Supported Independent Living (SIL): What does good look like? Commissioning

Public consultation to help inform a possible commissioning approach

Making food, nutrition, hydration, eating and drinking explicit quality and safeguarding requirements

Response
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Recipient

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Dietitians Australia acknowledges all traditional custodians of the lands, waters and seas that we work and live on across Australia. We pay our respect to Elders past, present and future and thank them for their continuing custodianship.

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About Dietitians Australia

Dietitians Australia is the national association of the dietetic profession with over 9,000 members, and branches in each state and territory. Dietitians Australia is the leading voice in nutrition and dietetics and advocates for the profession and the people and communities we serve.

The Accredited Practising Dietitian (APD) program is the credentialling program of Dietitians Australia. It provides an assurance of safe and quality dietetic practice and is the foundation of self-regulation of the dietetic profession in Australia. APDs assess and manage disability-related nutrition and hydration needs, malnutrition risk, tube feeding, allergies and intolerances, therapeutic diets, sensory and functional barriers to eating, and mealtime support in collaboration with participants, their families, support workers, other health professionals and SIL providers.

This submission was prepared by members of the Dietitians Australia Policy and Advocacy team. Members of Dietitians Australia and the Disability Expert Reference Group contributed to this submission, following the Conflict-of-Interest processes approved by the Board of Dietitians Australia. Contributors include APDs who are NDIS registered providers.

This submission answers the consultation's six questions through the lens of food, nutrition and mealtimes, from professional experience supporting SIL participants. The critical case material in Attachments B and C reflects what Accredited Practising Dietitians see in practice and outlines potential solutions.

Key recommendation

Establish a distinct, auditable SIL Food and Nutrition Standard modelled on Strengthened Aged Care Quality Standard 6, with four outcomes:[1]

- **Partnering with individuals on food and drinks**
- **Assessment of nutritional needs and preferences**
- **Provision of food and drinks**
- **Mealtime experience**

Cross-reference these requirements throughout the SIL Practice Standards and link them to individual clinical safeguards. Adapt the standard to the SIL context so the participant's home, rights, choice and control remain central.

Supporting recommendations

1. Require timely nutrition-risk identification, referral and reassessment, with independent Accredited Practising Dietitian access for nutrition and dietetic needs.

2. Mandate foundational food, nutrition and hydration training for SIL Support workers and SIL providers who plan, purchase, prepare or provide food and drinks or support mealtimes, plus participant-specific competency where required, reliable handover, supervision and escalation.

[1] https://www.agedcarequality.gov.au/strengthened-quality-standards/food-and-nutrition

3. Protect choice, cultural safety and the person's right to make informed choices about food and eating, while preventing coercion, unnecessary dietary restriction, fad diets or restrictions based on staff or provider preferences.[2]

4. Monitor participant mealtime experience, plan implementation, safety incidents, and clinical change without imposing simplistic weight targets or intrusive surveillance.

5. Price SIL to cover adequate mealtime staffing, mandatory nutrition training, supervision, Accredited Practising Dietitian liaison, multidisciplinary coordination and complex food preparation, including additional rural and thin-market costs.

6. Co-design, pilot and independently evaluate the nutrition-related commissioning requirements with people with disability, Accredited Practising Dietitians, other relevant clinicians, workers and providers before national implementation.

7. Fund what commissioning requires: where commissioning imposes obligations for training, implementation, monitoring or food-system review, fund them explicitly, and require that funded development and delivery is undertaken by people with the requisite qualifications and experience, including Accredited Practising Dietitians for nutrition content.

8. Keep individual dietetic services separately funded, separately assessed and chosen by the participant: commissioned SIL prices must not bundle, ration or gatekeep access to Accredited Practising Dietitian services, and commissioned food-system requirements must not be treated as substituting for individually assessed dietetic supports.

9. Include nutrition and mealtime measures in the Quality Supports Program SIL Pilot's examination of what drives high-quality SIL supports and their costs, if they are not already included.

Why explicit SIL food and nutrition requirements for commissioning are needed

SIL is for people with high support needs and expressly includes cooking and meal preparation. Around 37,000 participants receive SIL and annual expenditure exceeds $16 billion (Department of Health, Disability and Ageing, 2026). Commissioning could add clearer requirements for quality, safety, outcomes, provider capability, funding and performance monitoring. Food and nutrition should therefore be designed into commissioning, not left to variable interpretation after harm or deterioration occurs.

Dietitians Australia does not take a position in this submission on whether a commissioning approach should be adopted. It addresses what any commissioning model must include for food, nutrition and mealtimes if one proceeds.

What the SIL Practice Standards cover and what they miss

DA's analysis of the four SIL-specific Practice Standards and their Evidence Guide (NDIS Quality and Safeguards Commission, 2026a). found no explicit reference to food, nutrition, hydration, meals, menus, eating, drinking, swallowing, dysphagia or dietitians. The SIL standards were co-designed with people with disability, and the gap identified here is an opportunity for the same co-design process to address food and nutrition in the next iteration, not a criticism of what that process achieved. The Standards nevertheless

[2] In food and nutrition, this might mean a participant can choose foods they enjoy, eat at preferred times, or make choices that are not always the "healthiest", rather than staff imposing a restrictive diet simply because they think it is better. It does not mean ignoring serious risks such as choking, severe allergy or unsafe swallowing. Those risks should be explained and managed with the participant using the least restrictive approach possible.

contain principles that can support a nutrition interpretation. The problem is not that nutrition is legally irrelevant; it is that the SIL-specific requirements do not make it visible, consistent or readily auditable.

SIL-specific Standard	Current relevance	Material gap
Supported decision-making	Daily life, routines, will and preferences; accessible information; cultural values; dignity of risk.	The SIL-specific Standard does not expressly address food and drink choice, accessible menu or food information, or food-related coercion. The Core Module[1] addresses informed choice for participants requiring formal mealtime management, but not a universal food-choice framework for SIL.
Safeguarding	Protection from neglect and harm; risk assessment; consistent safeguards; collaboration with specialists.	The SIL-specific Safeguarding indicators focus on bullying and conflict. They do not expressly name malnutrition, dehydration, unsafe dietary restriction, deterioration in food intake or failure to implement a nutrition or mealtime plan. The Core Module[1] addresses some risks for participants requiring mealtime management, but not broader nutrition safeguards across SIL households.
Practice governance	Evidence-informed, person-centred support; workforce training and competency; consistency across workers and shifts; supervision and improvement.	The strongest platform for nutrition, but this SIL-specific Standard does not expressly address meal planning, food provision, nutrition risk, implementation of nutrition plans, or escalation to an Accredited Practising Dietitian where malnutrition or other clinical indicators warrant an Accredited Practising Dietitian's involvement.
Tenancy, housing and support agreements	Changes in support needs; participant control in the home; decisions about shared spaces and possessions.	The SIL-specific Standard does not expressly address meal planning, shopping, food budgets, kitchen access, shared versus individual meals, or responsibility for implementing nutrition plans and preserving individual dietary needs. This runs the risk that provider convenience may override individual participants' choice and control.

