

# this week

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## GPs advised to limit appointments

GPs should extend their appointments to 15 minutes, a move that would likely mean reducing the total number of appointments they offer, the BMA's General Practitioners Committee for England has advised.

In updated "safe working" guidance published on 6 September GPCE acknowledged that a reduction in appointments would mean non-urgent patients may have to wait longer to be seen. But it said GPs must focus on "delivering safe, high quality care" while making sure their workloads are manageable, noting that practices are currently seeing "nearly half the country's population every month."

The guidance, which also advises practices to "cease all non-contractual work and divert their resources to core services," came after GP partners in England began taking collective action from 1 August in response to the imposition of the 2024-25 contract, which included a core funding rise of 1.9%. Although the government has increased this to 7.4%, GPCE says it remains insufficient and has proceeded with action.

GPCE deputy chair Samira Anane said, "General practice continues to face extraordinary challenges, with unmanageable workloads and workforce pressures, against a backdrop of years of underinvestment.

Despite this, practices are offering record breaking numbers of appointments." Anane said the guidance had been created to encourage practices to work in a way "that helps protect and sustain general practice, with a focus on quality, not quantity."

The guidance advises GPs to ensure "no more than three hours out of a four hour 10 min session should be spent consulting" and that a daily "safe limit" of 25 consultations per GP be implemented to "prevent overload and ensure each patient receives adequate time and attention."

Once a practice reaches capacity, patients should be signposted to other services, it says.

Reducing workload to a safe level may help ensure the NHS retains GPs, the BMA has argued. It said the "never ending 'hamster wheel' of continually trying to keep up with demand" may be putting patients at risk while also leading to burnout among GPs.

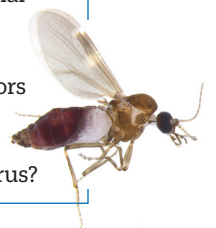
The guidance adds that practices may have to give notice on enhanced services, emphasising that GPs should "remember income does not equal profit." It also reminds GPs they can close their list to new patients "if they have reached the limit of their workforce's capacity to provide safe care."

Elisabeth Mahase, *The BMJ*  
Cite this as: *BMJ* 2024;386:q1980

**Samira Anane, deputy chair of the BMA's GP Committee, says the guidance is designed to encourage practices to "focus on quality, not quantity"**

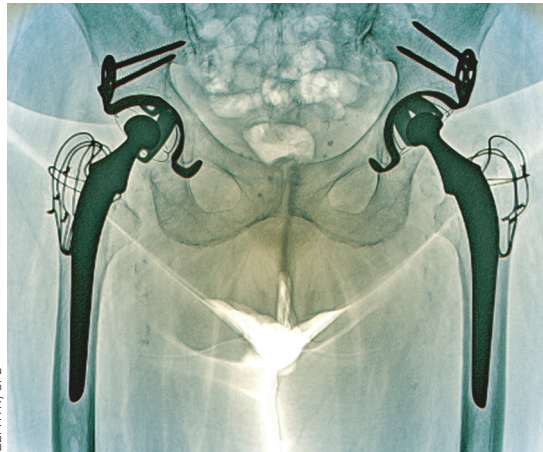
### LATEST ONLINE

- GMC appeals eight month suspension of surgeon who sexually harassed colleagues
- Doctor is struck off over "unconventional" treatments of children
- Why are doctors being warned about the Oropouche virus?



# SEVEN DAYS IN

## Surgical hubs can help tackle long waiting lists in England, study finds



ZEPHYR/SPL

The expansion of surgical hubs should be “turbocharged,” as research indicates they can help cut waiting lists, the Royal College of Surgeons of England has said.

More than 100 NHS trusts in England have set up surgical hubs with ringfenced capacity to carry out operations such as hip replacements (left) and cataract removals, aiming to improve productivity. New hubs were created to help services recover from the covid pandemic, initially focusing on high volume, low complexity specialties, and 26 more are planned to open by the end of 2025.

An NHS commissioned evaluation by the Health Foundation, which has not been peer reviewed, estimated the changes in elective activity in trusts with hubs and in trusts without hubs. After the pandemic, trusts with established hubs had an estimated 11.2% greater recovery in elective activity than they would have had without a hub—around 51 000 more procedures than expected from April 2021 to March 2022.

