BDA Response to the Select Committee on the Long-term Sustainability of the NHS of the House of Lords Call for Evidence

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## Contents

1. Executive Summary ........................................................................................................... 2
2. About the BDA .................................................................................................................. 3  
   What is a dietitian? .............................................................................................................. 3
3. The Future Healthcare System .......................................................................................... 4
4. Resources ........................................................................................................................... 4  
   Wider Societal Value ........................................................................................................ 5
   Funding Models ............................................................................................................... 5
   Hypothecated health taxes/sin taxes ................................................................................ 5
   Free at the point of use .................................................................................................... 6
5. Workforce .......................................................................................................................... 6  
   Options for increasing supply ........................................................................................ 7
   Effect of leaving the European Union on the continued supply of healthcare workers from overseas .................................................................................................................. 7
   Retention issues for key groups of healthcare workers ....................................................... 7
   Ensuring a sufficiently and appropriately trained health and social care workforce ...... 8
   New technologies to increase the agility of the health and social care workforce .......... 8
   Cost implications of a workforce equipped with a more adaptable skill mix to better meet the needs of patients ................................................................................................. 9
   Dietitian 2025 ................................................................................................................. 9
6. Models of Service ................................................................................................................. 9  
   Truly integrated budgets and Incentivising collaboration .................................................. 9
   Balance between Hospital and Community Services ......................................................... 10
   Balance between mental and physical health and care services ....................................... 10
7. Prevention and Public Health ............................................................................................. 11  
   Key elements of a public health policy to increase years of good health ......................... 11
   Role of the state, the individual and local and regional bodies .......................................... 11
   Mismatch between prevention and treatment .................................................................. 11
   Should the UK Government legislate for greater industry responsibility? ....................... 12
   By what means can providers be incentivized to keep people healthier? ......................... 12
   What are the barriers to taking on received knowledge about healthy places to live and work? ........................................................................................................................................ 12
   How can technology play a greater role? .......................................................................... 13
8. Technology and digital services .......................................................................................... 13  
   Role for technology .......................................................................................................... 13
2. References ......................................................................................................................... 14
1. Executive Summary

1.1. The BDA believes that dietitians have a vital role to play in the future sustainability of the NHS. Nutrition plays a vital role in keeping people healthy, treating disease and helping people to recover from ill health. As a relatively small but highly specialised profession, dietitians already do a great deal across healthcare to improve patient outcomes, drive NHS efficiency and improving public health to ensure it remains sustainable into the foreseeable future. This consultation response, summarised below, sets out our view on how wider sustainability can be achieved.

1.2. Demographic and health changes over the next 15 years fundamentally threaten the sustainability of the NHS. Diet and nutrition plays a critical role in reducing the impact of an ageing population and reducing the prevalence of long term conditions. 10.8% of all illness is caused by poor diet and for some conditions, better diet and nutrition can prevent them developing at all, while with others they can lessen their impact, speed recovery and reduce hospital stays.

1.3. The current spending envelope for the NHS is not realistic, and while we have a highly efficient health service we lag behind our neighbours in terms of outcomes, funding as a proportion of GDP and staffing numbers. We urgently need a model of funding that recognises the wider social impact of the health service, integrates health and social care and guarantees the principle of healthcare free at the point of delivery. There are opportunities to fund this through specific taxes, while also having desirable health outcomes through the use of sin taxes and levies.

1.4. There are currently insufficient dietitians in the UK to meet current needs, let alone the much wider roles that we believe they could perform. The removal of bursaries for dietitians, nurses and other AHPs will have an unknown effect upon the future expansion of the workforce. The government must take steps to ensure the UK still has access to talent from the EU and from around the world despite “Brexit”.

1.5. The NHS is struggling to retain existing staff, who have faced increasing demand while facing long-term pay restraint. The BDA’s own Safe Workload, Safe Staffing survey found 54.7% of respondents felt they could not see patients in a timely manner, and 39.7% felt they lacked opportunities to undertake important personal development work. Technology has the capacity to greatly increase the flexibility and agility of the workforce, but should not be regarded as a panacea that will enable the health service to do more ‘on the cheap’ with fewer members of staff.

1.6. Collaboration between healthcare organisations suffers because of the divide between investment and outcomes. Many of the most effective interventions or collaborative proposals will produce positive outcomes that do not directly benefit those paying for them. The imbalance in the current funding models between secondary and primary care and between physical and mental health need to be addressed.