[1] NDIS Quality and Safeguards Commission. (2026b). Core module: Provision of supports environment - Mealtime management. https://www.ndiscommission.gov.au/rules-and-standards/ndis-practice-standards/core-module-provision-supports-environment

Existing NDIS mealtime requirements are important but not sufficient

The NDIS Core module (NDIS Quality and Safeguards Commission, 2026b) already has a strong Mealtime Management outcome for each participant identified **as requiring** mealtime management (Attachment A). It includes comprehensive nutrition and swallowing assessment by appropriately qualified health practitioners, individual mealtime plans, worker training, nutritious and enjoyable meals, menu planning, management of chronic health risks, review when needs change, texture modification and safe storage. Severe dysphagia and enteral feeding also have high-intensity requirements. DA supports and does not seek to duplicate these protections.

The gap is the SIL food system around participants who do not have a mealtime management plan. There is no clear universal baseline for a participant whose provider plans, purchases or prepares most meals but who has not been identified as requiring formal mealtime management; no SIL-wide requirement to detect deterioration or refer for Accredited Practising Dietitian assessment; no provider-level review of menu adequacy where a provider substantially controls intake; and no explicit link between SIL governance, staffing and implementation of nutrition recommendations across every shift. The SIL-specific Standards do not treat food and nutrition as a clear, auditable whole-of-home and provider responsibility. They do not clearly address the food environment, household arrangements or provider responsibilities for participants who rely on SIL workers for shopping, meal preparation or eating and drinking support but have not been identified as requiring formal mealtime management.

This gap cannot be closed by better enforcement of the existing identification duty. That duty is triggered by individual clinical need, and by the time a participant is identified as requiring mealtime management, harm is often under way. The gap DA describes is the food system a provider operates for participants with no identified clinical need yet: the menus, shopping, budgets and household food environment through

which most future clinical need develops or is prevented. Identifying individual participants does not create accountability for the food environment the provider runs.

Why the aged care standard is a useful reference

Strengthened Aged Care Quality Standard 6 (Aged Care Quality and Safety Commission, 2026) translates broad rights and safety principles into four concrete outcomes: partnering on food and drinks; assessing nutritional needs and preferences; providing food and drinks; and the dining experience. It requires Accredited Practising Dietitian input into:

- clinical nutrition assessment
- menu development and
- annual menu/mealtime review.

It connects these duties with malnutrition and dehydration monitoring, workforce capability and escalation. Naming these functions is what makes the standard enforceable in practice. The SIL equivalent, proportionate Accredited Practising Dietitian review of provider food systems where providers substantially control food, should be named in the same way. These are transferable design principles. Age-specific nutrient emphases, institutional menu systems and blanket requirements for every SIL home are not. SIL is a person's own home, so it would not be appropriate to require every SIL home to operate like a residential aged-care facility with a standard menu, routine dietitian review or the same food requirements for every person. Instead, SIL should adopt the useful principles, safe food, choice, nutrition assessment and trained workers, only to the extent needed for each participant and the provider's role.

Example proportionate SIL Food, Nutrition and Mealtime Framework

DA recommends a distinct SIL Food and Nutrition Standard using the same four-part architecture as strengthened Aged Care Quality Standard 6 (Aged Care Quality and Safety Commission, 2026): (1) partnering with participants on food and drinks; (2) assessment of nutrition, hydration and mealtime needs and preferences; (3) provision of food and drinks; and (4) the mealtime experience. The standard should be auditable and cross-referenced with the four SIL Practice Standards: supported decision-making, safeguarding, practice governance, and tenancy, housing and support agreements.

The trigger for these obligations should be the provider's role, not the setting. Where a participant manages their own food and cooking, little of the standard applies. Where a provider plans, purchases and prepares most of what a person eats and drinks, the duty follows that control. Anchoring the standard to provider control of the food system keeps it proportionate, protects homes from institutional requirements, and places accountability with the party that controls the food system.

Evidence supports a systems approach

- A systematic review of nutrition health-promotion programs for people with intellectual disability found interventions were mostly individual-level and variably effective. Importantly, interventions targeting the physical environment or multiple socio-ecological levels achieved the largest improvements. The authors conclude that intellectual disability policies should consider the broader food environment. This supports standards and commissioning requirements that address provider systems, workforce and food environments, not education of the participant alone (Dean et al., 2021).
- A systematic review of 20 studies found wide variation in reported dysphagia prevalence and associations with more severe intellectual disability, comorbid cerebral palsy and motor impairment. The authors concluded that dysphagia may be under-recognised and requires improved recognition and management to avoid hospitalisations and premature death. A commissioning approach could

require timely trigger recognition and management through its service specifications. A related review of 35 studies found dysphagia can be under-recognised, is associated with respiratory infection and choking, and may involve silent aspiration; caregiver education and improved management were regarded as priority solutions (Robertson et al., 2017, 2018). Dietitians assess and manage the nutrition consequences of dysphagia such as inadequate intake, weight loss, dehydration, malnutrition, constipation and the need for suitable food and fluid choices. Accredited Practising Dietitians work alongside speech pathologists, who assess swallowing safety. Accredited Practising Dietitians are needed to ensure texture-modified meals and fluids are nutritionally adequate, enjoyable and practical for the person and SIL workers to provide. If commissioning proceeds, these are among the risks its specifications should address.

- Mealtime management and preventable deaths are a key regulatory priority for the NDIS Commission (NDIS Quality and Safeguard Commission, 2026c). **If commissioning proceeds, it should make food, nutrition, hydration, eating and drinking explicit quality and safeguarding requirements**. The NDIS Commission's 2025 nationwide mealtime campaign involved 184 visits to 98 providers. It identified inconsistent information sharing when participants changed locations, providers or staff as a preventable risk (NDIS Quality and Safeguard Commission, 2026c).

