Paper for information: The Nutrition Workforce for Achieving Public Health Competency, Training and Capacity Development

Agenda Item: AOB

This paper was discussed at a meeting of the Nutrition Professionals Confederation on the 12th July 2006. It has since been revised, taking into account comments from Members of the group.

In addition, the British Dietetic Association submitted a response to the initial draft of this document. As it cannot be published on the SACN website it has not been included with this version of the paper.

The Nutrition Workforce for Achieving Public Health

Competency, Training and Capacity Development

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Executive Summary

Background

1) The remit of the SACN is risk assessment. Its advice will cover scientific aspects of nutrition and health with specific reference to:

- Nutrient content of individual foods and advice on diet as a whole including the definition of a balanced diet, and the nutritional status of people;
- Monitoring and surveillance of the above;
- Nutritional issues which affect wider public health policy issues including conditions where nutritional status is one of a number of risk factors (e.g. cardiovascular disease, cancer, osteoporosis and/or obesity);
- Nutrition of vulnerable groups (e.g. infants and the elderly) and health inequality issues;
- Research requirements for the above.

2) Thus issues related to the ability to monitor and survey the nutritional status of the population in relation to the promotion of health, and how this might best be achieved from a technical perspective fall with the broader purview of the Committee. In the assessment of risk it is important that the data and information available from research is relevant and carried out to a high standard by people with the relevant competence.

3) SACN receives regular reports on the relevant activities of the Departments of Health and the Food Standards Agency. One important consideration that has been raised regularly is the extent to which interventions that have been planned or are ongoing have adequate systems in built for effective monitoring and evaluation. It is clear that the resource and capability to carry out monitoring and evaluation of use to risk assessment and hence policy formulation is weak. In part this weakness is a clear reflection of inadequate numbers of suitable trained staff with the relevant skills and competencies.

4) At an early stage SACN formalised its approach to the weighing of evidence, and recognised that although all forms of evidence should contribute to a balanced interpretation, greater emphasis needs to be given to some forms of evidence than others, eg human versus non-human investigations. Experience shows that nutritional interventions are often complex and multidimensional. The standard approach of randomised controlled trials may be limited in their ability to adequately address interventions of this kind. This may be because of inadequate power, or that there is increasing need to move from studies which test the efficacy of interventions under model conditions to the effectiveness of interventions as an integral part of the health delivery system. Increasingly it is becoming clear that there is the need to develop the ability to conduct community

based interventions and utilise the information generated from these studies in the assessment of risk and the definition of policy options. To achieve this requires a stronger technical ability in relevant monitoring and evaluation.

5) For the PSA for obesity to be achieved will require effective interaction across primary, secondary and tertiary care, together with the ability to embrace public health considerations and to act inter-sectorally. If effective, "joined-up" activities are to be developed there will be an increasing need to ensure that standardised approaches are used across settings, which cut across different care groups, and embrace a wide range of people with differing levels of skill and competencies.

6) In practice, there are no formally identified systems, structures or processes through which the totality of nutritional care is delivered for the protection of health, disease prevention and the treatment of disease. Nor are there adequate systems in place to regulate the knowledge and competencies in nutrition across the health workforce. This poses a serious risk to the health of the population, and incurs substantial direct and indirect financial costs.

7) This risk to health is best exemplified in three principal areas of concern.

   - Following an analysis of the evidence generated through the National Diet & Nutrition Surveys, it is clear that a substantial proportion of the population make imprudent food choices. Their diets and the pattern of foods they consume are associated with an increased risk of poor micronutrient intake and biochemical evidence of micronutrient deficiency.

   - The burden of ill-health arising from the increased prevalence of obesity in children and adults are related directly to poor dietary choices and inadequate levels of physical activity. One consequence of the rise in obesity is a substantial increase in risk of co-morbidities such as cardiovascular disease, diabetes and cancer. This makes clear that the failure of the protection of health through appropriate public health interventions impacts directly by increasing the costs associated with clinical care.

   - There is a high demand placed on healthcare resources arising from malnutrition-related disease. There is an important need to introduce appropriate screening in order to be able to provide prevention and care for those at greatest risk such as the elderly.

8) The responsibility for addressing these problems is shared across a wide range of health professionals. However, the training, knowledge and competency in nutrition for those charged with the responsibility of delivering care are poor and not adequate for the needs of delivering the service safely and competently.

9) There is a need to establish a process through which the professional responsibilities of those deemed to be competent in nutrition are formally recognised and regularised. This is of critical importance for those for whom nutrition is a core component of their professional practice as well as for those within the wider health workforce who access nutrition as a part of their responsibilities. This process must take into account the expectations of those for whom nutrition-related aspects of care are provided and those who are charged with the responsibility of developing and managing the delivery of care in both the community and hospital setting.

10) As a first step, there is the need to establish systems which are standardised across all professional groups. These systems should ensure that all the professional groupings that make up the health workforce are appropriately competent to meet the demands of the service for the delivery of nutrition related care to acceptable standards, for individuals, groups of individuals, and entire populations.

Review of current situation.

11) In this report we have assessed the opportunity for the development of effective capacity within the nutrition workforce. We have reviewed the extent to which a shared knowledge base underpins competency in the application of nutrition in protecting the health of the population and for the management of those whose nutritional status is compromised due to ill-health. Further, the report seeks to identify standards for training and practice for those health workers whose activities most obviously impact on the delivery of nutritional aspects of care. There is an emphasis on the need to develop Public Health Nutrition as critical to the protection of public health.

Key Findings

- Although the Core Curriculum explicitly underpins the training of nutritionists and that of doctors at basic, higher and specialist training, particularly that associated with nutrition support and the nutritional care of children, the extent to which this learning is incorporated and delivered within the overall portfolio of learning is highly variable. The Core Curriculum does not explicitly underpin standards for education in nursing, midwifery, dietetics, dentistry or pharmacy.
- Some, but not all, normative nutrition competencies were evident in the Skills for Health National Database of Standards, particularly the competencies required for the promotion of nutritional health and the primary prevention of nutrition-related disorders.
- Professional and occupational standards differ in the ‘levels’ of competency and in turn differ from the levels of learning outcome used in the National Qualifications Frameworks or NHS Knowledge & Skills Framework.
- There are numerous and varied job titles used by those who are responsible for the delivery of nutrition-related aspects of care reflecting the marked diversity of

roles within the workforce and the lack of standardisation in training, skills and function. Furthermore voluntarily registered nutrition professionals and other nutrition-related occupations are not included in the NHS census surveys. This lack of clarity or uniformity impedes the strategic assessment of workforce capacity.
- There is evidence of a lack of strategic capacity within the nutrition workforce in terms of public health. There is a considerable untapped potential as more than half of new nutrition graduates do not enter the workforce.

12) Based upon this analysis, it can be concluded that any discussions relating to workforce development must address the following issues.

- The extent to which the Core Curriculum (the so-called '18 bullet points') serves as the foundation for nutrition training across all professional groups.

- The extent to which the nutrition-related knowledge and the competencies required to deliver care have been clearly identified and communicated to those who develop, manage, deliver and examine professional training. This applies both for those for whom nutrition is core to their practice, and those who access nutrition from within other specialties.

- How this training would reflect a tiered system of increasing skill level and sophistication within pathways for career development which recognises the responsibilities of the deepening of understanding, knowledge and skills as an individual passes through higher levels of responsibility and with higher degrees of specialisation.

Conclusions

- There is a need to define the nutrition-related competencies for each level of occupational and professional groups within the workforce and for Government to state their requirements to steer the development of training for competency, as promised in Delivering Choosing Health – Improving the Workforce.
- There is a need to devise a programme for training in the application of nutritional knowledge and understanding and in the core health professional competencies (as stated in the NHS KSFs) to equip those entering the workforce at graduate levels.
- The regulated professions must ensure that referral and accountability is clearly stated in the database of standards, possibly by extending the work on standards undertaken within Skills for Health, in partnership with the nutrition professions in order to fill the gaps in existing standards to reflect care pathways for nutrition health promotion and primary, secondary and tertiary nutrition health prevention for any setting or patient group.
- Measurable standards for competency must be defined that include attitudes and practical professional competencies, as well as knowledge, and that are fit for purpose.

- There is a need to define the systems and structures within which those responsible for delivering nutrition-related aspects of care operate, especially within public health. Such action is timely given the stage of the Agenda for Change job evaluations of the health improvement workforce, the progress of Modernising Medical Careers and the proposal to open a category of registration on the UKVRPHS for public health nutrition as an area of specialist practice.
- The development of training will require resources to enhance the skills of the existing workforce and to enable the initial training of those joining the workforce, in a way that is comparable with or integrated within schemes for training other health professionals, especially the generalist public health specialists, public health nurses, community pharmacists and public health environmental officers.
- There is a need to identify ways to organise, involve and develop all categories of nutrition workers as part of a plan to invest in the delivery of health care and at the same time, to unify and strengthen the voice of the nutrition professionals for health benefit, for example through the Nutrition Professions Confederation (NPC).