1.7. The most severe imbalance in funding and priorities is between prevention and treatment. Only 4% of the NHS’s budget is currently spent on prevention, and public health is ringfenced and run separately by local authorities. This must change. The government should provide a strategic framework that encourages and facilitates healthy choices and lifestyles, using the full range of tools and levers at its disposal. Technology should play a key role, but is again not a panacea or a replacement for appropriate healthcare expertise.
2. About the BDA

2.1. The BDA is the only body in the UK representing the whole of the dietetic workforce. We are a trade union and professional body representing the professional, educational, public and workplace interests of our members. Founded in 1936, we are one of the oldest and most experienced dietetic organisations in the world. The majority of our members work in the NHS, Social Care or for an NHS funded service.

2.2. Membership is open to anyone working in dietetics, in nutrition, or who has an interest in diet or food, throughout the world. We represent the whole of the dietetic workforce - practitioners, researchers, educators, support workers and students.

What is a dietitian?

2.3. Registered dietitians are qualified health professionals that assess, diagnose and treat diet and nutrition problems at an individual and wider public health level. Uniquely, dietitians use the most up-to-date public health and scientific research on food, health and disease, which they translate into practical guidance to enable people to make appropriate lifestyle and food choices.

2.4. Dietitians are statutorily regulated, with a protected title and governed by an ethical code, to ensure that they always work to the highest standard. The spectrum of environments in which dietitians practise is broad and includes the NHS, private practice, industry, education, research, sport, media, public relations, publishing, non-government organisations and national and local government.
3. The Future Healthcare System

3.1. Demographic and health changes over the next 15 years fundamentally threaten the sustainability of the NHS. Age UK expects the number of people aged over 65 to increase to 16 million by 2030 – by 2040 one in four people will be aged over 65. They also estimate that by 2030, unless something changes, 6.25 million of those over 65s will have a long term limiting illness or disability, up from 4.5 million now.

3.2. 1.3 million over-65s are currently malnourished and a third of all older people admitted to hospital are at risk of malnutrition. At current rates, 5.5 million Brits could have diabetes by 2030 according to Diabetes UK. The WHO and UK Health Forum estimate three quarters of men (74%) and two thirds of women (64%) in the UK could be overweight or obese by 2030.

3.3. 51 per cent (£8.8 billion) of expenditure in adult social services in 2012-13 and two thirds of the primary care prescribing budget were on those aged 65 and over. While 70 per cent of health and social care spending is on people with long term conditions.

3.4. Diet and nutrition plays a critical role in all of the above and in a whole host of other health conditions. 10.8% of illness caused by poor diet, up to 35% of care home residents and 32% of over 65s admitted to hospital are malnourished which complicates care and has a detrimental impact on outcomes. In some instances better diet can prevent conditions developing at all, in others they can lessen their impact, speed recovery and reduce hospital stays.

3.5. To make the NHS sustainable we should not consider how we can adapt services to cope with additional disabilities, obesity or diabetes, but instead act quickly and decisively to prevent and reverse these trends. Our healthcare system needs to realign itself fundamentally to prevention, even if that involves shifting funding from acute care and regulating to improve the public’s diet. At the same time the UK population needs to take greater responsibility for its own health and wellbeing, or face losing the NHS it values so much.

4. Resources

4.1. The current spending envelope for the NHS is not realistic. There are certainly efficiencies that can be made to reduce wastage in some areas, and services could be reformed to improve their effectiveness. However, it is also true that we do not spend enough money in general on health if we wish to achieve the same sort of outcomes as our European neighbours. The King’s Fund, working from OECD data, shows that the UK around 2% less of our GDP on healthcare than the Netherlands, Denmark, France, Germany and Sweden. We have fewer health professionals per person than many of our western neighbours. This is also true in the specific case for dietitians – Canada had 25.92 dietitians per 100,000 in 2006 while the UK still has only 13.55 per 100,000 as of 2016.

4.2. Analysis from the Commonwealth Fund, which places the NHS as the best healthcare system on the world, highlights this critical problem. Although the quality of care and access to care is the best, the outcomes are amongst the worst – we continue to have much higher death rates from conditions amenable to medical care than nearly every other country from the 11 studied. The efficiency and quality of
our services should be lauded – but imagine what we could do if we resources those services as well as our neighbours.