Accredited Practising Dietitian experience

Accredited Practising Dietitians described substantial variability in SIL food and nutrition practice. Concerns included workers without nutrition qualifications developing menus, personal 'diet culture' influencing participant food intake, online claims about diets that purportedly 'cure' disability, inadequate basic nutrition knowledge, weak monitoring of food and drink intake, and delayed Accredited Practising Dietitian referral, with serious consequences including hospitalisation and, in one reported case, a death that followed years without dietetic input (see Attachment B). Accredited Practising Dietitians reported that provider nutrition guidelines are inconsistent and often absent, and that nutrition capability weakened when supported accommodation moved from government to non-government delivery.

Foundational nutrition and hydration knowledge is included in core units of the Certificate III in Individual Support. However, dedicated units in meal preparation and positive mealtime support are electives and are not required for every graduate. Our members report **gaps in translating nutrition recommendations into everyday SIL practice**. Commissioning should build on existing qualification and NDIS training requirements by ensuring workers receive role-appropriate practical training, participant-specific instruction and competency assessment, supported by supervision and timely access to Accredited Practising Dietitians and other relevant clinicians.

Question 1 - Participants

Which SIL participants could benefit most from additional government oversight?

Priority cohorts and circumstances

- Participants who rely on workers for most shopping, menu decisions, meal preparation, prompting or physical assistance, particularly where the provider supplies or substantially controls most food intake.
- Participants whose disability affects communication, understanding or capacity to make informed decisions about care, food, nutrition or mealtime support, particularly where they may be unable to report hunger, thirst, food dislike, coercion, unsafe practice or deterioration without accessible supported decision-making.
- Participants with dysphagia, enteral feeding, allergies or anaphylaxis, food intolerances, diabetes, underweight or obesity, pressure injuries or wounds, gastrointestinal conditions, progressive conditions, severe mental illness, sensory-based food restriction or other needs that affect food intake or nutrition.
- Participants without family, an advocate or other trusted informal safeguards, including people with a history of neglect, restrictive practice, food insecurity or provider conflict of interest.
- Participants with recent unplanned weight change, recurrent dehydration, constipation, choking/coughing, respiratory infection, poor wound healing, reduced intake, fatigue or a change in eating skills.
- People moving from hospital, family care, aged care or another provider, when plans and clinical recommendations can be lost or inconsistently communicated.
- Participants in shared homes, high-turnover services or arrangements with rotating/casual staff, where house-wide routines and inconsistent practice can override individual needs.
- People in regional, rural and remote areas, First Nations communities and culturally and linguistically diverse communities where access to culturally safe food, Accredited Practising Dietitians, and other clinicians may be constrained.

How oversight could operate

Oversight should include participant and supporter feedback, record and practice review, observation where appropriate and consented, trend analysis and unannounced regulatory activity where intelligence indicates risk. Commissioning should not create a two-class system in which participants outside a commissioned cohort receive weaker safeguards. The department should commit now that these protections will extend to all SIL providers through the SIL Practice Standards and Evidence Guide, with commissioning serving as the development vehicle rather than the boundary. Participants outside a commissioned cohort should not wait years for equivalent safeguards. If commissioning proceeds, it could pilot and operationalise these requirements ahead of their wider adoption through the SIL Practice Standards. The Quality Supports Program SIL Pilot should measure nutrition and mealtime quality as part of its examination of what drives high-quality SIL supports and their costs, if it does not already.

Question 2 - Quality

What do high-quality SIL supports look like?

High-quality SIL enables a person to eat and drink safely, adequately and enjoyably in their own home, with choice, dignity, cultural safety and as much independence as possible. It converts assessment and advice into reliable daily practice.

Core features

- A person-led food, nutrition and mealtime profile records choices, cultural and religious needs, communication, sensory preferences, routines, allergies, functional assistance, goals and the person's preferred balance of independence and support.
- Participants can choose what, when, where, how much and with whom they eat and drink; access food and fluids when they want; participate in shopping and cooking; and build skills without being forced into a house-wide menu.
- Providers identify concerns early and facilitate timely independent Accredited Practising Dietitian assessment. Speech pathology, occupational therapy, nursing, medicine, pharmacy and oral health expertise are involved according to need, with role clarity.
- All Allied Health providers, SIL providers and their staff understand the need for Accredited Practising Dietitian assessment and management when predetermined criteria are triggered. Dietitians Australia can work with the government to develop clear and evidence-based pathways.
- Workers have adequate paid time and mandatory foundational training in food, nutrition and hydration. Training covers healthy and adequate diets, food safety and allergies, participant rights and cultural safety, recognition of malnutrition, dehydration, constipation and unplanned weight change, implementation of nutrition and mealtime plans, understanding when to refer to an Accredited Practising Dietitian and escalation of concerns. Participant-specific competency is assessed where risk or complexity warrants it. This training does not replace assessment or advice by an Accredited Practising Dietitian. Training equips workers to recognise risk and implement plans. Assessment, prescription and changes to plans remain clinical tasks, and commissioning specifications should state the qualification required for each function. Workers should understand why each participant-specific strategy is required, the risks of not following it and when to seek clinical advice. Dietitians Australia and Accredited Practising Dietitians can work with government to develop high-quality mandatory training for SIL workers and role-appropriate guidance for providers, assessors, planners and other key stakeholders.
- The current plan is accessible at the point of support and implemented consistently across employees, agency staff, weekends, community activities and transitions to avoid malnutrition and other adverse consequences. Plans should include practical instructions and, where appropriate, visual eating and drinking guides, recipes, food and fluid lists, preparation instructions and escalation contacts.
- Food and drinks are safe, appetising and capable of meeting assessed nutrition and hydration needs. Where a provider controls the food system, options and menus are co-designed, supported by written nutrition guidelines and reviewed by an Accredited Practising Dietitian at a frequency proportionate to scale and risk.
- Quality monitoring combines participant-reported choice, enjoyment and dignity with process and safety indicators. Data should prompt review, not justify coercive dieting or uniform weight targets.

Practical example: A participant with a pressure injury and diabetes has an Accredited Practising Dietitian-developed plan. The SIL provider purchases and prepares suitable foods, ensures protein-rich options are available, trains every relevant worker, records agreed indicators, communicates across shifts and escalates reduced intake or wound deterioration. The Accredited Practising Dietitian remains chosen by and accountable to the participant, not the SIL provider.

Attachment C shows what this looks like for a participant with complex needs, and Attachment B case study 2 shows it working in an ordinary shared home.

Question 3 - Safeguards

How should SIL protect safety, health, wellbeing and rights?