Recommendations and Proposed Future Steps in the Process

13) It is recommended that the immediate challenge be addressed in each of the following six complementary areas:

The demand for nutrition-related activities – the potential.
What are the areas in which nutrition may be expected to contribute to the protection of health or the prevention and treatment of disease?

Identified needs for nutrition-related activities – the expectation.
How are these demands prioritised in the commissioning process within short, intermediate and longer-term expectations of the healthcare strategy? What targets, PSA or LSA have been set?

Characterising the service provision requirements – the shape of the required workforce.
What are the systems, structures, processes needed to support the delivery of these services? What knowledge, skills and competencies are needed within the workforce in order to meet these needs?

Current competence and capacity of the workforce.
Does the existing workforce possess the necessary knowledge, skills and competencies and standards of performance to meet these needs, both in terms of core professionals and those who access nutrition from within their own professional discipline?

Analysis of service delivery – the fit between supply and demand.

What is the extent, nature and implications of any mismatch or shortfall between the capacity and competencies of the existing workforce and that required to meet the service expectation?

Characterising the workforce improvement programme.
What are the implications for training - in terms of standards of performance and competencies - both of the existing workforce and those entering the workforce? In terms of the core professionals, what will they bring that nobody else can do, is more cost effective or bring added value to the activities of others? Who should have responsibility for the delivery of training and audit/regulation of service delivery?

1. INTRODUCTION

14) The terms of reference for the Scientific Advisory Committee on Nutrition (SACN) have been set and the remit of the SACN is risk assessment. Its advice covers scientific aspects of nutrition and health with specific reference to:

- Nutrient content of individual foods and advice on diet as a whole including the definition of a balanced diet, and the nutritional status of people;
- Monitoring and surveillance of the above;
- Nutritional issues which affect wider public health policy issues including conditions where nutritional status is one of a number of risk factors (e.g. cardiovascular disease, cancer, osteoporosis and/or obesity);
- Nutrition of vulnerable groups (e.g. infants and the elderly) and health inequality issues;
- Research requirements for the above.

15) Thus issues related to the ability to monitor and survey the nutritional status of the population in relation to the promotion of health, and how this might best be achieved from a technical perspective fall with the broader purview of the Committee. In the assessment of risk it is important that the data and information available from research is relevant and carried out to a high standard by people with the relevant competence.

16) SACN receives regular reports on the relevant activities of the Departments of Health, the Food Standards Agency and other government bodies. One important consideration that has been raised regularly is the extent to which planned or ongoing interventions have, as an integral part of their conduct, adequate systems for effective monitoring and evaluation. It is clear that the resource and capability to carry out monitoring and evaluation of use to risk assessment and hence policy formulation is weak. In part this weakness is a clear reflection of inadequate numbers of suitable trained staff with the relevant skills and competencies.

17) At an early stage SACN formalised its approach to the weighing of evidence, and recognised that although all forms of evidence should contribute to a balanced interpretation, greater emphasis needs to be given to some forms of evidence than others, eg human versus non-human investigations. Experience shows that nutritional interventions are often complex and multidimensional. The standard approach of randomised controlled trials may be limited in their ability to adequately address interventions of this kind. This may be because of inadequate power, or that there is increasing need to move from studies which test the efficacy of interventions under model conditions to the effectiveness of interventions as an integral part of the health delivery system. Increasingly it is becoming clear that there is the need to develop the ability to conduct community based interventions and utilise the information generated from these studies in the assessment of risk and the definition of policy options. To achieve this requires a stronger technical ability in relevant monitoring and evaluation.

18) The year on year increase in the prevalence of obesity is recognised as the most serious burgeoning problem with wide implications for health and disease. For the PSA for obesity to be achieved will require effective interaction across primary, secondary and tertiary care, together with the ability to embrace public health considerations and to act inter-sectorally. If effective, "joined-up" activities are to be developed there will be an increasing need to ensure that standardised approaches are used across settings, cutting across different care groups, and embracing a wide range of people with differing levels of skill and competencies.

19) In practice, there are no formally identified systems, structures or processes through which the totality of nutritional care is delivered for the protection of health, disease prevention and the treatment of disease. Nor are there adequate systems in place to regulate the knowledge and competencies in nutrition across the health workforce. This poses a serious risk to the health of the population, and incurs substantial direct and indirect financial costs.

20) The Government Public Service Agreement (PSA) for obesity serves to emphasise the serious nature of the immediate situation, and the need to develop a capability to improve the health of the population. However, there are wider nutrition-related risks to health, best exemplified in three principal areas of concern.

- Following an analysis of the evidence generated through the National Diet & Nutrition Surveys, it is clear that a substantial proportion of the population make imprudent food choices. Their diets and the pattern of foods they consume are associated with an increased risk of poor micronutrient intake and biochemical evidence of micronutrient deficiency.

- The burden of ill-health arising from the increased prevalence of obesity in children and adults are related directly to poor dietary choices and inadequate levels of physical activity. One consequence of the rise in obesity is a substantial increase in risk of co-morbidities such as cardiovascular disease, diabetes and cancer. This makes clear that the failure of the protection of health through appropriate public health interventions impacts directly by increasing the costs associated with clinical care.

- There is a high demand placed on healthcare resources arising from malnutrition-related disease. There is an important need to introduce appropriate screening in order to be able to provide prevention and care for those at greatest risk such as the elderly.

21) The responsibility for addressing these problems is shared across a wide range of health professionals. However, the training, knowledge and competency in nutrition for those charged with the responsibility of delivering care are poor and not adequate for the needs of delivering the service safely and competently.

22) There is a need to establish a process through which the professional responsibilities of those deemed to be competent in nutrition are formally recognised and regularised. This is of critical importance for those for whom nutrition is a core component of their professional practice as well as for those within the wider health workforce who access nutrition as a part of their responsibilities. This process must take into account the expectations of those for whom nutrition-related aspects of care are provided and those who are charged with the responsibility of developing and managing the delivery of care in both the community and hospital setting.

23) As a first step, there is the need to establish systems which are standardised across all professional groups. These systems should ensure that all the professional groupings that make up the health workforce are appropriately competent to meet the demands of the service for the delivery of nutrition related care to acceptable standards, for individuals, groups of individuals, and entire populations.

Scope of the Report

24) In this report we have assessed the opportunity for the development of effective capacity within the nutrition workforce. We have reviewed the extent to which a shared knowledge base underpins competency in the application of nutrition in protecting the health of the population and for the management of those whose nutritional status is compromised due to ill-health. Further, the report seeks to identify standards for training and practice for those health workers whose activities most obviously impact on the delivery of nutritional aspects of care. There is an emphasis on the need to develop Public Health Nutrition as critical to the protection of public health.

25) It is considered that the key group of health professionals that needs to be developed in order to achieve a competent workforce for the promotion of health and the prevention of nutrition related disease is the Public Health Nutritionist. The report contains an analysis of the job descriptions and national job profiles in public health nutrition building on recent research mapping of the nutrition workforce. This analysis serves to contextualise the problem, and a comparison is drawn with an American model of how public health nutrition might best be organised for the delivery of effective services.

26) Proposals are made for the elements of a plan for the development of the nutrition workforce through initial training and in-service training. This plan explicitly recognises different levels of competence and responsibilities and allows for structured career development. The basis for this training builds on integrating a common nutrition framework for competency and capacity, and the standards for public health within the National Health Service, Knowledge and Skills Framework.

Background

27) "The Government's health strategy aims to improve the health of everyone and the health of the worst off in particular". In 2001 the Chief Medical Officer published the results of a project to strengthen the "Public Health Function", within which was set out a programme in support of the implementation of the *NHS Plan* (Department of Health, 2000). The five themes identified as being essential for a successful public health function included "an increase in capacity and capabilities of the public health function, such as health protection".

28) This report on the Public Health Function (Department of Health, 2001) has led to the development of national standards for specialists (Healthwork UK, 2001). There is a UK Voluntary Register for Public Health Specialists, with identified funding to support public health through top up training, and national standards for public health practice (Skills for Health, 2004). There is the need to determine how Public Health Nutrition and the Public Health Nutrition Function fit within this broader national agenda.

29) Human nutrition embraces a range of considerations which are fundamental to the achievement and maintenance of health, embracing the amount and quality of food consumed and the extent and nature of physical activity. Normal growth and development is absolutely dependent upon a satisfactory nutritional state, as is the capacity to withstand a range of environmental stressors. Therefore, the Public Health Nutrition Function should be seen as an integral subset of the wider Public Health Function.

30) The importance of diet and nutrition for the wellbeing and health of the public is explicitly recognised by Government policies in the each of the countries of the United Kingdom. If better health is to be achieved for the population and if the risk factors that are significant determinants of mortality and morbidity within the society are to be improved there will need to be major changes in the pattern of dietary consumption and levels of physical activity across society and most particularly in those most vulnerable (Department of Health, 2005 a,b,c; Scottish Executive, 2003 & 2004; Food Standards Agency, Wales 2004). The government white paper on "Choosing Health" identifies a Public Service Agreement to halt the annual increase in childhood obesity by 2010. Further, there are commitments to tackle obesity in adults, substantially reduce mortality rates from heart disease, diabetes, cancer and stroke, and to ameliorate health inequalities that include the widening disparities in diet and nutrition.