**Wider Societal Value**

4.3. The NHS and wider healthcare system clearly has a social impact beyond simply its monetary cost. Improving quality of life, keeping people in work and improving productivity, the healthcare system has a huge impact in all these areas and more. The link between health (as measured in various forms) and economic performance has been recognised for some time; for example cardiovascular disease\(^{13}\). Models have been developed by NICE and others that can quantify the wider societal benefits of certain treatments or health interventions\(^{14}\).

4.4. However, it is clear that despite the wider impact of health services, this influence is not properly factored into our healthcare policy or the way we plan and fund healthcare. Research by the Office of Health Economics has shown that in the UK, like many of its neighbours, the link between health and wealth, including productivity gains and savings in other areas, does not influence decision making\(^{15}\).

**Funding Models**

4.5. As discussed above, changes to the way that funding is distributed are less important than ensuring that the quantum of funding is sufficient. Current mechanisms are intended to prioritise areas of greatest need, but still lead to a “postcode lottery” because some areas are always destined to lose out.

4.6. The government is already committed to guarantee funding as a proportion of GDP in both Defense and International Aid/Development. We believe it would be appropriate for a similar approach to be taken to health spending. At the moment, according to the Kings Fund, healthcare spending as a proportion of GDP will fall to 6.6 per cent in 2020/21 compared to 7.3 per cent in 2014/15\(^{16}\). If instead the government was committed to maintain healthcare spending as a proportion of GDP by 2020/21 there would be an additional £16 billion a year in funding to the NHS. By linking to GDP growth healthcare funding becomes sustainable and linked to the nation’s capacity to afford it.

4.7. The Barker Commission\(^{17}\) has highlighted the need to fully integrate and ring-fence the budgets of both health and social care. The NHS may have its budget protected to some degree, but it will feel the impact of a failing social care system that is seeing significant cuts unless something changes soon. Dietetic services in both community and secondary settings feel the impact of inadequate social care in the form of increased referrals, for example for malnutrition, when issues could have been dealt with at a much earlier stage within the care setting.

4.8. Ensuring budgets are managed by those with the most expertise are involved is a positive way to reduce unnecessary wastage, such as in Rotherham, where the nutritional products budget is managed by the dietetic department\(^{18}\). Efforts to encourage a collaborative or cooperative approach to care with patients and reduce unnecessary or unwanted treatment could have a significant effect. The Academy of Medical Royal Colleges’ Choosing Wisely campaign is a good example\(^{19}\).

**Hypothecated health taxes/sin taxes**

4.9. The BDA believes that there is scope to make constructive use of the tax system to both raise funds for specific health interventions, and to drive behaviour change on important issues of public health. We have already seen the successful use of “sin taxes”, in combination with comprehensive public health campaigns, to drive down
smoking rates, and believe similar outcomes could be achieved through the introduction of others, such as the sugar levy which has been proposed by the government. The BDA has welcomed the introduction of the levy, and believe it could be extended more widely.

4.10. Critically, we believe there is a strong argument for the funds raise by sin taxes to be specifically directed towards the services that deal with the consequences of those sins, and on the basis of need. In Again this has been reflected in the government’s decision to spend the monies raised from the Sugar Levy on school sports, which is positive. We would argue that this funding should also be spent on nutrition education and skills, especially as our obesity epidemic is more a consequence of excess consumption than a lack of exercise.

4.11. Given that we believe that the NHS requires more funding to become sustainable, other taxes that might raise the required funding should be considered.

Free at the point of use
4.12. We would object to any change to the principle that the NHS is free at the point of use. However, this does not preclude services from making informed decisions about the cost effectiveness of treatments and procedures. The BDA does not believe that anything and everything should be made available on the NHS, and efforts should be made to reduce unnecessary treatment and wastage due to issues such as over- or mis-prescribing of drugs, borderline substances and treatments.

5. Workforce

5.1. The NHS as a whole is facing a recruitment problem. A report by the Smith Institute indicates that NHS trusts and local government health teams are finding it difficult to fill staff vacancies, particularly in more highly skilled roles.

