

Introduction and reason for submitting evidence

This submission is from the British Dietetic Association (BDA), the professional body and trade union for the UK dietetic workforce, representing more than 12,000 members. Dietitians are one of the 14 allied health professions and have a distinctive role in translating nutrition science into practical, personalised advice that improves individual and public, treat disease and supports people to manage long-term conditions. Dietitians work across all sectors and age groups, and are particularly important in the NHS and social care workforce, where the majority of the profession is employed. Their contribution is a keystone to the Government's 10 Year Health Plan ambitions to shift care from hospital to community, from analogue to digital, and from sickness to prevention. The British Dietetic Association's (BDA) response to the NHS 10-Year Plan consultation emphasised that dietitians are central to preventing and managing diet-related conditions, reducing avoidable demand on pressured services, improving outcomes and supporting more sustainable use of NHS resources. Neighbourhood health will not achieve its potential unless dietetic expertise is designed into governance, pathways and delivery rather than left to local discretion.

Allied health professions and leadership – all questions

Dietitians provide leadership across life-course prevention, long-term conditions, including obesity, diabetes, gastrointestinal and cardiovascular diseases, maternal and child health, mental health, frailty and rehabilitation and much more. However, this expertise is not consistently reflected in neighbourhood health leadership structures.

However, this leadership is often not formally recognised within neighbourhood health models. In many local systems, dietitians are invited into multidisciplinary working only once a pathway has already been designed, rather than being involved from the outset as clinical leaders, pathway designers and population health experts. This means that nutrition and hydration, despite being core determinants of health, are too often treated as an addition to medical or nursing models rather than as a central component of neighbourhood care, and prevention. A neighbourhood model that aims to keep people well, reduce avoidable admissions and support people to live independently must include senior dietetic leadership in governance, planning, pathway design and delivery.

Moray Case:

The Moray case finder report is an example of how a primary care dietetic workforce can use case finding and digital health to identify unmet need and deliver health improvement across populations. Of 82 respondents, 65 (79%) opted for a telephone consultation with a dietitian; 87% of those answering the relevant question found the call very or somewhat helpful, and dietitians made 96 referrals or information interventions. Self-reported knowledge, confidence and motivation improved, but BMI did not change significantly, and the sample and questionnaire design limit the findings. [1]

Birmingham PCN dietitians:

Local service evaluations show measurable benefits. Six PCN dietitians working across nine Birmingham PCNs reported more than 600 GP appointments saved, more than £70,000 saved through reducing inappropriate prescribing, and access for most patients within one

week during the first 12 to 15 months. A care-home service reviewed 89 residents across 16 homes, saving £57.62 a day in oral nutritional supplement prescribing; staff costs were recovered after 54 days, with estimated annual savings of £21,031. These are promising, scalable examples.[2][3]

Birmingham care homes:

Birmingham Community Healthcare NHS Foundation Trust combined care-home training by a dietetic assistant practitioner with dietitian-led reviews of oral nutritional supplements. Across 2023–2025, 1,199 residents were reviewed and more than £1 million in annualised prescribing savings was realised. Between 841 and 952 staff were trained each year; all respondents recommended the training [4]

Torbay and South Devon:

Community dietitians worked across 33 care homes through staff training and hydration champions. Reported results included an 18.5% reduction in UTIs requiring antibiotics and a 63.6% reduction in falls resulting in hospital admission [5]

Somerset IBS pathway:

An integrated GP, diagnostics and community dietetic pathway achieved satisfactory symptom control for 63% of patients and improved quality of life for 74%. Secondary-care use and costs for the relevant patient group reduced [6]

Type 2 diabetes remission:

In the NHS programme, 32% of completers with the required measurements achieved remission at one year. This demonstrates the potential of structured dietary intervention at scale, while the independent evaluation also found inequalities in referral, uptake and completion that neighbourhood teams must address [7]

Community-based dietetic care gives people earlier access to evidence-based nutrition support while helping dietitians understand the social, cultural, financial and practical factors that shape health. Embedding dietitians within neighbourhood and primary care teams, supported by shared records and integrated working, can improve service user experience, enable timely intervention, guide people to the right support sooner and reduce pressure on specialist services. However, these benefits will remain inconsistent unless dietitians are included in neighbourhood models from the outset and outcomes are measured consistently, while retaining hospital-based specialist care where clinically necessary.