31) The subsequent document "Delivering Choosing Health" includes a supporting strategy within which the need to develop the workforce and its competence is identified (Department of Health, 2005a, 2005b, 2005c, 2005e). Public Health Nutritionists are not identified explicitly as having any specific role to play. At the present time dietitians are the primary specialist recognised as having responsibilities for delivering nutrition related services. However, it is acknowledged that there are too few dietitians to meet the current needs. Further, the competence of dietitians does not embrace the delivery of public health, which is properly the responsibility of public health nutritionists. In addition to the considerations related to diet and nutrition specialists, delivering public health will require much broader inter-professional working among all the members of the health workforce.

32) The inexorable rise in the prevalence of obesity reflects the difficulties in its prevention and treatment. National Institute for Clinical Excellence is in the process of preparing guidelines for the prevention and treatment of obesity, which are currently available for public consultation (NICE, 2006a). The Department of Health has prepared interim guidance for the prevention of obesity in adults and children, and guidelines in anticipation of the final report from NICE, expected in 2007. Haughton et al (1998) found that in the United States of America there was the need to build capacity to meet the challenges of the contemporary public health agenda, such as tackling obesity and its co-morbidities such as heart disease, diabetes and cancer (Griffiths & Dark, 2005). There is also a need for timely detection and intervention in obese patients with co-morbidities.

33) The direct costs of treating obesity are large, estimated in 1998 to be £9.4 million, with the costs of treating the co-morbidities being £470 million. Unchecked, it is estimated that the costs would rise to £3.6 billion in 2010 (Wanless, 2004).

34) There is substantial malnutrition in some vulnerable groups in the community that leads to worsening undernutrition before during and after hospital admission. There is the need to break this cycle (Malnutrition Advisory Group, 2003; Stratton et al, 2003). There are persistent problems of undernutrition in the vulnerable, such as the elderly, infirm, the disadvantaged and socially excluded with the lowest income (Allison, 1999; Malnutrition Advisory Group, 2003; Royal College of Physicians, 2002). NICE has produced guidelines for the identification and treatment of undernutrition (NICE, 2006b).

35) The cost savings associated with the implementation of NICE guidelines on nutritional support in adults is estimated to be as much as £7.8 billion per year (Elia et al, 2005; NICE, 2006).

36) In common with all other countries, the UK experiences the double burden of malnutrition, obesity and undernutrition (Standing Committee on Nutrition of the United Nations System, 2006). Both are more prevalent in the most disadvantaged groups in society. At both ends of the spectrum of malnutrition, the immediate effects of poor nutrition and the consequences of nutritional risk require attention. This attention has to be applied both at the level of individual care and also in relation to population based approaches. Individual care should not be seen as being dissociated from population approaches as both are intrinsic to the provision of holistic 'joined up' care. Joint approaches of this kind are already used in care pathways that straddle primary, secondary and tertiary health care settings. Recognition of this perspective would enable the public health nutrition workforce to be identified as, and function most effectively as, an integral part of the wider health workforce.

37) Improving nutrition related health services and the consequent improvements in nutritional health make sound economic sense, but the full benefit is only likely to be achieved within a "fully engaged" scenario (Wanless, 2004). As indicated by Wanless, achieving better health could only be afforded if clients and patients are enabled to act in partnership with health professionals. For this partnership to become a reality requires a workforce that is client/patient centred and works inter-professionally when this is in the best interests of individual client/patients or populations.

38) There is the need to plan and deliver a diverse range of nutrition services. Both the planning and delivery require specific nutritional competence in the professional and support workforce. These services will include the ability to effectively communicate nutrition and health information. Against this background, it is necessary to consider the extent to which England and the United Kingdom as a whole have the capacity to meet the expanding needs for

nutrition-related health care and services. Currently, the competent human resources required to achieve these objectives are grossly inadequate.

Inadequacies in the Delivery of Services in Public Health Nutrition

39) There is an acknowledged shortage of dietitians, which led the British Dietetic Association and Nutrition Society(2002) to publish Joint Professional Development Guidelines. This document encourages the employment of nutritionists within the Nutrition and Dietetic Departments of the NHS, appointment to new posts and programmes such as Sure Start, and in new areas such as local government and NGO-based community food work. Advice from the Health Development Agency on the implementation of the National Service Framework for coronary heart disease, included the need to protect funds for primary prevention: a service that would be delivered by Registered Dietitians or Registered Public Health Nutritionists.

40) The inadequacy continues and no effort has been made to correct the situation. In 2004, the Nutrition Society commissioned a report on the understanding and awareness of health professionals and others of the responsibilities and roles of Nutrition Health Professionals (www.nutritionsociety.org.uk). There was insufficient opportunity for access to and advice from dietitians in the primary care setting. Similarly, it was found that there are too few dietitians in the public health workforce in Hampshire and the Isle of Wight to meet the immediate needs (Jackson, 2005).

41) On the basis of this evidence it can be concluded that there is insufficient capacity within nutrition to deliver health and to meet the rising expectations which are implicit within policies such as Sure Start, Healthy Start, and Five a Day. The added demands imposed by the need to address the great challenge of preventing obesity, implementing DFES inspections of school meals; and enabling communities, workers and consumers, to choose and eat food for health, can not possibly be met without serious consideration being given to the need to support effective expansion of real capacity within the nutrition workforce.

Workforce planning

42) It is generally recognised that modern workforce planning and development is a fundamental aspect of the process for meeting the needs of effective health care. Within this context there has been a major revision of the regulations which govern the practice of all health professionals. Established professions have new regulators. For example, allied health professions are regulated by the Health Professions Council, and nurses and midwives by UK Nursing and Midwifery

Council. The objective is to strengthen public protection at a time of greater choice and greater diversity of health service providers.

43) The health workforce has increased in size, flexibility and capacity. The expansion in numbers of health professionals identified within the NHS Plan, the Agenda for Change and the related NHS Knowledge and Skills Framework (KSF) (Department of Health, 2004b and 2005e), seek to promote career development and staff retention while ensuring there is a high quality, client centred health workforce. For example, the situation which obtains for doctors within Modernising Medical Careers (Department of Health, 2004c; National Health Service, 2005).

44) Following the report from the Chief Medical Officer in 2001 on Protecting the Public Health Function, standards have been set for the Specialist Practice of Public Health (Healthwork UK, 2001) and for the Practice of Public Health (Skills for Health, 2003). A Voluntary Register of Public Health Specialists was established in 2003, providing the opportunity for registration for professionals who were not medically qualified. On June 1st 2006 the register opened to individuals who demonstrate higher levels of achievement in defined areas of specialist practice, which include public health nutrition.

45) There has never been formal consideration given to the number and types of nutrition health workers that would be required to meet the normative needs of the health service. There has never been a national census survey of the public health nutrition workforce in the UK. There has never been an estimate of the numbers and nature of the workforce required to enable safe choice of effective nutritional services in the food and health market place. Therefore the needs are not clear.

46) There is no consensus on what constitutes the “nutrition workforce”. The Nutrition Society recently commissioned research which represented the first attempt to map the primary nutrition workforce: that is those who are qualified in nutrition and involved directly in delivering a professional nutrition service (Nutrition Society, 2006). This information provides a basis against which different roles and functions might be identified, and how they might best be co-ordinated. It can be used as the basis from which to start planning for a modern nutrition workforce and to develop a strategy to achieve the ambitions identified within “Choosing Health” and related policies in the devolved administrations.

2. REVIEW OF THE CURRENT WORKFORCE FOR THE DELIVERY OF NUTRITION-RELATED SERVICES.

2.1 Introduction

47) In order to provide some background information from which to start formal consideration of the needs for workforce development we have provided a first level review of the considerations needed for strategy development and planning purposes. Here, we seek to address the nature of the workforce that will be required to meet the needs for delivering an effective service in Public Health Nutrition.

48) To meet this aim, the following were considered:

- a review of the key concepts of workforce planning, in order to clarify the language used to describe the nutrition workforce;
- a review of the extent to which the Nutrition Core Curriculum (Department of Health, 1994) is a common nutrition framework underpinning the training for health professionals – doctors, nurses, midwives, dietitians and voluntarily registered nutritionists;
- a review and scoping of normative nutrition competences in the National Occupational and other Standards for the health workforce and in professional standards for competency (performance) for doctors, nurses, midwives, dietitians and voluntarily registered nutritionists;
- a comparison of descriptions of jobs for public health nutrition workforce and a comparison of nutrition capacity in the UK and USA.

2.2 The Concept of Workforce Capacity

49) The Report of the Chief Medical Officer's Project to Strengthen the Public Health Function was published in 2001. It set out the broad framework within which public health should contribute directly to improving the wellbeing of the population.