The requirements of the future workforce
5.2. The BDA believes that there are currently insufficient dietitians in the UK to meet current needs as discussed above, let alone the much wider roles that we believe they could perform. Dietetic training programmes produce a workforce that can have much wider impact on NHS and public budgets, improve patient satisfaction and provide valuable consultancy, training and support to the wider healthcare team. Good nutrition is a crucial factor at the heart of positive outcomes from the majority (if not all) conditions. Given that long term conditions where nutrition is a factor (in particular diabetes and obesity) are increasing and our population and workforce is ageing we will need more nutritional and diet expertise in both clinical and community settings.

5.3. Steps being taken by the government to remove bursaries and in doing so the cap on student numbers for dietetic courses may increase the number of newly qualified dietitians available, although there are concerns about the availability of sufficiently high quality placements to ensure these students are properly trained. We would also want to ensure that dietetics remains a profession open to all. More detail on the BDA’s position in relation to this can be found in our response to the government’s consultation on reforming healthcare education funding.
Options for increasing supply

5.4. It is vital that professions such as dietetics are made as appealing as possible to the widest possible pool of talent. Ensuring that the education and training system is mindful of the widening participation agenda and tailors its offering to non-typical student population.

5.5. Dietetic courses already attract a disproportionately mature and female student makeup, often those beginning second or third careers and often with caring responsibilities. These students bring a unique and valuable skill and experience mix, but need to be specifically supported both in their training and once they enter the healthcare workforce.

5.6. It is also important that those that reach the higher reaches of the profession have sufficient opportunity to progress. Dietitians cover business and management issues, behavior change and leadership within their pre-registration curriculum, so are well placed to work in leadership roles. There need to be more aspirational band seven and eight positions available; there are currently very few (only nine) consultant dietitian posts in the whole of the English NHS.

Effect of leaving the European Union on the continued supply of healthcare workers from overseas

5.7. It is well known that a considerable proportion of the UK’s healthcare workforce come from the EU and elsewhere overseas. Over half of NHS trusts reported in 2015 that they intended to recruit from abroad and 41% said they would be recruiting more than in previous years. Foreign born healthcare professionals are a vital part of our workforce and should be made to feel as welcome and valued as possible. In the case of dietitians, registration with qualifications from abroad can be difficult, but EU students who study dietetics in the UK may find it difficult to remain in the UK to work as dietitians if income floors are imposed.

5.8. Uncertainty over their future security may drive existing healthcare workers to leave, or prevent or discourage much-needed healthcare workers from coming to the UK. The BDA has already received anecdotal evidence that foreign-born and BAME dietitians (from both within the EU and without) and healthcare staff more generally have seen an increase in racist and inappropriate behaviour directed towards them following the referendum vote. There is also a risk that EU students will no longer choose to study in UK universities at the same levels as before if required to pay full international fees.

5.9. The BDA has called on the government to take steps to ensure that as part of our “Brexit” negotiations the UK still has access to talent from the EU and from around the world, without which the NHS would be under even greater staffing pressure.

Retention issues for key groups of healthcare workers

5.10. Not only are we not recruiting sufficient dietitians, the NHS is struggling to retain those it does have, a trend borne out elsewhere in the NHS. Existing staff are facing increasing demand while facing long-term pay restraint, which has left them, according to the Nuffield Trust, “feeling undervalued”. Analysis of the NHS workforce survey by Quality Watch shows that stress related illness has increased (reversing a downward trend) and that 47% said there were not enough staff for them to do their job properly. Constant drives to improve efficiency and productivity are also reducing staff’s morale and stifling their capacity to innovate which would otherwise improve the sustainability of the NHS.
5.11. The BDA’s own Safe Workload, Safe Staffing survey of the dietetic workforce in 2015 identified some key concerns that reflect those seen elsewhere in the health service. 54.7% of respondents felt they could not see patients in a timely manner, and 39.7% felt they lacked opportunities to undertake important personal development work. Perhaps most worryingly, a fifth (21% and 20% respectively) reported poor health at work and low staff morale as significant concerns. As mentioned above, given the dietetic profession’s overwhelmingly female workforce, flexibility and support are particularly important to help people stay in work and continue to be carers.

Ensuring a sufficiently and appropriately trained health and social care workforce
5.12. The UK’s standard of dietetic training is currently very strong, with world class university-level education. However, as mentioned above, dietitians are finding it increasingly difficult to free up time for personal development and training once they are qualified, despite this being an important part of HCPC accreditation. Health Education England funding for CPD has been cut significantly this year and Allied Health Professionals already receive a smaller proportion of this funding than their workforce would justify.