Tim Mitchell, RCS president, said, “With the budget on the horizon, we hope these findings encourage the government to turbocharge the expansion nationwide, ensuring every patient can benefit from this proven initiative to receive faster

Matthew Limb, London [Cite this as: BMJ 2024;386:q1940](#)

## Patient safety

### Temp staff are discriminated against

An investigation by the Health Services Safety Investigations Body has found that temporary healthcare workers in England are being discriminated against by some staff and local and national organisations because of their working status and in some cases their ethnicity. Some temporary workers felt unable to raise patient safety concerns because they feared losing future opportunities or being seen as a “troublemaker.” Matt Mansbridge, senior safety investigator, said, “It was troubling to hear of the widespread discrimination against temporary staff and the negative impact this has on their daily lives.”

## Clinical trials

### Industry calls for more government investment

Industry clinical trials contributed £7.4bn of gross value added to the UK economy in 2022 and created 65 000 jobs, said a report commissioned by the Association of the British Pharmaceutical Industry. The drug sector is calling on the

government to boost investment in commercial clinical trial capacity, to help drive economic growth and bring wider health system benefits. Richard Torbett (below), the association’s chief executive, said, “This report demonstrates the financial and societal benefits that industry clinical trials bring to the economy, the NHS, and to R&D in the UK.”

## Rare diseases

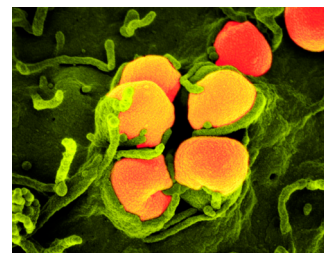
### Belzutifan is approved for rare genetic disease

NHS patients in England with von Hippel-Lindau disease can now get a pill prescribed to shrink their tumours and help avoid high risk surgery, after a recommendation from NICE. In clinical trials 95% of patients did not experience any growth in their tumours in two years of taking the treatment, and tumours shrank in 56% of patients. Around 800 people in England have the disease, which causes multiple malignant and benign tumours in major organs around the body. Currently, the only treatment available is invasive surgery or radiotherapy.

## Gonorrhoea

### Drug resistant cases detected in England

detected 15 new confirmed cases of infection with ceftriaxone resistant *Neisseria gonorrhoeae* (below) from June 2022 to May 2024, including five that were extensively drug resistant, said the UK Health and Security Agency. *N gonorrhoeae*, the bacterial species that causes gonorrhoea, has developed



resistance to every class of antibiotics used to treat it, and cephalosporins are the last remaining class of antibiotics available for use as empirical monotherapy. In 2023 some 85 223 cases of gonorrhoea were reported, the highest number since records began.

## Valproate

### Male users are warned to use contraception

Men who take valproate should use contraception while using the medicine, and for three months after stopping, because of a “potential small increased risk” of neurodevelopmental

disorders in any children conceived, said the UK drug regulator, the MHRA. The warning followed a retrospective observational study showing that around five in 100 children had a neurodevelopmental disorder when born to fathers treated with valproate, which compares with around three in 100 born to fathers treated with lamotrigine or levetiracetam.

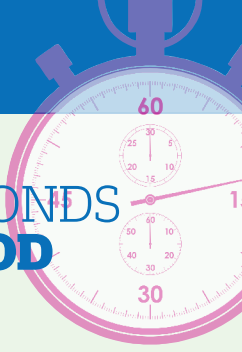
## GLP-1 drugs

### Regulator finds no suicide link to receptor agonists

The MHRA has concluded that the available evidence does not establish a causal relation between glucagon-like peptide-1 (GLP-1) receptor agonists and suicidal behaviour, suicidal ideation, self-injury, or depression. A review was carried out after initial post-marketing reports indicated potential safety risks with the medicines exenatide, lixisenatide, liraglutide, dulaglutide, and semaglutide. The MHRA’s evaluation aligns with that of a European regulatory review that analysed data from several sources. The agency said it would continue to closely monitor the risk of severe psychiatric reactions associated with these receptor agonists.