50) A successful public health function requires a range of professional staff working together to plan, coordinate, supervise and evaluate the delivery of services. These are the professionals who are ultimately accountable for the health of the patients/ clients. Thus, they are essential for the protection of public health and, essential to ensure the ongoing implementation of high standards of health care,

safe and effective prevention of illness and promotion of wellness. Public Health Nutrition is a fundamental and integral component of public health and therefore the Public Health Nutrition Function can be defined as a critically relevant subset of the Public Health Function. In order to be able to realise the full potential for the Public Health Nutrition Function will require a workforce that is competent in nutrition: the nutrition workforce.

What is the nutrition workforce?

51) In characterising the Public Health Workforce, the Chief Medical Officer has differentiated 'specialists' from 'generalists'. For nutrition, by analogy, specialists spend all or most of their time in nutrition service delivery whereas generalists spend some of their time in this area of practice. The term specialist may be problematic insofar as it can imply hierarchy. In other contexts, alternate terms have been coined such as 'primary' vs 'secondary' (eg Jackson, 2005), or 'direct' and 'indirect' (Hughes, 2004). Regardless of the terminology, the sense is that the relevant workforce can be divided into:
   - those health professionals for whom nutrition is their core business, and who are directly involved in providing professional nutritional services and,
   - those health professionals for whom nutrition is one element of their responsibilities, whose core practice lies elsewhere,
   - other workers with vocational qualifications in food and health.

52) According to these criteria, nutrition specialists would be dietitians, public health nutritionists and nutritionists, community food workers with professional qualifications, nutrition nurse specialists, and clinicians who have specialised in nutrition (clinical nutritionists), because they are all directly involved in providing professional nutrition services.

53) There are many other types of worker for whom nutrition is an aspect of their practice at some time, at an operational level. These would include medical doctors, dentists, nurses, midwives, pharmacists, physiotherapists, speech and language therapists and others.

54) There are other types of workers for whom an important aspect of their core practice includes aspects related to nutrition such as feeding and food provisioning. In its widest sense, the nutrition workforce would include community food workers, nutrition and dietetic assistants, food and health advisors and other such workers who have vocational rather than academic qualifications.

55) The literature on aspects of workforce planning and development for nutrition is relatively sparse. For the UK it mainly relates to consideration of professional education (eg Landman et al, 1998). There was an assessment of the dietetic workforce in Northern Ireland in 2003 (Department of Health, Social Services and Public Safety, 2003). A document from the United Nations University/

International Union of Nutritional Sciences (1997) is of particular importance because it draws upon an approach which is similar to that used in the mainstream planning and development for a public health workforce. This report is an international consensus statement on strategic planning for a public health nutrition workforce. A series of surveys of the size and nature of the public health nutrition workforce forms the basis of assessments of capacity for the USA (Dodds & Kaufman, 1991; Haughton & Shaw, 1992; Haughton et al, 1998) and Australia (Hughes, 2004a). Hughes suggests that the Public Health Nutrition Workforce capacity is the ability to effectively address public health nutrition issues in the population it serves (Hughes, 2004). This refers to the ability of the workforce to work effectively in terms of its size, competences and practices, as well as in the political and organisational cultural settings or workplaces.

56) Capacity building may be defined as an approach to the development of sustainable skills, structures, resources, and commitment to health improvement, in the health and others sectors such as local government, in order to multiply health gains. It increases the ability of specialist people, agencies and of communities to address health problems and the determinants of health and nutrition. Therefore it encompasses the para-professionals eg the health care assistants, the dietetic and community assistants and in due course, the accredited health trainers; and, importantly for the fully engaged scenario, the population itself.

The size of the specialist or direct public health nutrition workforce

57) In characterising the structure of the public health nutrition workforce the UNU/IUNS (1997) proposed a pyramidal arrangement. The largest group of professionals comprised 'implementers' whose function was at the operational level to manage community services, local projects and programmes. The second group was planners and trainers, and thirdly the policy and decision-makers. The total would be in the region of 110 to 500 professionals per 5 million of population. The detailed number and distribution would vary according to the resources available and the complexity of the problems to be addressed, but they cautioned against a simple scaling down of numbers for smaller populations. In the USA, the benchmark which has been suggested is for 1 whole time equivalent per 50,000 population ie 100 per 5 million (Dodds & Kaufman, 1991). This benchmark has been used in Australia (Hughes, 2004).

58) The Specialist Public Workforce in the UK has been derived by the Faculty of Public Health using an evidence based standard (2004), a proposal accepted by government. They suggest that there should be 125 Public Health Specialists per 5 million of population. By definition a Public Health Specialist occupies a senior strategic, managerial or leadership position and is responsible for planning strategy at the level of Primary Care Trust, regional and national levels.

Competency – common frameworks

59) In addition to identifying the structure of the nutrition workforce, there is the parallel task of establishing individual competences (also called skills and proficiencies). This normative task should identify the competencies expected of the nutrition specialist in the practical application of specialist nutrition knowledge and understanding.

60) Consensus has been reached on the definition of qualifications needed for *specialist professional competency* in the science of nutrition at graduate level (to develop knowledge and understanding of core concepts of nutrition), and post-basic education and/ or training to develop professional values, as well as practical (generic and specific) competences. However, there has been no attempt to test whether current benchmarks are fit for contemporary practice in terms of assessing the extent to which they effectively contribute to an expansion of nutrition capacity in the delivery of services. Similar considerations apply to the training of doctors, nurses and other health professionals.

2.3 Is the Nutrition Core Curriculum a common base for nutrition knowledge?

61) There has been a longstanding concern that the knowledge and skills of health professionals in nutrition is not adequate for safe and effective practice. In 1994 the Department of Health identified a core curriculum, enunciated as 18 bullet points, for undergraduate training. The eighteen bullet points were selected to capture those aspects of nutrition which were considered necessary for the safe practice of all health professionals. This curriculum was accepted in principle by the relevant professional groups. If nutrition health professionals were equipped for inter-professional practice, it would be expected that they would share a common base of nutrition knowledge, which would be identifiable, such as the Nutrition Core Curriculum, (Department of Health, 1994). This common base would serve as the framework for learning and would underpin preparation for practice for all nutrition health professionals. To identify whether the Nutrition Core Curriculum fulfils the need for a common base reviews and analyses were undertaken.

Method

62) A review was carried out to determine whether in the curricula for nutrition and other health professionals there was evident occurrence of the common nutritional

framework, the 18 bullet points from Nutrition Core Curriculum. The review included a search of benchmarking statements for Dietetics, Nursing and Midwifery (Quality Assurance Agency, 2001a, 2001b, 2001c, 2001d, 2001e, 2001f, 2002), within the emerging health professions framework; standards for training consultants prepared by the Royal Colleges for Paediatrics and Child Health; of Physicians for Gastroenterologists, and of Psychiatrists working with patients with anorexia nervosa; standards for the accreditation of courses that lead to eligibility to apply for voluntary registration in Nutrition and Public Health Nutrition by the Nutrition Society (General Medical Council, 2003; Royal College of Paediatrics and Child Health, 2004, 2005; Royal College of Physicians, 2002; Royal College of Psychiatrists, 2005; Nutrition Society, 2003, 2005a, 2005b).

Findings

Dietetics

63) The Core Curriculum is implicit in the Quality Assurance Agency (QAA) Benchmarking Statement for Dietetics but is not referred to or identified as a source. A systematic understanding of the key aspects of the range of disciplines underpinning dietetics and a detailed knowledge of some aspects is required. For example, sufficient knowledge is required of biochemistry and physiology to understand how they are integrated in relation to nutrition and related disease conditions. Thus, dietitians must know the fundamental mechanisms through which nutrition contributes to the maintenance of good health, and what methods are available to monitor nutritional intake and their limitations. They must have an understanding of the impact of nutrients on cellular mechanisms, including gene expression, and the contribution to diet-related disease and its management. They should be familiar with the British diet (QAA Dietetics Benchmark, 2001c)

64) There are more domains for knowledge of food, nutrition and diet in the dietetics benchmark than in the other documents reviewed. The Core Curriculum has no epistemological link with dietetics. Although reference is made to epidemiology, and to the practice of dietetics at population level, the knowledge base is more consistent with preparation for clinical practice and for primary prevention with individuals than with the practice at population level, judged by contemporary standards in public health. The practice of public health nutrition is not included in the standards required for registration in dietetics by the Health Professionals Council (Standards of Proficiency, Dietitians, 2003; Standards of Education and Training, 2004).

Nutrition and Public Health Nutrition

65) The Core Curriculum explicitly underpins the standards required for nutritionists (Nutrition Society, 2003, 2005a, 2005b). The 18 bullet points are extended in the statements of subject knowledge. The standards for Public Health Nutritionists

specify sufficient competency in the core curriculum to be able to teach health professionals, a responsibility which was clearly identified for nutritionists and dietetians when the Core Curriculum was first constructed (Nutrition Society, 2005).

Medical Doctors

66) The Core Curriculum explicitly underpins the training of medical doctors. An awareness of the 18 bullet points is expected at graduation (Jackson, 1996). This is set as the criterion for entry into postgraduate Certificate Course in Nutrition offered by the Intercollegiate Group on Nutrition (ICGN, Jackson, 2001). During the ICGN itself an understanding of these 18 bullet points is developed.