5.13. The BDA is committed to increasing the range and number of professional development opportunities across the UK for dietitians, support workers and others, including online and remotely. It is important that the NHS and indeed all healthcare providers that employ healthcare professionals allow time and resources for their staff to undertake training and development. Dietitians and other Allied Health Professionals would benefit from a more structured career development pathway after graduation (more akin to doctors). Development and promotion within the current grading structure is ad hoc and opportunistic, which means promising newly qualified dietitians can miss out.

5.14. It is also important that pre-registration dietetic students have broad opportunities to train in a number of vital sectors including charity and third sector, public health and social care beyond the usual secondary care settings.

New technologies to increase the agility of the health and social care workforce
5.15. Technology has the capacity to greatly increase the flexibility and agility of the workforce, such as increasing ease of access to patient data or allowing dietitians to undertake virtual clinics or consultations with patients in their homes.

5.16. However, the BDA strongly believes that technology should not be regarded as a panacea that will enable the health service to do more ‘on the cheap’ with fewer members of staff. Proper and effective use of technologies will require investment both in the resources and infrastructure of new technology and in training healthcare professionals in its use. Technology should be regarded as a means of helping our members to do their jobs better, rather than as a replacement for the vital skills of a dietitian. We have already seen examples from within the public health sphere of dietitian-led programmes being replaced with online toolkits or advice pages. Removing dietetic expertise from the process is a retrograde step and means patients no longer have access to the best advice.

5.17. In the BDA’s experience, the adoption of new technologies within the NHS is currently patchy. Successes, such as Focus on Undernutrition in Durham and Darlington, are usually down to individual skills and enthusiasm, and are not rapidly replicated elsewhere. Effort should be made to improve simple things such as
standardising processes and resources – such as education literature for example – and making patient records more easily accessible across teams and systems.

Cost implications of a workforce equipped with a more adaptable skill mix to better meet the needs of patients

5.18. Dietitians qualify with the skills to impact across all areas of healthcare and can therefore be mobile and adaptable in the way they deployed. Dietitians don’t just to help those who are ill but also focus on prevention and to help the ‘well’ remain active, mobile and productive. The barriers to a more adaptable workforce that is in the right place at the right time are often the systems, rather the abilities of the dietetic workforce. This includes the systems for professional development which need to be in place to ensure dietitians continue to have the opportunity to update their skills, such as in digital technologies.

Dietitian 2025

5.19. We have recently commissioned a piece of research, currently entitled Dietitian 2025\textsuperscript{30}, with the express purpose of considering the future needs and competencies of the dietetic profession in the future. The research is being independently undertaken by the University of Plymouth, with input from across our diverse membership. The BDA would be pleased to share the findings of this research with the committee as they become available.

6. Models of Service

6.1. At the most basic level health and care services need to be combined under one ringfenced commissioning budget. The current divide between social care and health services is exacerbated by the different funding mechanisms and governance arrangements.

6.2. The government’s vanguards are attempting to deliver truly “borderless” collaboration between health services in a number of areas. Anecdotally however it appears that professional, financial and structural divides still exist between primary and secondary care or NHS and local government services.

Truly integrated budgets and Incentivising collaboration

6.3. One of the most fundamental problems that prevents healthcare organisations working together is the divide between investment and outcomes. Many of the most effective interventions or collaborative proposals will produce positive outcomes that do not directly benefit those paying for them.

6.4. For example, providing gluten free products on prescription in primary care improves coeliac patient’s adherence to a gluten free diet, and therefore reduces the number of episodes of ill health and resultant expensive referrals to gastroenterology in secondary care\textsuperscript{31}. However, because of pressure on prescribing budgets, many CCGs are choosing to remove gluten free products.

6.5. Pooling budgets, or linking them to the patient through personal budgets may be one way to improve integration. However, if a patient is unaware of the services available, and if the control over purse strings remains in the hands of one section or part of the health service, divides will remain. Ensuring that healthcare professionals and services have mutual aims and targets, where everyone is contributing to collective outcomes, might go some way to removing divides.
Balance between Hospital and Community Services

6.6. The current focus of most funding – particularly in dietetics – is in secondary and hospital care. There is an important role for dietitians here, but effective interventions at the primary and community care level has the potential to significantly reduce pressures on secondary care and improve outcomes for patients if appropriately funded and staffed. The pressure and underinvestment in primary care has been recognised by the government and NHS in the recent GP Forward View32.