Nutrition and hydration-related safeguards must address both acute events and cumulative neglect. Choking and anaphylaxis may be immediate; malnutrition, dehydration, poor glycaemic management, constipation, weight change, pressure injury and loss of function may develop across weeks or months. Generic incident systems can miss the pattern.

Required safeguards for food, nutrition, hydration, eating and drinking

1. Identify and refer: providers use agreed triggers to identify risk and facilitate timely assessment by an appropriate independent practitioner. Nutrition assessment and advice should be provided by an Accredited Practising Dietitian; swallowing by a suitably qualified speech pathologist; positioning and equipment by an appropriate clinician.
2. Use one current plan: individual nutrition and mealtime plans are version-controlled, available wherever support is delivered, portable across providers and settings, and updated after hospital discharge or clinical change by an Accredited Practising Dietitian.
3. Train and verify competence: foundational food, nutrition and hydration training is mandatory for relevant SIL workers. Reading a plan or completing generic e-learning is insufficient for complex support. Competence must be observed for participant-specific tasks and supported by supervision and Accredited Practising Dietitian input where required. Refresher training and reassessment should occur when plans or participant needs change, when workers are new to the participant, or when infrequent task performance or observed difficulties indicate a need.
4. Build reliable handover and escalation: shift handovers communicate intake concerns, coughing/choking, bowel changes, allergies, equipment, plan changes and follow-up actions. Staff know when and how to contact the participant's practitioner, emergency services and nominated supporters.
5. Providers should nominate a lead responsible for ensuring all relevant workers receive and understand updated recommendations. Where a plan cannot be implemented safely, workers must promptly notify the responsible lead and treating clinician, with safe interim arrangements and corrective actions documented. Providers should maintain regular communication with the participant, treating clinicians and, with consent, family or carers
6. Monitor patterns, not only incidents: with consent and clinical purpose, providers monitor agreed indicators such as intake, hydration, weight or other condition-specific measures, and review complaints, near misses, food and drink refusal, plate waste and missed plan actions for trends.
7. Protect autonomy and dignity of risk: providers give accessible, unbiased information and support informed choice. Where a participant chooses an option involving significant food, nutrition or mealtime risk, the process records the person's will and preferences, explores safer alternatives without coercion, obtains independent advocacy and multidisciplinary advice as needed, agrees safeguards and sets a review date. Dignity of risk must not excuse inadequate staffing, delayed Accredited Practising Dietitian referral or failure to implement a plan.
8. Prevent food-related restrictive practice and coercion: locking food, blanket portion control, withholding preferred foods or imposing diets may restrict rights and, depending on context, constitute a restrictive practice. Providers must not use staff beliefs, cost control or house rules as substitutes for lawful, clinically and ethically sound processes.
9. Ensure independent access and complaints: participants can choose and contact an Accredited Practising Dietitian or advocate without provider permission, raise concerns confidentially and change providers without losing their current plan or access to food-related supports.

Where commissioning instruments require nutrition, hydration, food, or eating and drinking expertise, they should specify the Accredited Practising Dietitian credential. Dietetics is a self-regulating profession, and the Accredited Practising Dietitian credential is the mechanism that provides government the same

assurance of qualifications, continuing competence and professional accountability that AHPRA registration provides for other health professions. A specification that says only "nutrition advice" provides no such assurance.

Relationship with existing standards

The distinct future SIL Food and Nutrition Standard should operate alongside, and cross-reference, the broader Core Module (Provision of Supports Environment-Mealtime Management) and relevant high-intensity supports. The future SIL Food and Nutrition Standard should add what participant-specific provisions do not fully cover: universal food rights, provider food-system accountability, early nutrition-risk identification, adequate staffing and reliable implementation. The four SIL-specific Standards should contain reciprocal cross-references so these duties are visible in decision-making, safeguarding, governance and household agreements.

DA recognises that these changes sit across different policy and regulatory instruments. Commissioning could introduce explicit food, nutrition, hydration and mealtime requirements through service specifications, provider selection, contracts and performance monitoring. Changes to the legally binding SIL Practice Standards would require amendment through the NDIS rule-making framework, while the NDIS Commission can update supporting guidance such as the SIL Evidence Guide. Commissioning could therefore provide an opportunity to introduce and test stronger requirements, with the regulatory framework subsequently reviewed to support consistent protections across SIL.

Auditable evidence examples

- Participant-accessible food and mealtime profile; current clinical plans and consent records.
- Referral, reassessment and escalation records; evidence that Accredited Practising Dietitian and multidisciplinary recommendations were actioned.
- Records of mandatory nutrition and hydration training, participant-specific competency observation, supervision and Accredited Practising Dietitian-supported education where required.
- Rosters showing sufficient support at the person's preferred mealtimes and pace.
- Incident, near-miss, complaint and trend review, including corrective action and open disclosure related to food, nutrition, hydration, eating and drinking.
- Participant feedback on mealtime experiences, food and drink choices, culturally safe food and drink, enjoyment, privacy, dignity and confidence in workers.

Practical example: A participant with autism has a highly restricted range of familiar foods. Workers do not introduce an unproven elimination diet or remove familiar foods based on personal beliefs. The participant, supporters and Accredited Practising Dietitian co-design a nutrition and capacity-building approach that protects adequate intake, respects sensory needs and expands choice only at an agreed pace.

Question 4 - Innovation

How can innovation enhance quality and outcomes?

Innovation should solve implementation problems identified by participants and workers; it must not become a cover for reduced staffing, automated rationing or transferring clinical responsibility to support workers.

Promising approaches

- A participant-controlled digital food, nutrition and mealtime plan with version alerts, accessible formats, offline availability and a clear summary for the point of support. Interoperability should reduce re-entry and transition errors.
- Telehealth and hub-and-spoke Accredited Practising Dietitian services that support thin markets, paired with local hands-on assessment when clinically necessary, appropriate travel funding and funded time for Accredited Practising Dietitians to communicate with participants, workers, providers and the multidisciplinary team.
- Funded shared clinical-governance networks through which SIL providers can access independent Accredited Practising Dietitians, nurse practitioners with disability expertise, speech pathologists, occupational therapists, nurses, medical practitioners and specialists. Funding must cover case conferences, shared plan development, hospital transitions, worker education, competency assessment and follow-up to confirm nutrition recommendations are implemented.
- Co-designed picture menus, communication tools, shopping systems, adaptive equipment and assistive technology that increase choice and independence.
- Small-scale quality dashboards that bring together participant experience, implementation, incidents and clinical escalation while minimising data collection and protecting privacy.
- Outcome-based pilots that reward demonstrated choice, continuity, safety and skill development rather than meal standardisation or lowest input cost.