67) The review of the four available documents showed that the Core Curriculum explicitly underpins the training of

- Acute Care Nurse Specialists;
- Consultant Gastroenterologists in Nutritional Care;
- Consultant Psychiatrists who manage Anorexia Nervosa;
- Consultants in Paediatrics and Child Health

Nurses and Midwives

68) There is no definition of the nutrition disciplinary knowledge required within the emerging health professions framework, which concerns common professional competences and therefore is similar in scope to core KSFs. There is limited reference to nutrition in the knowledge base underpinning nursing and midwifery. Nutrition is one aspect of the natural and life sciences seen as having direct application to nursing practice with specific client groups. Nutrition is seen as being of relevance explicitly to the needs of women before conception, during pregnancy, in the puerperium, including infant feeding and healthy eating for the family. There is no indication that a sound knowledge of nutrition is fundamentally important for nursing practice across the board (QAA Nursing Benchmark, 2001e; QAA Midwifery Benchmark, 2001f)

2.4 Scoping and comparison of the normative nutrition competency in national standards for health workers

69) This review was undertaken to assess the extent of capacity for intra-professional as well as inter-professional working in nutrition. For this review, *normative nutrition competences* were defined as follows: assessment of diet; of devising dietary solutions/ plans; food procurement and feeding; assessing nutritional status, screening, diagnosis of nutritional risk or conditions; intervention; planning, coordination and /or audit of services.

Methods

70) A search was performed of the Skills for Health website using the key words ‘diet’, ‘food’ and ‘weight’ to identify the standards for areas specific to specialist

and to inter-professional nutrition practice. The Skills for Health website includes national standards for health workers: that is National Occupational Standards (NOS) and National Workforce Competences (NWC, Skills for Health, 2005, www.skillsforhealth.org.uk)

71) The national standards were mapped against statements of competency for selected health professionals: viz dietitians; nutritionists; nutrition specialist doctors – paediatricians, gastroenterologists; psychiatrists; and specialist nurses in acute care through nutrition support, most of which are in the public domain though some are in development.

Health Professionals

72) Some, though not all the normative nutrition competences are present in the national database of occupational and workforce standards, cross-referenced to the NHS KSFs. There may be more standards in existence than was revealed by this method of searching the very large volume of standards. Sometimes the same statements are coded differently. This may be partly because occupational or professional groups prefer specific to generic statements (personal communication from Skills for Health and from Prime R & D).

Dietetics

73) When admitted to their register, dietitians are expected to function autonomously, within professional boundaries, with limited supervision, in the areas of normative competency. "Working as a professional in dietetics: exercise substantial autonomy in most of the professional activities associated with dietetics: these will cover processes such as assessment, planning, execution and evaluation of safe dietary intervention" (QAA Dietetics Benchmark, 2001c). They have responsibility to guide and direct the work of others and there is an explicit list of normative competencies identified.

Nutrition and Public Health Nutrition

74) The Nutrition Society plans to develop standards for performance and for training for voluntarily registered nutritionists and public health nutritionists, based upon research into their occupational roles (Nutrition Society, 2006).

Medical Doctors and Specialist Nurses

75) A review of the current guidance on the curricula for undergraduate medical students failed to identify any specific reference to normative nutrition competencies.

76) Review of standards included three specialisms, nutritional support for gastroenterologists, paediatrics and psychiatry and acute care nursing and nutritional support.

77) Analysis of Guidelines for the Nutritional Management of Anorexia Nervosa (Royal College of Psychiatrists, 2005) revealed high order key skills are necessary to coordinate collaboration with other health professionals. For example, to have the awareness to arrange dietary assessment by a dietitian, to recognise and prescribe nutritional support by an appropriate route, if necessary, seeking advice from the specialists in a nutrition team; and to interpret laboratory and other investigations into health status and risk of complications; and to refer to and act on the advice of dentists, and others such as speech and language therapists. These competences require attitudes, knowledge and understanding, and practical application of nutrition integrated into the knowledge base of psychiatry.

78) The Diploma in Paediatric Nutrition of the Royal College of Paediatrics and Child Health (Royal College of Paediatrics and Child Health, 2004, 2005) includes the development of competency in personal practice and, as with Psychiatrists, coordination of the inputs of other health professionals. This covers all aspects of assessment and screening and intervention for healthy and sick individuals and groups within the population of infants and children. This includes an ability to advise mothers about the risks and benefits of infant feeding modalities; complementary feeding; recognising problems with breast feeding and refer; identify families at risk or in danger and refer. Competency in assessment, screening and monitoring of growth and development includes nutritional and dietary assessment; diagnosis or risk of undernutrition and obesity; and recognition of associated clinical complications; communication with others (mothers and colleagues) about these. Finally, paediatricians are able to refer mothers to sources of advice and support around supplementary feeding.

Discussion

79) The review found that the Skills for Health national standards for health professionals did not explicitly state all the normative competences in nutrition. If these gaps are real, it will be important that they are filled. Firstly, in order to meet the challenges of obesity in the forthcoming interim and NICE guidance and the NICE guidance expected for Nutrition Support in Adults. Otherwise, it is impossible to assess and monitor the training and capacity development needs of the nutrition workforce, or to achieve the requisite inter-professional work.

80) If the gaps are apparent and arise from the accessibility of the Skills for Health web-site, there is a need to raise the profile of existing nutrition-related standards. This would make it easier to identify the normative nutrition competences and use them in training, and/ or in the development of jobs as part of workforce planning. Improving access to or extending the range of normative nutrition

competences could be achieved by working with Skills for Health itself or with relevant independent consultants, such as Prime R & D.

81) Scoping Nutrition Training Needs for Health Practitioners in Primary Care for the Government Office for Yorkshire and the Humber by Hobbiss & Gallagher (2005) used a reference group of local practitioners to develop a consensus on nutrition skills needed for nutrition health service delivery. This was the most detailed study to date of specific skills focused on food and diet services provision within Primary Care Trusts and for differing types of client. Hobbiss & Gallagher's detailed work should help lay the basis for adapting relevant National Occupational Standards (NOSs) and National Workforce Competencies (NWCs).

82) There is a need to work with other professionals to check whether the normative competences are included in the standards for proficiency (performance) and training of nurses, midwives and newly qualified doctors as well as the specialist nurses and specialist doctors included in this review.

83) The review made clear that there is no consistency in the way in which different professions and organisations identify and describe competency. "Levels" used in relation to competency differ from the levels of learning outcome used in the National Qualifications Frameworks or the NHS KSFs.

84) There is evidence of a similar concept of hierarchy of level between the acute care specialist nurse and the consultant gastroenterologist. Here, the highest levels of training is seen to lead to specialist practice within which there are explicit responsibilities for leadership in the 'complex, challenging, demanding, unpredictable' situation. This is the sort of situation in which Public Health Specialists are expected to function.

2.5 Key Findings

- Although the Core curriculum explicitly underpins the training of nutritionists and that of doctors at basic, higher and specialist training, particularly that associated with nutrition support and the nutritional care of children, the extent to which this learning is incorporated and delivered within the overall portfolio of learning is highly variable. The Core Curriculum does not explicitly underpin standards for education in nursing, midwifery, dietetics, dentistry or pharmacy.
- Some, but not all, normative nutrition competencies were evident in the Skills for Health National Database of Standards, particularly the competencies requires for the promotion of nutritional health and the primary prevention of nutrition-related disorders.
- Professional and occupational standards differ in the 'levels' of competency and in turn differ from the levels of learning outcome used in the National Qualifications Frameworks or NHS Knowledge & Skills Framework.
- There are numerous and varied job titles used by those who are responsible for the delivery of nutrition-related aspects of care that reflects the marked diversity of

roles within the workforce and the lack of standardisation in training, skills and function. Furthermore voluntarily registered nutrition professionals and other nutrition-related occupations are not included in the NHS census surveys. This lack of clarity or uniformity impedes the strategic assessment of workforce capacity.

85) Based upon this analysis, it can be concluded that any discussions relating to workforce development must address the following issues.

- The extent to which the Core Curriculum (the so-called '18 bullet points') serves as the foundation for nutrition training across all professional groups.

- The extent to which the nutrition-related knowledge and competencies required to deliver care has been clearly identified and communicated to those who develop, manage, deliver and examine professional training. This applies both for those for whom nutrition is core to their practice, and those who access nutrition from within other specialties.

- How this training would reflect a tiered system of increasing skill level and sophistication within pathways for career development which recognises the responsibilities of the deepening of understanding, knowledge and skills as an individual passes through higher levels of responsibility and with higher degrees of specialisation.

3. THE CURRENT WORKFORCE IN RELATION TO THE NEEDS

86) There are a range of staff in nutrition employed at different grades within the NHS. There is evidence of a lack of strategic capacity within the nutrition workforce in terms of public health. There is a considerable untapped potential as more than half of new nutrition graduates do not enter the workforce (Nutrition Society, 2006).