# MEDICINE

## SIXTY SECONDS ON... BLOOD BY DRONE



### Paediatrics

#### Children's healthcare "lags behind" adult care

A lack of investment is creating a two tier system in the NHS that fails children because of long waiting times for treatment, paediatricians have warned. Despite children being frequent service users—0-14 year olds, for example, are more likely to attend emergency departments than any other age group—the Royal College of Paediatrics and Child Health said paediatric services had been deprioritised and largely overlooked in NHS recovery efforts.

### Cholera

#### World sees marked rise in cases and deaths

The World Health Organization reported a 13% increase in cases of cholera worldwide and warned of serious gaps in access to treatment. Last year 535 321 cases were reported to WHO, up from 472 697 in 2022. Reported cholera deaths rose by 71%, from 2349 in 2022 to 4007 in 2023. WHO said that conflicts, climate change, limited investment in development, and population displacement resulting from emerging and re-emerging risks had all contributed to a rise in cholera outbreaks.

### GP services

#### Private provider loses practice contracts

North Central London Integrated Care Board will not be renewing contracts for five general practices operated by AT Medics after a transfer of ownership that did not have the board's consent, representing a "serious contractual breach." An 18 month extension period has been agreed to ensure services are uninterrupted while new arrangements are made. Last month North West London ICB decided not to terminate its contract with the provider over the same breach but said it would closely monitor performance.



Health services are failing children, paediatricians have warned

### Polio

#### Gaza's children vaccinated during humanitarian pause

The World Health Organization said that more than 187 000 children under age 10 were vaccinated with novel oral polio vaccine type 2 (nOPV2) in central Gaza during



the first phase of a two round polio vaccination campaign, conducted from 1 to 3 September. The UN body said the campaign had been a success, with all parties respecting a humanitarian pause. Circulating variant poliovirus type 2 (cVDPV2) was detected in Gaza in wastewater samples collected in June, after 25 years of the country being free of polio.

### Preterm birth

#### Target of 6% "won't be met" in England by 2025

Gillian Merron, women's health minister, said there was no chance of meeting the previous government's target of reducing the premature birth rate to 6% in England by 2025. In 2022, 7.9% of babies born in England were premature, and every year an estimated 53 000 babies are born prematurely.

Cite this as: *BMJ* 2024;386:q1964

### FLU

England had an estimated 2776 deaths from influenza in the 2023-24 season, down from 15 465 in 2022-23

[UK Health Security Agency]



### ANOTHER AMAZON DELIVERY?

Not this time. This is a recent study by NHS Blood and Transplant (NHSBT) and Apian, a medical logistics startup, looking at how quickly and safely five drones could deliver 10 packs of blood in comparison with five ground vehicles in a round trip between two hospitals in Northumberland.

### SPEEDIER SERVICE?

NHSBT said all blood products arrived at their destination without damage, suggesting patients could safely receive drone delivered blood. But there wasn't much difference in time. The drones travelled 42 miles (68 km) in 61 minutes, while the ground vehicles drove 46 miles (75 km) in 68 minutes.

### DRONING ON AND ON?

The research team said the study's drone route—planned with the Civil Aviation Authority—was not direct and that distances are expected to be shorter and quicker in real world scenarios.

### ANY ENVIRONMENTAL IMPACT?

This feasibility study wasn't set up to measure that, but previous analysis has indicated that the impact would depend on factors such as the size of the drone and the emissions from existing transport.

### ARE HEALTHCARE DRONES COMMON?

They are increasingly being considered for use in areas with vast and difficult terrain. For example, Rwanda was the first country to use drones to deliver blood and essential drugs to rural hospitals. Zipline, a Silicon Valley company, began operating in Rwanda in 2016 and now delivers an estimated 75% of the country's blood supply outside the capital, Kigali.

### HOW DOES IT WORK?

Healthcare professionals place orders through a mobile phone, and drones deliver supplies within 15 minutes to villages hours away by road. The drones in Rwanda typically carry around 4 lb (1.8 kg)—similar to a large loaf of bread—and have a range of 60 miles (96 km).