Conditions for responsible innovation

Commissioning should require co-design with people with disability; independent ethical and clinical review for higher-risk models; accessibility and privacy impact assessment; a human decision-maker for clinical or restrictive decisions; a safe non-digital fallback; published evaluation; and a route to stop or modify an innovation that worsens safety, autonomy or equity.

Question 5 - Participant choice

How can effective choice and control be enhanced, including in smaller regions?

Choice must operate at three levels: everyday food decisions, choice of practitioner and support model, and genuine ability to change provider. Shared support must never convert a person's diet, routines or clinical needs into a majority vote by housemates or a provider's convenience.

Commissioning requirements

- Service agreements clearly state who plans menus, shops, pays for food, prepares meals, provides physical assistance, monitors agreed risks, arranges clinical review and implements each plan. Ordinary food costs and funded support costs must be transparent and separated.
- Participants receive accessible information about provider capability, worker training, Accredited Practising Dietitian access, meal flexibility, shared support arrangements, complaints, incidents and how clinical recommendations are implemented.
- Participants choose their Accredited Practising Dietitian and other practitioners. SIL providers may facilitate access but must not require use of an in-house or preferred practitioner or make service access contingent on provider approval.
- Individual plans and key records are portable, with consent, so changing a SIL provider or moving home does not create a safety gap.
- Household processes allow individual cultural foods, allergies, sensory needs, routines and informed dignity-of-risk arrangements. Shared purchasing efficiencies cannot override assessed nutrition need or personal preference, and multidisciplinary input must support rather than override autonomy.

- Independent advocacy, supported decision-making and accessible complaints are available, particularly for participants without family or trusted informal supports. Information about food, diets, nutrition recommendations, risks and alternatives is accessible and unbiased.

Choice in thin markets

Government should fund regional clinical networks, telehealth infrastructure, practitioner travel and outreach, workforce training pools and transition support. Commissioning should permit small and specialist providers to participate through proportionate administration, regional consortia or subcontracting safeguards. Provider panels should include meaningful diversity and transparent exit and transfer arrangements, including continuity of food and mealtime supports. Where provider choice is inherently limited, choice over workers, routines, meals, practitioners and daily decisions becomes more important, not less.

> **Practical example: A participant in a remote shared home chooses culturally significant foods and meal times that differ from housemates. Commissioning funds adequate worker time, remote Accredited Practising Dietitian input and periodic outreach; the service agreement protects individual food purchasing and preparation; and accessible planning supports the participant to direct decisions.**

Question 6 - Provider sustainability

What is needed to ensure SIL providers are sustainable?

Sustainability requires a respected, safe, rewarding and appropriately remunerated SIL workforce, together with the resources and governance needed to deliver food, nutrition and mealtime support over time. A price that excludes cooking, mealtime assistance, mandatory nutrition training, Accredited Practising Dietitian liaison and multidisciplinary coordination creates incentives to standardise food, shorten support, defer clinical input and rely on unpaid labour, with increased risk of malnutrition, reduced health, hospitalisation and other adverse consequences.

Obligations that are not funded will not be met reliably, and participants carry the consequences. Where commissioning imposes new obligations for worker training, plan implementation, monitoring, or menu and food-system review, those obligations should be explicitly funded, and where new frameworks, training or resources must be developed, that development should be funded as skilled work performed by people with the requisite qualifications and experience, including Accredited Practising Dietitians for nutrition content. The alternative costs more: malnutrition, aspiration pneumonia, unhealed wounds and premature entry to residential aged care are paid for by health systems and by participants.

Attachment C illustrates this at the level of one participant: a clinically sound nutrition intervention succeeded only when funded dietetic work extended beyond assessment into implementation support, worker training, monitoring and review. Commissioning should fund that continuum, proportionate to complexity and risk, rather than assume an assessment and a written report are sufficient.

Pricing and contracting

- Pricing must recognise competitive remuneration and secure employment; adequate worker ratios and time for shopping, preparation and mealtimes; participant pace; food safety; texture modification; documentation and handover; paid nutrition training; participant-specific competency; supervision; Accredited Practising Dietitian liaison; multidisciplinary case conferencing; and continuity across shifts. **Pricing of dietetic inputs and pricing methodologies should be developed in close consultation with Dietitians Australia.**

- Accredited Practising Dietitian assessment and individual disability-related nutrition support should remain separately assessable and fundable. The SIL provider must not absorb these services into a bundled price, ration access or act as clinical gatekeeper.
- A commissioning specification covering a provider's food system is not evidence that a participant's individually assessed dietetic supports are no longer required, and must not be treated as such in planning or support determination decisions.
- Funding should cover proactive Accredited Practising Dietitian monitoring and routine reviews at a frequency determined by clinical need, as well as timely reassessment when concerns arise. Participants should not have to wait for deterioration before further dietetic input is funded.
- Where the provider operates a substantial food system, the contract should fund proportionate Accredited Practising Dietitian menu/meal-system review and improvement as a provider quality cost, distinct from an individual participant's clinical care.
- Contracts should use risk-adjusted quality expectations and avoid financial penalties for supporting participants with complex needs. Payments can reward continuity, demonstrated implementation and participant outcomes.
- Food purchasing arrangements must be transparent. Commissioning should clarify which costs are ordinary living expenses, which are provider operating costs and which disability-related supports or products require separate funding. Transparency over pooled food money is itself a safeguard against the financial exploitation the Disability Royal Commission examined.
- Commissioning should recognise that establishing a safe and effective mealtime support system may require more intensive allied health input initially, including on-site training, practical resource development and follow-up. Funding should support this implementation work and ongoing review, rather than assume that an initial assessment and written report are sufficient.