Funding and commissioning – all questions

Commissioning does not consistently require AHP leadership, so access to dietetic expertise depends too heavily on local advocacy. This creates unwarranted variation and risks leaving nutrition, prevention and rehabilitation out of neighbourhood planning. National commissioning standards should require AHP involvement and access to dietetic expertise in pathways where nutrition materially affects need, outcomes or cost.

Commissioning standards should therefore mandate AHP involvement in neighbourhood multidisciplinary teams, long-term condition pathways, frailty services, children and young people's services, weight management, public health and prevention programmes.

Neighbourhood health commissioning should include clear requirements for named AHP leads in primary care networks, neighbourhood health centres and integrated care systems at board level. These roles should have explicit responsibility for pathway design, outcomes, workforce planning, quality improvement and partnership working with local government, social care and voluntary and community organisations. Without named accountability, there is a risk that neighbourhood health will reproduce existing medical and nursing dominant leadership cultures and continue to marginalise AHP voices in strategic decision-making. Dietitians should lead or co-lead pathways in which nutrition is a material driver of need, outcomes or cost.

There is a further risk that neighbourhood health could repeat some of the implementation problems seen with previous attempts to expand the multidisciplinary team in primary care. Expanded roles can be beneficial, but only if staff are genuinely embedded in local teams, have stable employment arrangements, receive supervision, understand each other's contribution and are supported to work at the top of their capability. Neighbourhood health must therefore be designed around integration, not simply co-location or a list of professions.

Commissioning must also join-up fragmented pathways. A practical example is weight management: service users, GPs and community teams can struggle to know where to refer, and this is likely to become more complex as GLP-1 medicines are rolled out. NHS England is prioritising about 220,000 people in the first three years of a 12-year tirzepatide rollout, which will require trained staff and community capacity. High eligibility thresholds can delay access until need has escalated. Neighbourhood services should support earlier, risk-based intervention and clear referral routes. [8]

Digital transformation is also essential, but current IT systems are a major barrier to productive neighbourhood working. Shared records, single sign-on and interoperable systems are essential. Dietitians working across neighbourhoods should not have to navigate multiple versions of the same clinical system. Digital tools must fit clinical workflows, retain necessary functionality and reduce rather than add administrative burden. A commitment to single sign-on and better infrastructure is welcome, but implementation must retain functionality and be designed around clinical workflow rather than relying on simplified or cheaper versions that do not meet frontline need. Without this, digital neighbourhood health risks creating more administrative burdens rather than increasing productivity.

Health inequalities - How can allied health professionals working within neighbourhood health models help address health inequalities and improve access, experience and outcomes for underserved populations?

Diet-related ill health is strongly patterned by deprivation, ethnicity, geography and access to services. People living in more deprived communities are more likely to experience obesity, type 2 diabetes, cardiovascular disease, food insecurity, malnutrition, frailty and poorer access to timely specialist advice. For example, adult obesity prevalence in England was 37.4% in the most deprived areas and 19.8% in the least deprived in 2023/24 [9]. Dietitians can use population data and co-create culturally relevant interventions, that help to reduce the inequalities caused by poverty, housing or the food environment. Effective

neighbourhood action requires partnership with public health, local government, social care, education and voluntary, community and social enterprise organisations.

Culturally tailored nutrition programmes are a practical example. Dietitians working with African, Caribbean and South Asian community organisations can co-design dietary interventions that reflect food traditions, cultural and religious practice, cooking facilities, language needs and health beliefs. This improves engagement and makes advice more actionable.

