Hospital food can be improved only by legislation

As the government announces a review of hospital food, **Katharine Jenner** writes that voluntary standards have failed to ensure that inpatients get adequate nutrition

Which of these statements are true?

a) Hospital food is less environmentally friendly than food served at McDonald's

b) Food served to children in hospitals is so unhealthy it couldn't legally be offered in schools

c) Prison food is served fresher and warmer than hospital food

Unfortunately, for some hospitals all are true. This is why action is needed. Twenty years' worth of government initiatives have failed because they rely on hospitals to voluntarily adopt food standards for patients' meals.[1] The voluntary approach is not working, and the government should set mandatory standards for hospital food without exception. This would help improve the quality, healthiness, and environmental standard of patients' meals, and ensure that they lead by example, helping to inspire patients, visitors, and staff to eat better food outside of hospital.

Evidence shows that hospital food is not good enough.[2]

The government has said that as many as 50 000 people a year could be dying with malnutrition in NHS hospitals in England.[3] Age UK categorises malnutrition among older hospital patients as elder abuse because it results in longer periods of illness, slower recovery from surgery, and increased mortality rates.

Furthermore, a survey of hospital meals by the Campaign for Better Hospital Food found that three out of every four hospital meals would qualify for a red light, under the Food Standards Agency's traffic light model, for high saturated fat, and 15 of the 25 meals surveyed contain more salt than a Big Mac.

Robert Francis QC's report on the Mid Staffordshire NHS Foundation Trust Public Inquiry highlighted many concerns about the standard of care in the NHS, including the standard of hospital food. The report concluded that the NHS needs clearer, better enforced standards.[4] In February in the *BMJ* experts called for the government to include nutritional care in its mandate to the NHS England.[2]

Most British public sector institutions already have to adhere to mandatory standards for the meals they serve, including mandatory nutritional standards for school food and the food served in hospitals in Wales and Scotland. Several nutritional and environmental standards apply to food served in government departments and prisons. So why are there no mandatory standards in English hospitals?

I am not asking for standards that you would find only in a Michelin starred restaurant; rather, healthier and more nutritious food with less salt and saturated fat that is sustainable, with higher animal welfare standards, and fair trade. Meals should be accessible to patients within reasonable meal times.

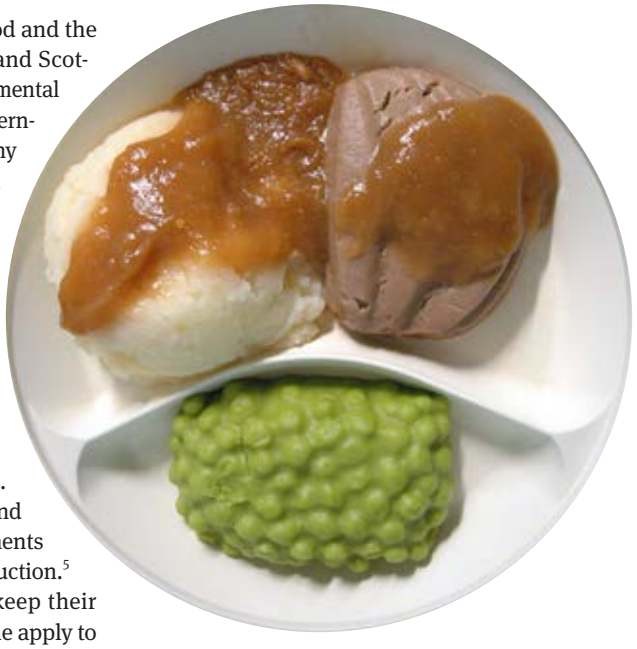
Throughout the retail sector, demand from customers has led to improvements in the food sold, as seen with salt reduction.[5] It is in retailers' best interests to keep their customers happy. Shouldn't the same apply to hospitals?

The first steps towards better standards are outlined in the Government Buying Standards, which the Department for Environment, Food and Rural Affairs recommends that hospitals implement, and which have been introduced for government departments and prisons.[6] They are clear, simple, and workable, and there is no reason why they shouldn't be extended to hospitals. Nottingham University Hospitals NHS Trust has announced that it made a daily saving of £2.50 (€3; $4.10) per patient, as well as a reduction of 150 000 food miles a year, by switching to fresh local ingredients.[7] The trust says that the NHS could make a national saving of £400m a year if the same standards were implemented throughout the health service.[7]

A staggering two thirds of hospital staff say that they would not be happy to eat the food that they serve to patients

About half of hospital meals are made by catering companies such as Compass Group and Sodexo and are reheated after delivery to hospitals. The other half are freshly made either in the hospital's own kitchen or in a facility off site. Even suppliers are asking for standards. They want to know exactly what they need to deliver in terms of local sourcing, sustainability, welfare, and healthier food.[8] If hospitals demanded higher standards from their suppliers the cost of good food would come down, because of economies of scale, to the benefit of all consumers.

It's not clear whether hospitals would oppose mandatory standards. But a staggering two thirds of hospital staff say that they would not be happy to eat the food that they serve to patients.[9] Although some hospitals are already seeing the benefits of adopting voluntary food standards, including higher satisfaction rates among patients and less waste and spending on food, take-up has been very slow.