Workforce and provider capability

- A national mandatory nutrition and hydration training framework should be co-designed with people with disability, DA and Accredited Practising Dietitians. It should cover food choice and rights, adequate diets, recognising nutrition and hydration risk, safe assistance, allergies, chronic disease, plan implementation, escalation, cultural safety, restrictive practice and the boundaries of the worker role.
- Training must be role- and participant-specific, include observed competency where risk warrants it, and be supported by practice leadership, Accredited Practising Dietitian access, supervision and paid learning time. Commissioning should monitor worker continuity, turnover and nutrition capability as quality and sustainability indicators.
- Providers need continuity strategies for casual, agency and relief staff, including access to current plans before a shift and restrictions on unsupported deployment to complex tasks.
- Small providers need templates, implementation grants or transition funding and access to shared clinical governance so compliance does not unintentionally consolidate the market.
- Accredited Practising Dietitians engaged by providers to review food systems or deliver training must be able to report findings, escalate concerns and document non-implementation without interference, because clinical independence protects participants.
- Commissioning workforce plans should include the clinical workforce the model depends on: supervision structures, student placements in SIL settings and rural pathways that grow the disability dietetics workforce alongside the demand the standard creates.

Implementation roadmap proposal

Phase	Action	Safeguard
0-6 months	Co-design the outcome, triggers, indicators, pricing assumptions and tools with people with disability, Dietitians Australia, Accredited Practising Dietitians, other clinicians, workers, providers and First Nations and culturally diverse representatives.	Map against current Core, high-intensity and SIL standards to avoid duplication; publish a rights and privacy impact assessment.
6-18 months	Pilot the proposed SIL Food and Nutrition Standard modelled on Strengthened Aged Care Quality Standard 6 across metropolitan, regional, remote, small and large providers	Independent evaluation of safety, choice, quality of life, equity, workforce burden, provider cost and unintended restriction.
18+ months	Refine, phase into commissioning contracts and update the SIL Practice Standards and Evidence Guide.	Transition funding, implementation support, transparent audit guidance and public reporting of aggregate results.

Examples of measures

- Participant dining experience: choice, enjoyment, cultural safety, dignity, independence, social participation and confidence that concerns will be addressed.
- Implementation: current plans, timely referrals, competent workers, sufficient staffing, plan adherence and continuity across shifts and transitions.
- Safety and clinical response: incidents and near misses, delayed escalation, unplanned change that receives appropriate review, and corrective action. Measures must be interpreted clinically and must not become punitive targets.
- System performance: time to Accredited Practising Dietitian and multidisciplinary input, rural access, workforce continuity, provider sustainability and participant ability to change provider.

Proposed commissioning outcome - concise drafting option

Outcome: Each participant is partnered with in decisions about food and drinks; has nutrition, hydration and mealtime needs and preferences identified and assessed; receives safe, adequate, appetising and culturally appropriate food and fluids; and experiences mealtimes that support dignity, choice, enjoyment, independence and social participation. Providers identify and respond to risk, facilitate timely independent clinical assessment, and reliably implement current plans.

Example minimum quality indicators

- The provider identifies each participant's food, nutrition, hydration, eating and drinking needs, preferences, goals, communication and required support, and records these in an accessible, current plan.
- Where nutrition risk or need is identified, the participant is supported to access timely, independent Accredited Practising Dietitian assessment and review; other practitioners are involved according to scope and need.
- Workers have the time, information, training, supervision and participant-specific competency needed to implement plans consistently and escalate change or concern.
- Where the provider supplies or substantially controls food, its food system enables assessed needs and informed choices to be met and receives proportionate Accredited Practising Dietitian review.

- The provider monitors participant experience, plan implementation, incidents, near misses and agreed indicators, and uses findings for open disclosure and continuous improvement.
- Food-related restrictions are not imposed for provider convenience, cost control, house rules or worker preference; participant rights, informed choice and lawful restrictive-practice safeguards are upheld.

Continuing engagement

Dietitians Australia requests formal involvement in the next design phase, including the development of provider specifications, workforce requirements, outcome measures, pricing assumptions and pilot evaluation. This submission is consistent with DA's September 2026 submission on the Inclusive Communities Fund, which sought the same recognition of food and nutrition in community settings, so that safeguards follow people with disability across the places they live and participate (Dietitians Australia, 2026). DA can convene disability Accredited Practising Dietitians and work with disability-led organisations and other professional bodies to co-design practical tools and training.

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Attachment A - The Core Module Mealtime Management Standard

Under the Rules and NDIS practice standards, the 'Core Module: Provision of supports environment' contains a Mealtime Management Standard.

Dietitians Australia does not propose duplicating the existing NDIS Core Mealtime Management Standard. Rather, SIL commissioning should close the gap around it. The Core Standard provides important individual clinical safeguards for participants identified as **requiring** mealtime management (e.g. participants with dysphagia), but there is no equivalent SIL-wide requirement addressing food and nutrition for participants who rely substantially on their SIL provider for menu planning, shopping, meal preparation or support with eating and drinking.

The current Mealtime Management Standard is listed below.[3]

"Mealtime management

Outcome: *Each participant requiring mealtime management receives meals that are nutritious, and of a texture that is appropriate to their individual needs, and appropriately planned, and prepared in an environment and manner that meets their individual needs and preferences, and delivered in a way that is appropriate to their individual needs and ensures that the meals are enjoyable.*

To achieve this outcome, the following indicators should be demonstrated:

- *Providers identify each participant requiring mealtime management.*
- *Each participant requiring mealtime management has their individual mealtime management needs assessed by appropriately qualified health practitioners, including by practitioners:*
  a) undertaking comprehensive assessments of their nutrition and swallowing; and
  b) assessing their seating and positioning requirements for eating and drinking; and
  c) providing mealtime management plans which outline their mealtime management needs, including for swallowing, eating and drinking; and
  d) reviewing assessments and plans annually or in accordance with the professional advice of the participant's practitioner, or more frequently if needs change or difficulty is observed.
- *With their consent, each participant requiring mealtime management is involved in the assessment and development of their mealtime management plans.*
- *Each worker responsible for providing mealtime management to participants understands the mealtime management needs of those participants and the steps to take if safety incidents occur during meals, such as coughing or choking on food or fluids.*
- *Each worker responsible for providing mealtime management to participants is trained in preparing and providing safe meals with participants that would reasonably be expected to be enjoyable and proactively managing emerging and chronic health risks related to mealtime difficulties, including how to seek help to manage such risks.*
- *Mealtime management plans for participants are available where mealtime management is provided to them and are easily accessible to workers providing mealtime management to them.*
- *Effective planning is in place to develop menus with each participant requiring mealtime management to support them to:*
  a)be provided with nutritious meals that would reasonably be expected to be enjoyable, reflecting their preferences, their informed choice and any recommendations by an appropriately qualified health practitioner that are reflected in their mealtime management plan; and
  b) if they have chronic health risks (such as swallowing difficulties, diabetes, anaphylaxis, food allergies, obesity or being underweight) – proactively manage those risks.
- *Procedures are in place for workers to prepare and provide texture-modified foods and fluids in accordance with mealtime management plans for participants and to check that meals for participants are of the correct texture, as identified in the plans.*

[3] https://www.ndiscommission.gov.au/rules-and-standards/ndis-practice-standards/core-module-provision-supports-environment#paragraph-id-7950:

- *Meals that may be provided to participants requiring mealtime management are stored safely and in accordance with health standards, can be easily identified as meals to be provided to particular participants and can be differentiated from meals not to be provided to particular participants."*

Attachment B - De-identified Accredited Practising Dietitian short case studies

These de-identified practice examples were provided by Accredited Practising Dietitians during consultation. Names, locations, providers and non-essential identifying details have been removed or generalised. They illustrate system issues and do not establish legal liability or, where an outcome followed, clinical causation.

