but also patient related work, e.g. communication with carers, other agencies and local authorities.

3. Manpower/Service Relationship (Critical Mass)

Nutrition and dietetic services vary in sizes, some with just three or four in a department whilst others have as many as sixty or seventy dietitians within one Trust. There will be a minimum number of staff within any department or team which is necessary to ensure safe practice when underpinned by appropriate prioritisation. The service manager must inform the organisation when the necessary skill and competence is not available within the team, otherwise staff will be breaching their duty of care. This in itself is not easy to judge. Often, another member of staff in another team can be supported to provide cover in such circumstances, especially if it offers them a training and development opportunity.

4. Bed Occupancy/Length of Stay

Changes in health care provision, for example pre-operative and an increase in outpatient treatment and day cases have led to a reduction in the number of inpatient days. Treating patients in an outpatient setting rather than on an inpatient basis will affect length of initial contact and the number of follow ups. Reduction in the length of hospital stay may also affect the location of follow up. Reduction in early hospitalisation may result in the admission of sicker or more complex patients, which will affect skill level and expertise/competency of the staff involved within the acute/community unit.

5. Complexity of Caseload and Intervention

The complexity of the caseload will have an impact on the time needed for each consultation and the frequency of the consultations. This should be considered when assessing the resources required in a given situation.

6. Input Hours

Below a number of quantitative measurements are identified for which individual nutrition and dietetic services should have useful supporting data, and which can be factored into the overall framework:

- **Current caseload**:
  The number of cases for which 1.0 WTE dietitian is carrying responsibility at a point in time i.e. all patients a dietitian has assessed and is dealing with, and have not yet been discharged.
- **Weekly/daily/annual contacts:**
  The number of direct or indirect patient contacts that a 1.0 WTE dietitian carries out in a given period.
- **Frequency of treatment**:
  The number of times a patient can be treated in a time period in relation to the current caseload.
- **Potential caseload**:
  Unmet need, number of patient referrals on waiting list/refused care.

7. Processing a New Referral

When the nutrition and dietetic service receives a referral, there is a duty of care to assess and act accordingly. If the referral is inappropriate, this should be discussed with the referring practitioner. A time element is attached to any decision relating to the process.

8. Skill Mix

Historically, nutrition and dietetic services have consisted of trained professional staff, catering staff and limited administrative and clerical staff. In recent years, departments have embraced the dietetic helper grade and to date there are now two recognised levels of dietetic support workers. It is essential that there is an appropriate match between the work to be done and the skills necessary to do it. Skilled clinical time may be misused for arranging appointments, answering telephones, obtaining records, filing and collecting routine data when clerical help could be more effective and cheaper.

9. Health Informatics

(i) Documentation

Duplication of information in record keeping may occur if there is a combination of systems in use to record information, for example having paper records alongside electronic records. Also having different electronic systems to record the same information but for different purposes. Duplication is wasteful of resources of both manpower and time, and needs to be acknowledged as healthcare records become more digitalised.

(ii) Availability and Use of Information

Hospital information systems are now more sophisticated and permit access to patients' information, e.g. PAS (Patient Administration System) or PATH (pathology results). Patient- related information is much more accessible and timely, though many departments still need to generate their own appointments, letters, and discharges.

(iii) Management Data

Manual management of departmental data has been the norm and can be incredibly time consuming. However, all departments should actively seek to access an electronic system for data management. There are now packages available, and in some areas home-grown systems, which can help to collect and collate relevant management data for use with business cases etc. The sophistication of such systems will affect workload and needs to be built into any patient- related or non-patient-related calculations. Having an electronic system will help to ease the burden of data collection and analysis.

10. Travel

Travel could be a significant time issue and should be considered as an average when calculating patient-related work. Travel may be:

Internal:

- Between wards and departments on site. An audit should be made on an individual activity diary for the percentage of time spent on daily site travel.

External:

- Between department and GP clinics, health centres or other designated outreach centres
- Between department and patient's home
- Between Trust hospital sites where there is more than one hospital within the Trust and service provision is a Trust-wide speciality across the different sites

Toolkit Three – Checklist for Assessing Workload

It is important to remember that your duty of care is first and foremost to those service users already on your caseload, so you should not accept referrals for new patients if you are not able to manage them – but discuss this with your line manager first.

1. Have you gathered all the evidence/data?

   - benchmark data ☐
   - audit data ☐
   - service specification ☐
   - workload evidence (Toolkit 2) ☐
   - ☐

2. Do you have your job description? ☐

3. Is there anything else affecting your ability to carry out your workload? ☐

4. Has a risk assessment been undertaken? ☐

5. Have you discussed the situation with your line manager? ☐

6. If so, are they in a position to help? ☐

7. If not, do you need to escalate to your department manager/someone above your line manager? ☐

8. How can you demonstrate that you are managing your time as effectively as possible? ☐

9. Could you improve your time management by delegating certain tasks to your admin colleagues, support workers or nursing staff? ☐

10. Have you considered different ways of working e.g. defer reviewing some patients, delay seeing new patients, see some patients less often without increasing risk, undertaking group education sessions, triaging referrals through prioritizing and protocols? ☐

11. Have you sought advice from the BDA? (Employment Relations or Professional Practice) ☐

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