On 8 November 2013 Julia Cumberlege introduced a Hospital Food Bill to the House of Lords. This bill would require the health secretary to convene a body of experts to draft mandatory food standards for hospitals, and it would task the Care Quality Commission with ensuring that these standards were met. The bill's success depends on government support, which has not yet been forthcoming. As a compromise, the government has created a hospital food standards panel to review how such standards can be more stringently applied to patients' meals and to food sold on hospital premises to staff and visitors, without making them legally binding.

We should all act now to give our backing to this bill to give it the best possible chance of success.

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FROM THE FRONTLINE **Des Spence**

Evidence based medicine is broken

Evidence based medicine (EBM) wrong footed the drug industry for a while in the 1990s. We could fend off the army of pharmaceutical representatives because often their promotional material was devoid of evidence. But the drug industry came to realise that EBM was an opportunity rather than a threat. Research, especially when published in a prestigious journal, was worth more than thousands of sales representatives. Today EBM is a loaded gun at clinicians' heads. "You better do as the evidence says," it hisses, leaving no room for discretion or judgment. EBM is now the problem, fuelling overdiagnosis and overtreatment.[1]

You see, without so called "evidence" there is no seat at the guideline table. This is the fundamental "commissioning bias," the elephant in the room, because the drug industry controls and funds most research. So the drug industry and EBM have set about legitimising illegitimate diagnoses and then widening drug indications, and now doctors can prescribe a pill for every ill. The billion prescriptions a year in England in 2012, up 66% in one decade,[2] do not reflect a true increased burden of illness nor an ageing population,[3] just polypharmacy supposedly based on evidence. The drug industry's corporate mission is to make us all sick however well we feel.[4] As for EBM screening programmes, these are the combine harvester of wellbeing, producing bales of overdiagnosis and misery.

Even the National Institute for Health and Care Excellence and the Cochrane Collaboration do not exclude authors with conflicts of interest, who have predetermined agendas

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Corruption in clinical research is sponsored by billion dollar marketing razzmatazz and promotion passed off as postgraduate education. By contrast, the disorganised protesters have but placards and a couple of felt tip pens to promote their message, and no one wants to listen to tiresome naysayers anyway.

How many people care that the research pond is polluted,[5] with fraud, sham diagnosis, short term data, poor regulation, surrogate ends, questionnaires that can't be validated, and statistically significant but clinically irrelevant outcomes? Medical experts who should be providing oversight are on the take. Even the National Institute for Health and Care Excellence and the Cochrane Collaboration do not exclude authors with conflicts of interest, who therefore have predetermined agendas.[6 7] The current incarnation of EBM is corrupted, let down by academics and regulators alike.[8]

What do we do? We must first recognise that we have a problem. Research should focus on what we don't know. We should study the natural history of disease, research non-drug based interventions, question diagnostic criteria, tighten the definition of competing interests, and research the actual long term benefits of drugs while promoting intellectual scepticism. If we don't tackle the flaws of EBM there will be a disaster, but I fear it will take a disaster before anyone will listen.

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BMJ BLOG OF THE WEEK **David Lock**

Inconsistent CCG legal duties—can the circle be squared?

There are times when, as a lawyer advising NHS bodies, I get close to advising that the law is unworkable. An example emerged the day when I had to deal with the fact that clinical commissioning groups (CCGs) have legal duties to "promote the involvement of patients and their carers in decisions made about healthcare services" under section 14U of the NHS Act 2006. They also have a legal duty to "act with a view to enabling patients to make choices with respect to aspects of healthcare services provided to them" under section 14V of the NHS act.

However, CCGs also have precise legal procurement obligations under the snappily titled "National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013," which require CCGs to take decisions concerning the placing of healthcare contracts in accordance with a specific set of factors guiding the decision.

The views of patients on how and where they wish to have healthcare services provided to them form no part of the decision making process under the 2013 regulations. So if CCGs take patients' wishes into account as a major factor in decision making they will comply with their duties under sections 14U and 14V, but will potentially act outside the framework for decision making under the 2013 regulations. Alternatively if a CCG sticks strictly to the framework of decision making under the 2013 regulations it will have to place little weight on patients' choice and the involvement of patients in decisions about their own healthcare.

There are serious difficulties in squaring this circle because it involves a clash between NHS services as a public service tailored towards individual needs and designed for an individual (the personalised healthcare agenda) and NHS services as contracts that must be placed in the open market in a way that is fair to all potential suppliers of the services (the "NHS as a market agenda"). The CCG decision makers who are in the middle of this political and philosophical clash can look forward to an interesting year.

David Lock is a barrister and QC, No5 chambers. He is a board member of Brook Sexual Health, a member of the BMA Ethics Committee, and an honorary professor at the University of Birmingham.

Competing interests: I am a member of the Labour Party and chair the West Midlands Branch of the Labour Finance and Industry Group. I am a non-executive board member of Heart of England NHS Foundation Trust. My wife is a doctor who is employed by Worcestershire Partnership NHS Trust.

Read this blog in full and other blogs at bmj.com/blogs.