Case study 1 - Delayed referral and failure to implement a nutrition plan

An adult man living in supported accommodation had a psychosocial disability and type 2 diabetes. He had experienced a chronic leg ulcer for approximately 13 years and a pressure wound for approximately four years before receiving dietetic input. An Accredited Practising Dietitian assessed him and developed practical nutrition recommendations intended to support wound healing and diabetes management.

Implementation was unreliable. The service relied heavily on rotating and casual workers, recommendations were not consistently carried across shifts, and there was no effective mechanism for monitoring whether the plan was followed or escalating non-implementation. The participant died about six months after dietetic support commenced. The available information cannot establish that nutrition or the implementation failures caused his death. The case nevertheless demonstrates the safeguarding risk created by delayed referral, poor continuity, inadequate handover and weak accountability for acting on clinical advice.

Commissioning implication: require early risk identification and Accredited Practising Dietitian referral; one current, accessible plan; participant-specific worker competency; documented implementation; and escalation where staffing or service systems prevent the plan from being followed.

Case study 2 - Continuity and food capability supporting good outcomes

Four adult men who had known one another since school shared a home. A small, stable core team of approximately four or five workers supported them. Several workers were confident cooks and most meals were prepared from basic ingredients. The residents had different eating and texture needs, which the team accommodated through flexible meal preparation, including slow-cooked meals that could be adapted safely.

The Accredited Practising Dietitian met repeatedly with the same workers and was able to build a working relationship with the household. Workers understood the residents' preferences and plans, noticed emerging concerns and initiated an additional dietetic referral for another resident. Consistency made it easier to translate advice into daily routines and to distinguish a genuine change from a person's usual pattern.

Commissioning implication: quality depends not only on a written menu or plan, but also on workforce continuity, practical cooking capability, sufficient time, stable clinical relationships and worker confidence to identify and escalate change. These features should be observable in audit and recognised in pricing.

Case study 3 - An inflexible food system undermining choice and intake

A woman living in a larger congregate setting experienced severe mental ill-health, including a belief that food was poisoned. The service relied on commercially prepared meals and had limited functional cooking facilities. She ate very little of the standard meals and at times relied largely on toast with jam. A preferred oral nutrition support product was accepted, but the available budget was insufficient to provide it consistently. Management did not agree to redirect funds from repeatedly uneaten meals to a less costly, acceptable nutrition option. Shared mealtimes were not part of the service model.

During a student-led activity, simple portable cooking equipment was used to prepare a preferred garlic prawn meal with her. This created an opportunity for choice and participation that the routine food system had not provided. She later moved from the service and the longer-term outcome was not known.

Commissioning implication: provider convenience and rigid purchasing arrangements must not override assessed need, supported decision-making or reasonable flexibility. Where a provider controls food provision, it should be accountable for access to workable kitchen facilities, acceptable alternatives, participant involvement, clinical escalation and review of persistent low intake or food waste.

Attachment C - De-identified Accredited Practising Dietitian long case study applied to the consultation questions

Background

A 58-year-old male participant with a degenerative neurological condition and severe dysphagia requires texture-modified food and fluids. He has significant difficulty maintaining body weight despite a high level of dietetic intervention.

His nutrition management includes detailed high-protein, high-energy meal plans, food fortification strategies, a daily high-protein/high-energy drink and commercial oral nutritional supplementation.

A dietitian became involved following an unintentional weight loss of greater than 5% of total body weight associated with an acute illness. Although the participant subsequently returned to his usual eating pattern, he was unable to regain the weight lost. This indicated that, due to disability-specific factors and increased nutritional requirements, his nutritional needs could not reliably be met through food alone.

The case demonstrates an important system-level issue:

For participants with complex clinical needs, access to an appropriately qualified allied health professional is necessary but not sufficient. **Clinical recommendations are only effective when the SIL environment has the workforce capability, systems, communication and clinical oversight required to implement them consistently**. A good dietetic assessment, management plan and advice cannot compensate for an implementation gap within the support environment.

What does good SIL look like when a participant has complex nutrition, hydration, swallowing, feeding or mealtime support needs?

Good SIL for this participant means that his clinical nutrition and swallowing needs are embedded into his everyday support, rather than existing solely within a dietetic or medical report. This requires SIL staff to consistently implement:

- appropriate texture-modified meals and fluids
- high-protein, high-energy meals and snacks
- food fortification strategies
- appropriate preparation and portioning
- the recommended high-protein/high-energy drink
- commercial oral nutritional supplementation and
- monitoring and escalation where there are concerns about intake, weight, swallowing or changes in health.

Initially, the dietitian identified that there were barriers within the SIL environment, including poor communication and insufficient oversight between SIL leadership and support workers. As a result, there was a gap between the recommendations made by the dietitian and what was consistently occurring in the participant's day-to-day care.

This is an important distinction: the participant did not simply need a dietitian to write a meal plan. He needed a support environment capable of reliably implementing that plan.

Good SIL therefore requires an integrated approach where Accredited Practising Dietitian's recommendations are translated into practical routines, staff understand their responsibilities, implementation is monitored and there is a clear pathway back to the treating clinician when problems arise.

How do we ensure support workers have the skills and training to safely implement dietetic recommendations?

In this case, providing written recommendations alone was not sufficient. The dietitian responded by working directly with the SIL team, providing on-site, participant-specific training to support workers and developing practical procedures to improve the consistency of implementation. This included helping staff understand the participant's nutritional requirements and translating the dietetic recommendations into practical actions within his home and

mealtime environment. The process took several months to embed. This was not because the clinical recommendations were unclear; rather, it took time to address communication, workforce and oversight issues within the SIL environment. This highlights that competency should be considered in terms of what a support worker can safely do in practice, rather than simply whether they have received or read a written recommendation.