87) There has never been a formal consideration of the extent to which the numbers of different grades of staff match against the needs of the service and how these might change from time to time. Within the Agenda for Change (AfC) bands are assigned to post holders which reflect different levels of experience, skill and responsibility. It would be desirable to have the entire nutrition workforce characterised within this system of bands, especially the public health nutrition workforce. In Table 1 the range of different grades of nutrition staff within the NHS in the UK are summarised (column 1). Each individual post holder has been assigned to a suitable band (column 2). These have in turn been placed at a suitable position for the health work force within the NHS (column 3), as summarised in the Career Framework for Health on the Skills for Health website.

88) As a relatively new group of health professionals, there is no national profile for a Public Health Nutritionist in the NHS library of National Profiles. This creates an anomaly in the employment of Public Health Nutritionists and the effective utilisation of their abilities. Attempts have been made to resolve the problem to enable local employment. For example, managers have adapted job descriptions intended for community dietitians or dietetics assistants in the appointment of nutritionists. As a consequence, for nutritionists there are a range of job titles with varied AfC bands according to the level of the individual employee rather than the title and responsibilities of the post. A recent study on the Developing a Workforce Competent in Nutrition for Hampshire and the Isle of Wight (Jackson, 2005) noted the diversity within the community nutrition or public health nutrition workforce and the lack of standardisation in training, skills, function or title. This lack of clarity or uniformity impedes strategic assessment of workforce capacity.

Table 1 Map of a sample of nutrition posts against the Career Framework for Health (excluding doctors)

Categories of Nutrition Post[1]	AFC band	Notes from Health Career Framework[2]
AHP Consultant (Public Health/Public Health Nutrition)	9	SFH "More senior staff"
Food and Health Leads (England); Regional Public Health Nutritionists (Scotland)	8	SFH Consultant practitioners
PCT Nutrition Services Manager	7 (?)	SFH Advanced practitioners
Senior Public Health Nutritionist/ Community Nutrition Assistant programme coordinator	7	SFH Senior / specialist practitioners Post graduate post experience degree/ professional development experience
Sure Start Nutrition Team Leader/ Public Health Nutritionist	6	SFH Practitioners Post graduate degree, experience
Community Nutritionist	5	Degree
Sure Start Nutritionist/ Community Nutritionist	4	SFH Assistant Practitioners degree
Dietetic /Nutrition Assistant	3	Senior Healthcare assistants / technicians Foundation degrees (Diploma)
Community Food Worker	3	National Open College Network (NOCN)
Accredited Health Trainer (?)	2/3	SFH Support workers NOCN
1		SFH Initial entry level jobs

Sources
1. The categories among positions for nutritionist were taken from a convenience sample of Job Descriptions from nutritionists in Hampshire, London, Scotland, Midlands; based on discussions with public health nutritionists in these areas and in the North West, the British Dietetic Association and Prime R&D.
2. Skills for Health (2005)

Who will deliver and how can workforce capacity be planned?

89) There is the need to know the current numbers of specialists employed in the service, and how this compares with any estimate of capacity. As is clear from the above the critical specialist health professional which will be required to deliver the "Choosing Health" agenda is the Public Health Nutritionist. The problem in estimating capacity is because the NHS census surveys do not include voluntarily registered nutrition professionals and other nutrition-related occupations, it is not possible to obtain a sense of numbers currently in service, or the real nature of the service they provide. Simply, there are no nationally held databases or sources of information about the nutrition workforce (Nutrition Society, 2006).

90) An estimate of the current employment of nutritionists can be made. In England in 2004, in the NHS community services, there were 66 nutrition support staff to 1,042 nutrition professional staff. This can be compared with the most recent survey in USA of 3344 nutrition paraprofessionals to 7530 nutrition professional staff (Herzog et al, 2003).

91) A survey carried out amongst nutritionists who are members of the Nutrition Society, identified 52 public health nutritionists employed at strategic levels, (Nutrition Society, 2006). These were either in national or local government or agency (n=50) or Public Health Observatories (n=2). This equates to 13 per 5 millions of population.

92) It seems reasonable to expect at least one public health nutritionist for each of the 303 PCTs in England (boards or regions in the devolved countries). It was reported in 2002/3, that 280 PCTs had directors of public health, with a vacancy rate of 8% or 11% when shared posts were included. There were far fewer public health nutrition staff in PCTs than public health specialists in 280 PCTs (Wanless, 2004).

93) These comparisons demonstrate a severe lack of capacity. The Nutrition Society (2006) analysed the first destination for employment of graduates from Higher Education Statistical Agency. Of 528 graduates in 2004, there were 285 who were potentially eligible for voluntary registration and who would represent the first entry level for employment in the public health nutrition workforce. By contrast, there were 23 who were employed in the health service other than in dietetics. This implies a severe shortage of appropriate employment opportunities even for those who might be suitably trained.

94) The situation in the UK can be compared with international benchmarks. This comparison may provide some guide to potential routes for future development of capacity.

95) An analysis carried out for the USA provides a helpful example to identify the normative needs for the different categories of Public Health Nutrition workforce in the UK (Table 2). Public Health Nutritionists are licensed in the USA (regulated at state level in 45 states). An Association of Public Health Nutrition Directors undertakes regular census surveys of this more highly developed and organised workforce. Around 90% of those in Public Health Nnutrition were employed in the Women, Infants and Children (WIC) programme, which would compare with Healthy Start and Sure Start in England.

96) By analogy with the USA, in England there would be strategic Public Health Nutritionists in government departments and arms length bodies central to the delivery of Choosing Health. These would include:

- the Department of Health, and Department of Education;
- the Office of the Deputy Prime Minister;
- the nine Governments of the Regions, alongside Regional Directors of Public Health;
- within the Obesity Programme;
- within other programmes to make strategic contributions to planning
- implementation, coordination and evaluating key programmes, or their components
- within the Choosing Health Delivery Plan – Helping Children and Young People to lead healthy lives;
- Promoting Healthy Active Life amongst older people;
- delivery for communities among the new regional facilities for Food Standards Agency as well as national level;
- School Fund;
- NICE;
- as well as in larger NGOs such as National Consumers Council, Food Commission and Sustain.

97) Given their evolving roles and responsibilities it is likely that there should be a qualified Public Health Nutritionists in every PCT. At the very least there should be clearly identified staff with the necessary knowledge and skills to carry out the tasks directly related to nutrition. However the NHS is configured there will need to be adequate numbers of suitably trained staff if the current ambitions are to have any likelihood of success.

98) Public Health Nutritionists fulfilling these responsibilities will be eligible for admission to the UK Voluntary Register of Public Health Specialists (UKVRPHS) as well as the Nutrition Society's voluntary register of Public Heath Nutritionists. Therefore, collaboration between these two voluntary registers should be encouraged, as a means of building capacity efficiently, as part of the national plan outlined in Department of Health's Choosing Health - Investing in the workforce (2005e) gaining from support for the development of the public health function. The UKVRPHS and NS's (or the successor body that will hold an independent) voluntary register should collaborate to assess competency and thereby assist with developing training comparably with the regulated health professionals.

Table 2 International comparison of the size of the public health workforce.

Category within the Public Health Nutrition Workforce	UNU/IUNS[1] (1997)	USA[2] (2003)	Australia[3] (2004)	England[4] (2005/6)
	Numbers per $5x10^6$ population			
National policy makers and macro planners/ decision makers	1-5	13.2	Not stated	Not stated
Researchers, mid-level planners, trainers	10 - 50	37.1	Not stated	Not stated
Programme implementers "field level" directly serve and relate to communities	200 - 500	99.8	Not stated	Not stated
All public health nutritionists	111-550	76 -172.7	38	41 – 224

1. Excludes support, paraprofessional and operational nutrition staff
2. Calculated from numbers in Survey of the Public Health Nutrition Workforce 1999-2000, by Herzog, McCall & Keir (2003) & the USA (2000) census for a population of 218 million. The table shows combined numbers of PHN directors (10) and assistant directors (3.2); and combined numbers of clinical nutritionists, public health nutritionists (25.4) and nutritionists (79.6). Excluding the clinical nutritionists and nutritionists who do not work at individual or operational population levels, there were 76 per 5 million in the public health nutrition workforce. Support staff, such as nutrition technician, nutrition assistant or nutrition aides who numbered 3344 (31%) were not included here. The workforce appears to have increased from 2,393 full time equivalents reported by Haughton et al (1998).

   The proportion of RDs was 42% with 2.4% dietetic technicians, the same proportion of dietitians in the public health workforce as in 1994.
3. Hughes (2004) full-time equivalent numbers of all staff with roles in public health nutrition, but not the same categories as in the other sources
4. Nutrition Society (2006) estimated the size of the public health nutrition workforce; the higher number includes all dieticians employed in NHS England Community Services and the lower includes only the designated public health nutrition workforce identified in surveys and scoping review by Stockley & Associates in 2005 (Nutrition Society, 2006).

Development of Capacity for Nutrition Workforce

99) In order to deliver an effective service there is the need to ensure an adequate and competent workforce. Currently there is lack of clarity about the numbers, roles, responsibilities of those with any training and experience in nutrition. The result is ineffective and inefficient utilisation of the limited resource that is available currently.