6.7. The BDA believes that there is a bigger role for dietitians in primary and community care, as part of a general redesign of the way primary and community care is run. Reform33 and the NHS Alliance34, amongst others, have highlighted the significant number of GP appointments that could be handled by other, more appropriately skilled health professionals. This could be done by creating much easier access to dietitians from secondary care or by directly employing dietitians (and other allied health professionals and healthcare specialists) within primary care. Examples would include patients with diabetes, where dietitians may be better placed that GPs to provide support to patients for self-care.

6.8. This model, as epitomised in the much publicised “Southcentral model”35 from the US, has the potential to save significant resources while ensuring that the patient receives the most appropriate treatment as quickly as possible. For example, patients with conditions such as Diabetes, Irritable Bowel Syndrome or Coeliac Disease can be supported by dietitians without first needing a referral from their GP, and provided with the most appropriate dietary and lifestyle advice, when they need it, to help patients manage their condition themselves. However, if primary care remains the poor relation within our healthcare system such significant change is unlikely to occur.

Balance between mental and physical health and care services

6.9. It is well recognised that the current balance between the prioritization of physical and mental health is skewed towards physical health. The Health Secretary Jeremy Hunt has called for “parity of esteem” between the two areas36, and others, such as the Mental Health Foundation make the further point that mental and physical health should not be regarded as separate but considered holistically37.

6.10. This is of course true in relation to diet and nutrition. People with mental health problems are at higher risk of physical health problems than the general population and often have coexisting co-morbidities. Having depression can double the risk of developing Coronary Heart Disease and people with mental illnesses such as schizophrenia are more likely to develop cardiovascular disease, obesity, abnormal lipid levels or diabetes38.

6.11. In the best instances, dietitians are able to work with a diverse multi-disciplinary team within a mental health setting by providing nutritional education, training, and developing resources and competency frameworks. This can lead to reduced malnutrition, weight management, reduction in nutrition related side-effects of psychiatric medications, improve self-care and management of co-morbid conditions, and improved health and nutritional status.39
7. Prevention and Public Health

Key elements of a public health policy to increase years of good health

7.1. Effective public health policy needs to be integrated, focused on the determinants of health as far upstream as possible, and perhaps most critically, have a long term outlook. Crises such as obesity and diabetes have developed over many years and have a wide variety of causal factors, from poor diet and exercise to economic hardship and poor education.

7.2. Any strategy needs to be led at a national level but delivered locally, with a focus on helping communities help themselves. However, there needs to be a particular focus on disadvantaged communities, where health outcomes are the worst.

Role of the state, the individual and local and regional bodies

7.3. As a nation we need to have a real conversation about the scope of NHS treatment and our role in looking after ourselves. The conflict between the desire to have the freedom to eat, drink and do as we please while maintaining a health service free at the point of delivery in nearly all circumstances is something we need to collectively address.

7.4. The BDA believes that if we wish to continue to protect our NHS services, it is clear that the population needs to either assume greater responsibility for our own wellbeing, or accept a greater role for the state to intervene to ensure we live healthier lives and therefore reduce pressure on the health service.

7.5. The government should provide a strategic framework that encourages and facilitates healthy choices and lifestyles, using the full range of tools and levers at its disposal. This would include the use of the tax and regulatory systems, funding for education and advertising and incentives to encourage positive lifestyle behaviours. Particular support should be provided to those in the most deprived areas to have the greatest impact and reduce health inequalities. We would argue that the government’s recent Childhood Obesity: A Plan for Action falls well short in this regard, by failing to address the full scope of causal factors and to make use of its regulatory powers.

Mismatch between prevention and treatment

7.6. The NHS itself has recognised that there is a fundamental mismatch between the amounts the UK spends on treatment compared to prevention. The latest estimate is that the NHS spends only 4% of its budget on prevention. If the NHS is to be put on a sustainable footing, it will be vital that efforts are made to slow or reduce future demand. This will only be possible if prevention is funded appropriately.

7.7. At the moment, because public health is the responsibility of local authorities, it is not ring fenced by central government in the same way as the NHS budget and faces ongoing cuts. The LGA, in their response to the government’s latest public health budget have said that this “sends entirely the wrong message” about the government’s commitment to the NHS Five Year Forward View and its prevention focus. The BDA would agree completely.