For participants with complex needs, effective implementation may require:

- participant-specific education
- practical demonstration
- observation of staff practice
- competency assessment where appropriate
- accessible written/visual resources
- clear escalation procedures
- refresher training and
- processes to ensure new or replacement staff receive the relevant training.

There also needs to be clear responsibility within the SIL organisation for ensuring that recommendations remain current and are communicated to the workers responsible for implementing them.

How can commissioning strengthen safeguards without reducing participant choice or access to appropriate Accredited Practising Dietitian expertise?

This case demonstrates why commissioning needs to recognise that clinical assessment, clinical instructions and clinical implementation support can be interdependent. The participant required dietetic input not only to develop a nutrition intervention, but also to:

- respond to clinically significant weight loss;
- develop and adjust a high-energy/high-protein nutrition strategy;
- support implementation within the SIL environment;
- train support workers;
- develop practical procedures;
- monitor the effectiveness of the intervention; and
- provide specialised reporting to advocate for the participant's ongoing need for commercial oral nutritional supplementation.

The commercial supplementation was required above and beyond oral food intake because the participant was unable to meet his nutritional requirements through food alone due to disability-specific factors.

A commissioning model that focuses narrowly on an initial assessment or written report may therefore miss the clinical work required to make the intervention successful. **Commissioning should instead support a continuum of Accredited Practising Dietitian involvement proportionate to the participant's complexity and risk: Assessment → intervention → implementation → training → monitoring → review → advocacy**. Safeguards should establish a minimum standard of quality and clinical governance while allowing appropriately qualified clinicians to determine the level and type of intervention required for the individual participant. Participants should be able to choose their Accredited Practising Dietitian and other treating clinicians, rather than being required to use a SIL provider's preferred practitioner. Commissioning should set minimum expectations for safe, effective support while enabling access to the type and amount of specialist clinical input each participant needs.

What is working well?

The most positive aspect of this case has been the shift from a model where dietetic recommendations were documented but inconsistently implemented, to a more collaborative model involving dietetics, SIL leadership and support workers.

The Accredited Practising Dietitian:

1. identified the implementation barriers
2. engaged directly with SIL leadership

3. provided on-site training to support workers
4. developed practical procedures to improve consistency
5. supported communication between the clinical and support teams, and
6. continued to monitor the participant's nutritional situation.

Although this process took several months, there are now signs that the recommendations are being implemented more consistently and that the intervention is beginning to achieve the desired outcome. This is an example of clinical expertise being combined with implementation support. It also demonstrates why dietetic input should not be viewed as a one-off assessment or report. In complex cases, the clinician may need to work alongside the support provider to ensure that recommendations are understood, achievable and sustained.

Where are there gaps?

The major gap identified in this case was the disconnect between clinical recommendations and SIL implementation. The participant had access to appropriate dietetic expertise and a comprehensive nutrition plan, but initially did not have a sufficiently reliable support system to ensure that the recommendations were consistently implemented.

Key gaps included:

- inconsistent communication between SIL leadership and support workers
- insufficient oversight of implementation
- variability in support-worker understanding
- reliance on written recommendations without sufficient practical training
- risk that new or replacement workers may not receive adequate participant-specific education
- limited mechanisms for monitoring whether recommendations are being followed
- unclear escalation processes when nutritional concerns arise, and
- the time and clinical work required to establish effective systems.

There is also a broader gap in recognising that nutrition, hydration and mealtime support can constitute complex clinical care. For some participants, achieving adequate nutrition is dependent on the interaction between allied health expertise and the capacity of the SIL workforce to implement that expertise.

Where are there risks / barriers?

Risk or barrier	Details
Commissioning and funding barriers	There is a potential systemic risk if commissioning arrangements assume that complex allied health needs can be addressed through a limited or one-off intervention. This participant required ongoing clinical input, implementation support, staff training, monitoring and advocacy. Similarly, the process of establishing the disability-specific rationale for commercial oral nutritional supplementation required specialised dietetic assessment and reporting.
Implementation gap	The most significant risk is the gap between what the clinician recommends and what happens in practice. A comprehensive dietetic intervention can be unsuccessful if the SIL environment cannot consistently implement it. This is particularly important for a participant who is already nutritionally vulnerable.
Swallowing and mealtime safety	The participant's severe dysphagia creates additional risk if texture-modified food and fluid recommendations are not implemented correctly or consistently. This reinforces the importance of appropriate collaboration between dietetics, speech pathology and the SIL team where swallowing management is involved.
Workforce turnover and variability	Multiple support workers may be involved in a participant's care. Staff turnover, variable experience, competing priorities and inadequate handover can all result in inconsistent implementation.

Lack of clinical oversight	There is a risk when responsibility for implementing complex clinical recommendations sits within a support environment without adequate mechanisms for ongoing communication with the treating clinician.
Risk of over-restricting participant choice	Finally, safeguards need to balance safety with autonomy and quality of life. Having dysphagia or complex nutritional needs should not automatically mean unnecessary restrictions on food, social eating or participant choice. The objective should be supported decision-making and proportionate risk management, rather than eliminating all risk at the expense of quality of life.

Key commissioning message

This case highlights a broader principle that should be considered when designing SIL safeguards and commissioning arrangements:

- Access to allied health expertise and the capacity of SIL to implement that expertise depend on each other.
- For a participant with complex nutrition, hydration or swallowing needs, it is not enough to commission a dietitian to complete an assessment and provide recommendations. The system also needs to ensure that:
    - the participant has access to the right clinical expertise
    - the clinician can develop an appropriate intervention
    - the SIL workforce is trained and competent to implement it
    - implementation is monitored
    - problems can be escalated
    - the intervention can be reviewed as the participant's needs change.

Where any link in this chain is missing, there is a risk that a clinically appropriate intervention will fail to achieve its intended outcome. Conversely, this case demonstrates the value of investing in collaboration between allied health and SIL providers. The additional time spent training workers, improving communication and establishing implementation processes has the potential to turn a dietetic recommendation from a document into an effective intervention that actually changes the participant's day-to-day care.

Therefore, commissioning should not view allied health as an isolated service sitting alongside SIL. For participants with complex nutritional, hydration and feeding needs, dietetic expertise, workforce capability and clinical governance within SIL are interconnected components of safe and effective support. The measure that matters is the participant's health, safety, nutritional status, autonomy and quality of life at home, not the completion of reports or training.