Written evidence submitted by the British Dietetic Association  
(PHP0030)

Executive Summary

Para 1. Diet and nutrition forms the second largest modifiable risk factor impacting health. We must get the design and delivery of nutrition and diet related services and interventions right in order to make a real difference to the health of the nation. Dietitians are uniquely placed, as the only statutorily regulated experts in diet and nutrition, to help make this happen. This submission records the evidence, observations and experiences of dietitians working the field of public health after the transfer to responsibility for public health functions to local authority. They are submitted under four headings:

- The delivery of public health functions
- The effectiveness of local authorities in delivering the envisaged improvements to public health
- The public health workforce
- Public health spending

Para 2. The recent transfer of responsibility for public health functions to local authority has adversely impacted the role of dietitians who have specialised in public health as well as the diet and nutrition services and interventions that they have led and delivered. The effects include:

- Adverse impact (including duplication of work, gaps in service and lack of clinical governance) on the delivery of diet related public health functions e.g. weight management services
- Errors or omissions in specifications for diet / nutrition services and unrealistic outcome targets. All of which are due to lack of diet/nutrition expertise at local authority level.
- Poor morale and resignation of public health dietitians and the subsequent loss of public health related diet and nutrition expertise and experience.
- Lack of nutrition knowledge amongst public health workers leading to the public being given incorrect information and advice which could be dangerous.
- Short term savings do not help long term public health: what might be seen as a saving made by not employing band 6 or 7 specialist public health dietitians in local authorities may result in poor advice being given to the public and ineffective public health services for all the reasons stated above - under all the headings.

Para 3. This paper makes four recommendations for action by the government which will help resolve the problems outlined in the document. The main thrust of these recommendations is to ensure that dietitians are involved in the design and delivery of nutrition and diet related activities and also to ensure that dietitians are involved in the training in nutrition of the wider public health workforce.

Introduction:

Para 4. I am the Policy Officer for England working for the British Dietetic Association. Registered dietitians are qualified health professionals that assess, diagnose and treat diet and nutrition problems at an individual and wider public health level. Uniquely, dietitians use
the most up-to-date public health and scientific research on food, health and disease, which they translate into practical guidance to enable people to make appropriate lifestyle and food choices.

Para 5. Dietitians are statutorily regulated, with a protected title and governed by an ethical code, to ensure that they always work to the highest standard. The spectrum of environments in which dietitians practise is broad and includes the NHS, private practice, industry, education, research, sport, media, public relations, publishing, non-government organisations and national and local government. Their advice influences food and health policy across the spectrum from government to local communities and individuals.

Para 6. The title 'dietitian' can only be used by those appropriately trained professionals who have registered with the Health Care Professions Council and whose details are on the HCPC website. We have a leaflet that explains the roles of nutrition professionals further.

Para 7. Much of evidence we are submitting is anecdotal and reported by dietitians working in public health specialty. For various reasons they cannot be attributed to a particular local authority or CCG or NHS Trust to protect the source of the information and also because Trusts which lose contracts to deliver public health functions are often reticent to admit this. The evidence, experiences and observations submitted below are divided into four areas:

A. The delivery of public health functions
   - Lack of clinical governance procedures in new services.
   - Duplication of work: Teams that were working together now working in different organisations leading to duplication of work such as resource preparation.
   - Gaps in services as new providers in Local Authority choose to cover certain roles and not others e.g. specialist weight management services for people with comorbidities
   - Decommissioning of highly effective services delivered by dietitians e.g. specialist weight management services for people with comorbidities

B. The effectiveness of local authorities in delivering the envisaged improvements to public health
   - Lack of training in nutrition for public health staff leading to the public being given incorrect information and advice
   - Errors and omissions in service specifications:
     1. In one example a local authority had made an error in a service specification i.e. they had quoted out dated NICE guidance – CG43 instead of PH189 bringing in to question whether up to date guidance was considered when the service specification was written and also the competence of the person writing the specification (a dietitian would not have let this happen)
     2. In another example, physical activity is no longer always commissioned as part of some weight management services despite substantial evidence and guidance supporting its role in weight management (a dietitian would not have let this happen)
     3. In yet another example: The acceptance criteria on a weight management service were too vague and had the potential for patients requiring complex therapeutic diets to access the service and be given inappropriate advice (a dietitian would not have let this happen)
   - Unrealistic outcome measures are being demanded for some services: There is evidence of a lack of understanding within CCGs leading to them asking for some outcomes that no evidence base suggests is possible. For example, one lifestyle intervention, expected pre-adolescent children to lose 10% of their waist
circumference in 12 weeks. They also expected the providers to deliver the new service on day one of the contract, with no set up time. This demonstrates a lack of experience running community projects, which are very difficult to run successfully and a lack of specialist expertise in the setting of realistic and safe outcome measures.

C. The public health workforce
- Loss of unhappy, experienced public health dietitians who feel that their experience and expertise is not being used to good effect
- Clinical dietitians being expected to do public health and vice versa leading to loss of expertise and staff looking for new jobs
- Lack of nutrition training for new public health staff resulting in: Inaccurate information being given to the public: ‘Public Health colleagues who have had very basic nutrition training (1-2 days) have been seen repeatedly giving the public incorrect information and advice. ’
- Loss of capacity to provide student training as departments become smaller with some staff being moved to local authority. This means that there will be fewer dietitians with the right level of experience and education to do public health roles in the future.