7.8. If prevention and public health is to be funded properly, and given the limits placed upon the public finances and the health budget, it may be necessary to shift funding from acute care to prevention. Clearly this would be a difficult and potentially unpopular decision but if the government is truly committed to prevention we may require this kind of brave decision.
**Should the UK Government legislate for greater industry responsibility?**

7.9. Yes – there is an acceptance that voluntary measures only bring on board those that are already willing to take positive steps. Market forces mean that those that are willing to reformulate products to for example reduce sugar, risk losing their business to less scrupulous producers who are willing to do otherwise. Industry bodies such as the British Retail Consortium have themselves said they would benefit from the clarity provided by a clear regulatory framework for all retailers or producers, rather than recommendations or guidance which is only implemented in a patchy fashion. In the same way that we expect industry to pay for the consequence of their actions in relation to issues such as pollution, it is not unreasonable to make the same demands of them with regard to their impact on public health.

7.10. To take the example of the Sugar Levy specifically, there is scope to go much further in terms of regulation, which currently applies only to sugar sweetened beverages. Excess sugar can be found in a whole range of products, and steps need to be taken to ensure that the public doesn’t just substitute taxed soft drinks for other products.

**By what means can providers be incentivized to keep people healthier?**

7.11. There are steps that could be taken to remove the perverse funding incentives that see healthcare providers funded according to the number of patients they treat. Although the BDA doesn’t doubt that all healthcare professionals only want what is best for their patients, this model does not encourage them to prevent patients coming to them in the first place, particularly when they feel that their funding is already stretched.

7.12. The biggest issue is that changes need to be sustained for many years to see improvement, so the money needs to go towards setting up the work and then measuring change over five, 10 or 20 years. Giving money for a two year project will not have the desired outcomes. There is uncertainty about what works, so the research also needs to be done.

**What are the barriers to taking on received knowledge about healthy places to live and work?**

7.13. One area of particular interest to the dietetic profession is the obesogenic environment and what changes can or should be made to our cities, homes and workplaces to encourage people to maintain a healthy weight, with all the positive knock-on effects this has for the wider health system.

7.14. Research has highlighted the significant effects of certain elements of environment, such as unhealthy food promotion and inappropriate portion sizes for children and the cities designed for exercise and active living. However, the evidence base in this area is still developing, and the government’s own Foresight report on this topic shows limited evidence that changing the obesogenic environment helps those most in need. Simply increasing access to healthy food and places to exercise may not be sufficient to reduce unhealthy behaviour – and may only benefit those already making healthy choices. More research is required to understand how we should change where we live to encourage healthier lifestyles.

7.15. The BDA has developed the Work Ready programme in an attempt to tackle unhealthy work environments, bringing dietetic expertise into the workplace. Using measurable and evidence-based interventions, dietitians are able to help companies and businesses make their workplaces healthier, improve the health of their workforce and in turn reduce sickness absence. Merseyrail’s “Heart on Track” is an
excellent example of the sort of positive effect a dietetic intervention can have, but also highlights the commitment needed from employers.

How can technology play a greater role?
7.16. Technology and social media mean that it is easier for healthcare professionals to connect with members of the public and promote vital public health messages. The capacity to more accurately track progress against aims and to provide patient-led data on weight or health outcomes can help to improve the effectiveness of interventions.

7.17. Evidence from a number of studies have shown that telephone based counselling in conjunction with other materials is effective in promoting positive dietary change and weight loss in both healthy adults and those with chronic conditions\textsuperscript{50,51}. Systematic reviews have demonstrated that technology-assisted interventions (e.g. Internet/website, email, text messaging, mobile applications) can achieve positive dietary behaviour change and/or promote weight loss in adults who are overweight/obese compared to no intervention or minimal care\textsuperscript{52,53}.

8. Technology and digital services

Role for technology
8.1. There is a clear role for mobile technologies and virtual consultations, which are already being utilised within the dietetic and other healthcare professions. The BDA itself has launched the BDA Dietitian App\textsuperscript{54}, which provides a Web-based Coaching suite for dietitians to use with clients and a secure communication channel. Healthcare services across the country are already using virtual clinics to increase their reach and save resources, and they are particularly effective for established patients, and is regarded by patients as preferable to often time consuming face to face appointments\textsuperscript{55}. 
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