### WILL THE CONCEPT FLY?

The jury is out because of the lack of independent published studies.

Catherine Schuster-Bruce, London

Cite this as: *BMJ* 2024;386:q1951



## Staff still struggling with trauma of covid, report finds

**D**octors and other NHS staff are still dealing with the devastating events they experienced during the pandemic, whether seeing patients, colleagues, and loved ones die or feeling fearful for their own lives, a report by the UK Covid Inquiry has found.

The inquiry's Every Story Matters team has been tasked with collating the personal experiences that have been shared with the inquiry during its investigation. As part of their first report they have looked at the lasting effects of the pandemic on doctors and other healthcare staff and the availability of support for them during and since.

The team found that many healthcare staff struggled to deal with "overwhelming" workloads and the sheer number of patients who were dying, especially as many were also facing the deaths of their own family members, friends, and colleagues.

"Experiencing so many deaths had a huge

emotional impact on many in the workforce who shared their stories with us," the report said. "Many contributors said they experienced damaging impacts on their mental health and wellbeing. Some shared how helpless they felt in the face of so many lives being lost."

One paramedic told the team, "I know that I see a lot of trauma a lot of the time, but this . . . was on a different kind of level. It was something that none of us had experienced. And everyone was sort of just winging their way through this situation, that no one really knew how to handle, but we were trying our best."

A hospital nurse described how their small hospital was dealing with 80 deaths a day at one point. "We couldn't store the bodies. We had to bring in a massive, big freezer unit, which was just humongous, just to put these

bodies in. It was quite devastating to just see, it continues to have an impact on me."

The report emphasised that healthcare professionals were also facing the "same personal challenges everyone in society did," which only added to the pressure on them. This led to many staff members experiencing a deterioration in their physical and mental health. "You didn't have time for having mental health issues, you just needed to get on with it because you were doing a job and you were, you felt like you were fighting for your own life every day," said one A&E doctor.

### Dealing with death of colleagues

On top of their workload and personal pressures, staff were very aware of the risk to their own health from the virus but believed that their sacrifices were not "properly recognised and compensated," the report said.

Staff also shared how difficult they found it when colleagues died. "They grieved deeply even if they did not know them personally. There was a sense of unfairness that some workers died and a concern for the devastating impact on their loved ones," the authors wrote.

One hospital porter who lost a close friend and colleague was left questioning whether the risk was worth it after the hospital failed to provide any support to the bereaved family. "He caught it from the hospital . . . but no one from

**I DON'T THINK** I've come back to 100%  
of how I normally was. It takes its toll

## "RCP showed bias in handling members' PA concerns"

The Royal College of Physicians demonstrated "organisational bias" and was dysfunctional in its handling of members' concerns over physician associates, a damning review has found.

An independent inquiry by the King's Fund into the events around a "painful" and "shocking" RCP extraordinary general meeting on 13 March was published on 10 September, just a few hours before the college's AGM.

The 45 page review found a "range of collective failures in leadership" across the college, a "clear lack of accountability and due process," and evidence of "poor behaviours" in council meetings, including shouting and use of intimidatory language.

The review called for a major reset by the RCP and described how reputations had been damaged. The RCP council "is not operating effectively," decision making processes are unclear, and "more generally there is a pervasive lack of trust and confidence in its governance," it warned.

It found failings in the running of a member survey "without clear processes in relation to design, sign-off, and quality assurance," which fuelled accusations of bias and concerns the survey results were skewed to seem more positive towards PAs. The report said, "When the evidence did not meet the aims of the survey or match the apparent preconceived views of those behind the survey, it led

**There is a pervasive lack of trust and confidence in the college's governance**  
King's Fund report

to the results being presented in a biased way."

Trish Greenhalgh, professor of primary care health sciences at Oxford University, told *The BMJ*, "The report's findings are troubling in at least two distinct ways. First, there are serious governance problems, with confusion about who makes key decisions. Second, it describes a toxic culture that raises questions about the behaviour of some individuals. Both must be addressed."