D. Public health spending.
- In one example: No service for patients with complex clinical conditions had been considered, leaving a gap in service. This led to significant work for CCGs and the Trust to ensure that there was not a gap in service for patients. This had not been budgeted for as CCGs were not made aware that this gap would occur.
- Short term savings do not help long term public health: what might be seen as a saving made by not employing band 6 or 7 specialist public health dietitians in local authorities may result in poor advice being given to the public and ineffective public health services for all the reasons stated above - under all the headings.

Real example of the decommissioning of a highly effective service in one local authority:

Para 8. In one local area there is an Adult Weight Management Service led by dietitians for anyone with a BMI ≥28 with co-morbidities and ≥30 without co-morbidities. Care was provided by dietitians and/or weight management advisors/practitioners (AFC bands 3 and 4) depending upon clinical need. A robust triage process and supervision programme was in place. Non HCPC/NMC registered staff were trained in behaviour change levels 2 and 3, as well as training around nutrition and a variety of health conditions relevant to the role. Waistlines provided a robust service incorporating clinical and non-clinical weight management which allowed a smooth transition for patients when clinical needs changed.

Para 9. This service was previously commissioned by the local PCT in April 2012. In April 2013 the responsibility for commissioning of this service moved to the local authority. In October 2014 the service was served notice and was decommissioned on 30th June 2015.

Para 10. The local authority now commissions a county wide Healthy Lifestyles Service incorporating weight management (for children and adults), smoking cessation and alcohol reduction.

Para 11. Key Changes/points to commissioning:
Staff training is not required to be at the same level as the previous service (minimum requirements are: RSPH Level 2 in 'Encouraging a healthy weight and healthy eating' and 'Level 2 Certificate in Youth Health Champions')

There is no dietitian required within the service model or any HCPC/NMC registered staff.

Physical activity is no longer commissioned as part of this service despite substantial evidence and guidance supporting its role in weight management.

The original service specification quoted out dated NICE guidance – CG43 instead of PH189 bringing in to question whether up to date guidance was considered when the service specification was written.

Acceptance criteria for clinical conditions were vague and had the potential for patients requiring complex therapeutic diets to access the service and be given inappropriate advice as self-referral is an access route.

“Clients with a body mass index (BMI) greater than 28kg/m2 with co-morbidity(s) or clinical condition(s) or Clients with a BMI greater than 30 kg/m2 (*see below)

* this definition assumes that any existing co-morbidity or clinical condition is considered sufficiently stable by a medical practitioner to benefit from basic healthy lifestyle advice (healthy eating and physical activity advice) unless such advice would cause deterioration in a Client’s:
  • general health and wellbeing and / or
  • comorbidities and / or
  • clinical condition"

No alternative service for patients with complex clinical conditions had been considered, leaving a gap in service. This led to significant work for CCGs and the Trust to ensure that there was not a gap in service for patients. This had not been budgeted for as CCGs were not made aware that this gap would occur.

**Recommendations for action by the government:**

Para 12. Below are four recommendations that aim to both rectify the issues described above that have occurred as a result of the transfer of responsibility for public health functions to local authority and to ensure that the public health activities and programmes are effective and make a real difference to the health of the nation.

1. Invite a dietitian to have a permanent position on all local authority Health and Wellbeing boards
2. In all local authority have a dietitian(s) lead all projects that have a diet and nutrition focus – from the outset at project initiation
3. Refer to a dietitian when setting outcomes for diet and nutrition related interventions, services and work
4. Ensure that all local authorities implement an dietitian approved nutrition education programme for the public health workforce to include:
   - When to refer to a dietitian
   - What the limitation of their nutrition knowledge is
   - How to respond to a question about nutrition that they do not know the answer to
Conclusion

Para 13. Dietitians are the only statutorily regulated experts in diet and nutrition and have a vast wealth or experience of working in diet related public health interventions. Since the responsibility for public health was transferred to local authority dietitians have seen their specialist roles eroded and highly effective services that they led and delivered being decommissioned. The BDA believe that this is detrimental to the health of the nation now and in the future.

Para 14. We would be the first to admit that there are too few dietitians in the country to deliver all the diet related public health interventions that are required to make a difference to public health, however, we are concerned that the public health workforce who are being asked to design and deliver services have a poor understanding of the nutrition evidence base and also of their limitations (as non-experts) in delivering these interventions.

Para 15. The BDA believe that there is a real and urgent need to train the wider public health workforce in nutrition. This training should include making the workforce aware of the limitations of their knowledge of diet and nutrition and also when to refer to an expert i.e. a dietitian. Dietitians are keen and ready to help train public health staff to an adequate and safe level.

Para 16. The BDA are signed up to Public Health England’s Allied Health Professional Public Health Strategy and, in the near future, all dietitians working in all spheres of practice (acute, community and public health) will be involved in helping to nudge the behaviour of the public in the direction of a healthier lifestyle.

Para 17. Diet and nutrition forms the second largest modifiable risk factor impacting health. We must get the design and delivery of nutrition and diet related services and interventions right in order to make a real difference to the health of the nation. Dietitians are uniquely placed, as the only statutorily regulated experts in diet and nutrition, to help make this happen. This paper makes four recommendations for action by the government which will help resolve the problems outlined in the document. The main thrust of these recommendations is to ensure that dietitians are involved in the design and some of the delivery of nutrition and diet related activities and also to ensure that dietitians are involved in the training in nutrition of the wider public health workforce.

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