100) There needs to be better categorisation of staff in relation to their knowledge, skills. We suggest the following in the first instance:

Directors of Public Health Nutrition who direct a nutrition unit, conduct needs assessment and prepare comprehensive plans, in state, county, large city or large voluntary agencies sometimes with an Assistant Director.

Public Health Nutrition Supervisors whose duties include overseeing the work of public health nutrition staff, training, evaluating, coordinating and reporting.

Public Health Nutritionists has formal specialist training employed by state, county, or local agency assesses community's nutrition needs, and to plan, direct and evaluate interventions to promote health and prevent disease.

Clinical Nutritionists plan and deliver services for the ill and healthy patients and clients in the USA. In the UK this role is fulfilled by dietitians but it is unclear to what extent it aims to coordinate individual care and secondary prevention at population level, as would be necessary to coordinate the primary and secondary prevention of undernutrition and of the obese with co-morbidities, in the community and care facilities with hospital care.

Nutritionists provide nutrition education to the public and direct nutritional care in health and disease throughout the life span. In the UK this role is fulfilled by the (community) dietitian.

Nutrition Technicians are paraprofessionals, who, closely supervised by a nutritionist works in clinics to provide education, using prescribed protocols for screening, record keeping and outreach. In the UK this role is occupied by Dietetic Assistant or Nutrition Assistant.

Nutrition Assistant or Aide an auxiliary worker from the community trained on the job. In the UK there are Community Food Workers and Food and Health Advisers in this kind of role whose numbers will be swollen by the new Accredited Health Trainers.

5. CONCLUSIONS

- There is a need to define the nutrition-related competencies for each level of occupational and professional groups within the workforce and for Government to state their requirements to steer the development of training for competency, as promised in Delivering Choosing Health – Improving the Workforce.
- There is a need to devise a programme for training in the application of nutritional knowledge and understanding and in the core health professional competencies (as stated in the NHS KSFs) to equip those entering the workforce at graduate levels.
- The regulated professions must ensure that referral and accountability is clearly stated in the database of standards, possibly by extending the work on standards undertaken within Skills for Health, in partnership with the nutrition professions in order to fill the gaps in existing standards to reflect care pathways for nutrition health promotion and primary, secondary and tertiary nutrition health prevention for any setting or patient group.
- Measurable standards for competency must be defined that include attitudes and practical professional competencies, as well as knowledge and that are fit for purpose.
- There is a need to define the systems and structures within which those responsible for delivering nutrition-related aspects of care operate, especially within public health. Such action is timely given the stage of the Agenda for Change job evaluations of the health improvement workforce, the progress of Modernising Medical Careers and the proposal to open a category of registration on the UKVRPHS for public health nutrition as an area of specialist practice.
- The development of training will require resources to up-skill the existing workforce and to enable the initial training of those joining the workforce, in a way that is comparable with or integrated within schemes for training other health professionals, especially the generalist public health specialists, public health nurses, community pharmacists and public health environmental officers.
- There is a need to identify ways to organise, involve and develop all categories of nutrition workers as part of a plan to invest in the delivery of health care and at the same time, strengthen the NPC's unified voice for the nutrition professions to benefit health.

6. RECOMMENDATIONS AND PROPOSALS FOR FUTURE STEPS

101) If the immediate challenge is to be addressed effectively, it is recommended that the there is the need to take consistent and co-ordinated action as a priority. We have identified six areas in which action is required. Each of these six areas is distinct in itself but each area carries complementarities to the other. It has to be emphasised that action is required in all six areas and there needs to be coordination to bring coherence across the areas. We have presumed a model in which the need for professional support is determined by the demand for effective and reliable service delivery.

1. The demand for nutrition-related activities – the potential.
   What are the areas in which nutrition may be expected to contribute to the protection of health or the prevention and treatment of disease?

2. Identified needs for nutrition-related activities – the expectation.
   How are these demands prioritised in the commissioning process within short, intermediate and longer-term expectations of the healthcare strategy? What targets, PSA or LSA have been set?

3. Characterising the service provision requirements – the shape of the required workforce.
   What are the systems, structures, processes needed to support the delivery of these services? What knowledge, skills and competencies are needed within the workforce in order to meet these needs?

4. Current competence and capacity of the workforce.
   Does the existing workforce possess the necessary knowledge, skills and competencies and standards of performance to meet these needs, both in terms of core professionals and those who access nutrition from within their own professional discipline?

5. Analysis of service delivery – the fit between supply and demand.
   What is the extent, nature and implications of any mismatch or shortfall between the capacity and competencies of the existing workforce and that required to meet the service expectation?

6. Characterising the workforce improvement programme.
   What are the implications for training - in terms of standards of performance and competencies - both of the existing workforce and those entering the workforce? In terms of the core professionals, what will they bring that nobody else can do, is more cost effective or bring added value to the activities of others? Who should have responsibility for the delivery of training and audit/regulation of service delivery?

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ANNEX 1

Professor Alan Jackson
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16th August 2006

Dear Professor Jackson

Nutrition Professions Confederation Minutes 12.7.06 and Briefing Paper – The Nutrition Workforce for Achieving Public Health Competency, Training and Capacity Development – The BDA Response

Thank you for sending the above document to the BDA for comment. It was unfortunate that we did not have a representative available to attend the meeting on the 12th July, however, this was due to a decision on my part to secure a more appropriate representative from the BDA for the NPC, and some internal communication issues created by a change in staff at the BDA. I apologise for not having a presence at the meeting.

Firstly can I correct the minute of the meeting of the 12th July when our previous representative, Anne Pridgeon has been allocated the title of President of the British Dietetic Association. A more accurate term would be "Professional Representative" and I would be grateful for this amendment to be recorded.

I would be grateful if the secretariat could note that any future correspondence regards the NPC should be directed to myself at the BDA offices or on email to my PA, Nula Marnell on n.marnell@bda.uk.com and not to Mrs Anne Pridgeon as previously advised.

There are a number of comments I would like to make on the NPC in general, its direction and constitution and the briefing paper which you presented to this group at the meeting on the 12th July. For ease of reading I will concentrate on the general comments and issues regarding the NPC initially and then provide feedback on the briefing paper.

Nutrition Professions Confederation

The BDA supports joint working between those groups which make up the NPC. We can see the value in the nutrition scientists and those professions who work in implementing nutrition science into practice within the health community, working together to raise the profile of our associations and groups, promote a coherent vision for nutrition and public health and to support a greater knowledge and understanding of nutrition and it's application to human health within the health professions. However, we have a number of concerns about the structure, mode of operation and the current work of the NPC:

1. The BDA is confused by the constant reference to the work of the NPC being an "activity of SACN". I am unable to see the relevance of the current agenda of the NPC to the terms of reference of SACN as a scientific advisory body. Despite reading all the papers which have been tabled at the NPC, I am unclear of the key drivers for the creation of the NPC. Clarity on this issue would serve to support a clear vision for the NPC's purpose and help to derive a set of terms of reference for the NPC which, in the view of the BDA, is clearly needed.

Clarity needs also to be given to the Constitution of the NPC, including the election of a Chair, the bodies who are part of the confederation and who sign up to it's purpose and function and a clear set of ground rules for decision making.

I would be very grateful for early consideration of these fundamental issues if we are to support the work of what could be an influential body, supporting a unified voice for the bone fide nutrition scientists and professionals.

2. There is frequent reference in the minutes and other documents of the need for the SACN to be able to undertake risk assessments accurately. There is inference that such risk assessments are not easily made at present due to lack of evaluation and other data from Government agencies and others. These references serve to illustrate the need to be clear about the Terms of Reference and purpose of the NPC as this should have a distinct function to that of SACN. In addition it is not clear if the requirement for accurate risk assessment is about the risk to the public of poorly informed/knowledgeable health staff regards nutrition or the risk to SACN of not having a sufficient evidence base of evaluation of nutrition interventions to make effective recommendations. Indeed, it could be both of these and I would welcome clarity on this matter.

3. It would be helpful, and indeed I feel is critical, to the constitutional position of the NPC, that the relationship between the NPC member organisations and the FSA and DH observers is clarified. The BDA has concerns about the current role of the FSA as secretariat to a body which is neither a function of the FSA nor a function of government. We believe the secretariat for the NPC needs to come from within the member bodies and the NPC should have independence from government bodies and other agencies. This would not preclude the NPC inviting government representatives and agencies to observe at meetings, and contribute to discussion, as appropriate.

4. One of the potential reasons for poor attendance at the last meeting was because meeting dates are not planned far enough in advance. It is crucial to the success of the

NPC that any meeting date in January/February 2007 is notified to member bodies now, to allow planning of diaries and commitments. Indeed the NPC should have a calendar of its events which is transparent to all member bodies.

5. As with other Confederation or Federal bodies to which the BDA belongs, it seems reasonable to suggest the need for the NPC to consider the development of a strategy and clear work plan to which all members organisations can sign up and support. Such a work plan needs to be developed by all member bodies and through a system of transparent prioritisation. It is not clear to the BDA if the NPC has any clear plan and this is of concern to us as a member organisation. This would serve to develop the "agenda" for the NPC and ensure shared ownership across the member organisations.