In an opinion article on *bmj.com* Greenhalgh and colleagues, who

include Martin McKee, professor of European public health at the London School of Hygiene and Tropical Medicine, said, "We respectfully suggest those who held the highest executive and board level oversight roles during this period might consider their positions."

The EGM of fellows in March was arranged to debate issues relating to PAs and hear challenges to the college's position. The King's Fund was asked to review the events leading up to the meeting. It found that the RCP was slow to hold the meeting and could have met petitioners' concerns sooner within its bye-laws. A delay of several months meant that parliament had by then passed the statutory

the hospital had given any bit of support to his family, and that was the saddest part.”

The report found much variation in the wider support given to staff. Some people reported their workplace set up support hubs and encouraged people to take breaks throughout the day, while others said they had no emotional or mental health support.

### Lasting impact of pandemic

The report said many staff were still processing what had happened to them, including their “traumatic memories of delivering care during the pandemic.”

One paramedic said, “I don’t think I’ve come back to 100% of how I normally was. It takes its toll. But it’s almost like having this piece of paper, that’s nice, and flat, and straight, and then you’ve crumpled it and then you try and straighten out that piece of paper again. It’s still creased up, no matter how much you try and straighten it out.”

Another told the report their colleague had died by suicide towards the end of the pandemic. “We will never know why they took their own life, but we know the pandemic had a significant impact on their mental health.”

The report called for the government and NHS to “do more to support and reward staff, recognising the lasting impact of a crisis.”

If you’re struggling, you’re not alone. In the UK and Ireland Samaritans can be contacted on tel 116 123 or email [jo@samaritans.org](mailto:jo@samaritans.org)

Elisabeth Mahase, *The BMJ*

Cite this as: *BMJ* 2024;386:q1969



instrument giving the GMC powers to regulate physician associates.

In their opinion piece Greenhalgh, McKee, and colleagues wrote, “The missed opportunity to influence parliamentary discussion . . . in a way that reflected the concerns of its membership is among the most serious issues faced by the college in its 500 year history.”

The RCP said it accepted the report and its recommendations in full.

Matthew Limb, London

Cite this as: *BMJ* 2024;386:q1987

## Coroner issues anaesthetic safety warning after death of patient



**Rachel Gibson’s cardiac arrest was caused by excessive use of ropivacaine during her hip replacement surgery, said the coroner**

A coroner has warned that a common practice used by anaesthetists could lead to deaths after concluding that a woman died because she received too large a dose of a local anaesthetic during an operation.

Rachel Gibson, 47, a cancer scientist who had severe osteoarthritis, underwent hip replacement surgery at Spire Lea Hospital in Cambridge in April 2022. She had an unwitnessed cardiac arrest when back in her room and was transferred to Addenbrooke’s Hospital, where she was found to have irreversible brain damage. She died three months later.

Philip Barlow, assistant coroner for Cambridgeshire and Peterborough, found that Gibson’s cardiac arrest had been caused by excessive administration of the local anaesthetic ropivacaine during surgery.

Barlow wrote in a prevention of future deaths report, sent to Fiona Donald, president of the Royal College of Anaesthetists, “The intention was for a 2% solution of ropivacaine to be diluted 50/50 with normal saline before it was infiltrated. The evidence suggested that this was not done. The result was that excessive ropivacaine was administered by mistake.”

Barlow added that the way the anaesthetic had been prepared was “common nationally” and therefore “in my opinion there is a risk that future deaths could occur unless action is taken.”

Barlow’s report noted that the instruction had been given orally by the anaesthetist, who did not check what the nurse had written. The nurse drew up the drug and checked it with another nurse but not the anaesthetist. He said Spire Lea had now introduced a system for labelling and countersigning but that there was wide variation nationally.

Donald said, “We will do all we can to address the issues raised by the coroner to help prevent similar tragedies in future.”

Clare Dyer, *The BMJ* Cite this as: *BMJ* 2024;386:q1936

## GOSH reviews former surgeon’s cases

Great Ormond Street Hospital for Children is urgently reviewing all 721 patients of a former consultant orthopaedic surgeon after an external review by the Royal College of Surgeons (RCS) raised concerns about his practice.