Dietitians support babies, children and young people across maternal and infant nutrition, allergy, faltering growth, neurodiversity, eating disorders and weight management. Earlier community access can prevent escalation and support families, but services must connect with maternity, health visiting, paediatrics, mental health, schools and family hubs.

In older adult communities, dietitians can reduce inequalities through proactive frailty, malnutrition and care home work, including review of oral nutritional supplement prescribing, food-first approaches and support for carers and care staff. These interventions improve quality of life while supporting system sustainability.

Workforce - Which commitments within the NHS 10 Year Health Plan depend on greater deployment of AHPs, and what policy changes are needed to realise this contribution? What are the key workforce challenges and opportunities, including recruitment, retention, advanced practice, leadership and training for allied health professionals?

Government should require access to dietetic expertise within the national service specification for neighbourhood health, supported by needs-based workforce planning and named dietetic leadership for pathways where nutrition materially affects need, outcomes or cost. This would enable earlier intervention, reduce avoidable prescribing, referrals and admissions, improve outcomes in long-term conditions and support more equitable access.

The NHS 10 Year Health Plan's commitments on neighbourhood care, personalised care planning, rehabilitation, weight management and prevention all depend on sufficient dietetic capacity. Nutrition is a major determinant of health across many of the conditions driving NHS demand, including obesity, diabetes, cardiovascular disease, cancer and malnutrition. If dietitians remain concentrated in overstretched specialist services, neighbourhood health will miss a significant opportunity to prevent deterioration and reduce avoidable escalation.

Current barriers include insufficient funded primary and community dietetic posts, inconsistent commissioning, limited advanced-practice opportunities and poor visibility of AHP leadership. While digital tools can improve case finding and prioritisation, they cannot replace a workforce able to assess need, deliver interventions and evaluate outcomes.

The HCPC register includes 12,592 dietitians, around three quarters of whom work in England, with approximately 70% employed in the NHS or social care [10]. Although the profession has a relatively strong education pipeline, vacancy rates remain around 10% and some specialist areas experience persistent recruitment difficulties. Retention is also a concern. Dietitians are drawn to the NHS by opportunities for professional development, specialist practice and multidisciplinary working. If community roles become isolated or unsupported, the NHS risks losing experienced staff to other sectors.

Neighbourhood roles must therefore be professionally sustainable. Community dietitians often manage complex clinical risk and safeguarding concerns while working with less immediate peer support than hospital colleagues. Integration requires more than co-location or remote working; it requires genuine multidisciplinary team structures, supervision and career development.

Continuing professional development (CPD) must also be properly funded. Staff need protected time and backfill to access training, yet many AHP services operate without sufficient staffing headroom and vacancies can make releasing staff difficult. Advanced practice pathways should reflect the distinct contribution of dietitians and other AHPs rather than being based solely on medical models. Apprenticeships and training routes should be fully funded to avoid reducing already stretched service capacity.

Workforce development should include advanced practice dietetic roles in areas such as diabetes, obesity, frailty, paediatrics, mental health and public health. Advanced practitioners can manage complex risk, support medicines optimisation, lead quality improvement and provide clinical leadership within neighbourhood teams.

Conclusion - If Government were to make one policy or commissioning change to support the expansion and development of allied health professionals, what should it be and why?

Neighbourhood health offers a major opportunity to redesign care around prevention, earlier intervention, population need and local partnership. However, it will only succeed if AHPs are built into leadership, commissioning and workforce models from the start. Dietitians bring specific expertise in nutrition, prevention, long-term condition management, public health, behaviour change and system efficiency. The APPG inquiry should therefore recommend that neighbourhood health models include formal AHP leadership, mandated dietetic involvement in relevant pathways, investment in primary and community dietetic posts, advanced practice development, digital case finding linked to real workforce capacity, and commissioning standards that make prevention and nutrition core business rather than optional extras.

References

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