The Nutrition Workforce for Achieving Public Health Competency, Training and Capacity Development

The BDA express deep concerns about the content of this document and the rational for the creation of it. The document makes an attempt to consider the workforce needs to deliver a complete public health nutrition function and programme across the UK and the BDA would support the creation of a joint vision for this aspirational aim. However, as it stands at present, the document fails to consider the current pressures and planning processes in the health service and the wider public sector partner agencies concerned with public health. The document naively suggests the main reason for this are an inadequately trained workforce and the lack of development of a public health nutrition workforce. While the workforce dimension is one of the reasons for the current underdevelopment of nutrition health improvement programmes, other reasons have been ignored including the health and public sector planning and financial allocation process and the divergence of pressures on the health sector in particular to deliver on many targets, not just those with a relevance to public health nutrition.

In general terms there is a total lack of acknowledgement and misrepresentation of the current roles of Dietitians within the document. Statements are made which are clearly at odds with our professional practice roles such as "the competence of dietitians does not embrace the delivery of public health, which is properly the responsibility of public health nutritionists" (page 10).

Indeed the whole document, while masquerading as a workforce plan to deliver improvement in the health of the population, instead focuses on promoting the role of nutritionist and public health nutritionists as the saviour of the nutritional health of the population. It pigeon holes the role of the Dietetic Profession almost exclusively into clinical practice which is a misinterpretation of the current role of our profession. The BDA is happy to provide many examples of Dietitians who are working at all levels in the field of public health, including at generalist/graduate level, specialist level, strategic/leadership levels and in Consultant roles across the UK. The development of support worker roles in Dietetic services also encompasses delivery of lower level public health nutrition practice. The table outlining the potential career for a "nutrition

workforce" on page 25 and page 29 ignores the existing roles of Dietitians at all levels of the career pathway in the delivery of public health nutrition functions or strategy. The structure takes no account of the existing well defined roles of the Nutrition and Dietetic Services Leader or other dietetic professional lead roles in each Trust in England, and equivalent in the home countries. Indeed it is interesting to note the reference to an AHP Consultant in Public Health Nutrition – a role which by nature of being an Allied Health Professional can only be filled by a Registered Dietitian. There is one post in the UK with this title and is it is filled by a Dietitian working at a strategic level to direct and drive public health nutrition across the health board area. The BDA can also provide other examples of dietitians work in other similar roles at health authority or PCT level.

We accept there is a lack of uniformity across the UK in access and development of these services, however it must be recognised, such development is subject to the planning processes in each health community/area, and not solely within the gift of professional groups. It is with regret the authors of this document have failed to acknowledge the development of the dietetic profession in recent years as we have benefited from the strategic support of documents such as the "Scottish Diet Action Plan" (1996) which recommended "health boards should consider appointing public health nutritionists or suitably experienced dietitians" to assist in delivery of this plan. It is clear the dual and complementary role of dietitians and public health nutritionists had been made clear in Scottish health policy in the mid 90's. The BDA believe the focus of the NPC in workforce planning should be on promoting the benefits of existing models of public health nutrition leadership (which exist in many regions in the UK) and in expanding this model across all regions. On page 4 of the report the authors suggest the importance of establishing systems which standardise competence across the professional groups at a level appropriate to their role in nutrition. We would support work to define competence in a role (whether that be a Public Health Nutritionist or Public Health Dietitian) as opposed to the professional qualification and background.

The BDA have supported the development of the roles of nutritionist and public health nutritionists as ***part*** of the public health workforce. However, we see these roles as complementary to the existing function of dietitians. Your paper marginalises the role of Dietitians and indeed, others in the nutritional health of our nation. While it outlines at the beginning the variation in training and education of the broad nutrition workforce (including nurses, medics etc.), it does not attempt to support the standardisation of a national approach to the wider workforce competency in nutrition and proposed no long term solutions to this, other than the proliferation of the roles of nutritionists. The creation of a workforce of nutritionists will not provide the total solution to the wider workforce educational needs. The document takes no account of the current status of training for nutrition graduates, who undertake "education" in nutrition science but do not consistently on a UK wide level receive "professional training" in nutrition practice. There is little point in promoting a workforce who as yet has still to standardise their undergraduate training in professional practice skills.

Page 16 refers to the potential of a nutrition workforce is broader terms, however, the authors refer to nutrition specialists/primary nutrition workers as those who spend "most

of their time nutrition service delivery". The authors include nutrition nurses and medics who have specialised in nutrition within this term. The BDA find this definition difficult to accept. Primary or specialist nutrition workers should be those with a primary graduate qualification in nutrition science with training in the practice of this science. This would narrow the definition to what we would commonly refer to as nutritionists, public health nutritionists and dietitians. All other components of the nutrition workforce are either non-specialists/secondary nutrition workers, who have a specialist interest in nutrition but form part of another professional group (e.g. nurses, medics, pharmacists etc.) or form part of the support worker workforce which would include dietetic assistants, food workers and nutritional assistants among others. The level of training and expertise at each of these three levels can then be defined by whether the practitioner works in public health, clinical practice or in both areas.

While it is accepted some medics will train to a very specialist level in nutrition and may become specialist or primary nutrition workers, this is rare and most practising medical professionals rightly rely on dietitians to provide the nutrition expertise they need within the wider multi-disciplinary team. A potential model is provided in the table below however, this list is not exhaustive and provided purely for illustration;

	Specialist/Primary	**Secondary/generalist**	**Support worker**
Public health nutrition	Dietitians Nutritionists Public health nutritionists	Medics trained in public health nutrition Public health nurses Public health specialists Health Promotion Specialists	Dietetic Assistants Nutrition Assistants Public health assistants
Clinical nutrition	Dietitians	Medics trained in clinical nutrition Nutrition Nurses Clinical pharmacists trained in nutrition	Dietetic Assistants Therapy Assistants Care Assistants

One positive outcome from the paper is the clear need to support standardisation of nutrition training in the non specialist/generalist health service workforce and in particular the support worker workforce. Unfortunately, the document does not suggest a clear way forward in this crucial area. The NPC could usefully concentrate their efforts in this arena and create a common framework for this.

The document at times confuses the reader by initially focussing on public health and primary health improvement in the nutrition field but then draws in further complexity by including reference to malnutrition screening and implementation of the NICE guidelines

for Nutrition Support in England and Wales. There is a need to be clear about the competency and scope of practice of the existing and potential public health nutrition workforce, as some of this blurs the boundaries with clinical nutrition. This is very clearly a complex area requiring greater clinical expertise developed through under and post graduate dietetic training (and in the case of medical staff and nurses etc. post graduate education in the field of nutrition) and is not a suitable field for nutritionists and public health nutritionists to practice within due to their lack of clinical training and knowledge.

There is frequent reference to the "Core Curriculum", however, the BDA can find no reference to this on the Dept. of Health website and it would appear the document is now 12 years old. The BDA can find no evidence that the dietetic profession signed up to this document. While we support the value in such a document, we feel the time is right to review any core nutrition curriculum and develop and up to date framework based on the perspectives of all NPC members. It would be useful to us if the authors of the original core curriculum could be established and the origins of the document made clear to the BDA.

On page 3 of the Executive Summary there is a statement that the "training, knowledge and competency in nutrition for those charged with the responsibility of delivering care are poor and not adequate for the needs of delivering the service safely and competently". The BDA would disagree with this statement, as Dietitians and their assistants are clearly trained in the "delivery of nutritional care" as part of the multi-disciplinary team. Other nutrition based workers may not have such skills and indeed we would agree, there is a need to develop the knowledge and skill of the wider health workforce.

On page 12 the authors state there is a "shortage of dietitians", however while this may have been the case in the late 90's, it is not necessarily the situation now. There has been a 50% increase in the commissioned training places for dietitians and the courses remain very popular and over subscribed. However, public sector funding constraints have limited further growth for dietetics in the nutrition workforce and we believe such funding constraints in the public sector to be of equal importance to the development of roles for nutritionists etc. While the BDA will continue to promote the role of the Dietitian in the nutrition and health workforce, we can no longer claim a shortage, based on the funding available to provide jobs for our graduates. It is important this is acknowledged, as workforce planning for any growth in the nutrition workforce will need to take established planning mechanisms and affordability into account.

The conclusions and recommendations are more promising however, they do not clearly reflect the proposals with the body of the document. They do provide some questions for wider debate which is clearly required for a consensus to be reached which meets the perspectives of all the member organisations that form the NPC.

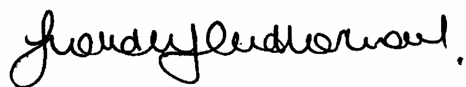
Finally, the length of the document is not helpful. There are areas of duplication and the wordiness of the text may not help us in promoting our aims to the wider world. The

BDA would suggest future documents concentrate on the key facts, which should be developed by all stakeholder organisations.

I look forward to receiving the clarity the BDA proposes is required on the constitution of the NPC and to ensuring future drafts of this document or future documents, more clearly resemble the wider perspectives of member bodies to ensure our continued support of the NPC in the future.

I look forward to hearing from you.

Yours sincerely



Judith Catherwood
<u>Honorary Chairman</u>