Of the 39 cases examined so far, the review has found that 13 patients of Yaser Jabbar suffered severe harm and another 13 have experienced low or moderate harm. Another two have been referred to peer review, with outcomes awaited.

Jabbar worked at GOSH between 2017 and 2022. He undertook lower limb reconstruction, including limb lengthening operations. At least one child has had to have a leg amputated, and another is at risk of amputation. Other children have been left with different length legs.

A hospital spokesman said it asked the RCS to review its paediatric orthopaedic service after staff and

**Yaser Jabbar lacked understanding of deformity correction surgery and lacked insight, the RCS report said**

patients’ families raised concerns.

The college’s report, completed last October, has not been published but was leaked to the *Sunday Times*. According to the newspaper, the report said Jabbar “demonstrated a lack of understanding of the principles of deformity correction surgery in addition to a lack of insight.”

The hospital review, carried out by five expert orthopaedic surgeons, began in May and is expected to take 18 months.

Jabbar qualified at St George’s Hospital Medical School in London in 2004 and worked privately at the Portland Hospital as well as GOSH, from where he moved to Dubai. He has not been licensed to practise in the UK since January 2024. He had interim conditions imposed on his registration in January pending an investigation by the GMC.

A GOSH spokesman said it accepted the college’s findings in full and was taking steps to act on all the recommendations.

Clare Dyer, *The BMJ*

Cite this as: *BMJ* 2024;386:q1977



# OBESITY: Only half of England has access to comprehensive weight loss services

Treatments are being restricted by cash poor local services, with many patients denied specialist drugs, surgery, and support. **Elisabeth Mahase** investigates



**Current weight management services don't in any way meet the need**

Nicola Heslehurst



**England has one of the lowest rates of bariatric surgery in the developed world**

Ahmed Ahmed

**EXCLUSIVE** Access to services across England for obesity treatment is severely restricted, an investigation by *The BMJ* has found.

Patients in nearly half the country cannot get appointments with specialist teams for weight loss support and care, including treatment with drugs such as semaglutide, showed responses to freedom of information requests. And in nearly one in five local health areas patients don't have access to a bariatric surgery service.

Obesity specialists told *The BMJ* that services for weight management in England are not given the priority they deserve, often being the first to be cut when budgets are tight. Patients are also often the victims of prejudice among many people, including some health professionals and commissioners, who believe that they are less worthy of care than other patients.

Integrated care boards (ICBs) receive annual funding from NHS England to commission services for their local areas, referred to as integrated care systems (ICSs). The boards then allocate money to the services they deem most important to their local population, meaning that those that the commissioners believe are least important may not receive any funding.

ICBs are under huge financial pressure, with some reporting large budget deficits and others cutting services in attempts to save money.

*The BMJ* analysed responses from all 42 of England's ICBs about the weight loss services they commission. The responses showed that just over half of the ICBs (24 of the 42)

commission both tier 3 and 4 (box) adult weight loss services that cover their entire population and are accepting new referrals.

Just over a third of ICBs (15) reported problems with tier 3 services such as that they were currently closed to new patients (six ICBs), that they only covered part of the ICB's catchment area (seven), or that the ICB didn't commission any services at this level (four). Access to tier 4 services, which provide bariatric surgery, is also restricted in many parts of the country, with seven ICBs not providing a bariatric surgery service to patients in their area.

Although most ICBs said that they did fund bariatric surgery, even if they didn't have a dedicated service, *The BMJ* found that the referral criteria were inconsistent. Although some hospitals follow NICE guidance, others have further limited access to surgery by, for example, allowing only patients with a BMI >50 (or >40 and with at least one agreed comorbidity) to be accepted.

NICE guidance states that surgery should be available to suitable patients with a BMI  $\geq 40$  or between 35 and 39.9 if they have a significant health condition.

## Stigma and poor provision

Nicola Heslehurst, senior lecturer in maternal nutrition at Newcastle University and chair of the UK Association for the Study of Obesity, told *The BMJ* that the current provision of weight management services "doesn't in any way meet the need." Whenever there's a financial squeeze, obesity services always seem to be at the top of the list of care

to be cut, she said. "I think there's a general misunderstanding, including among health professionals and commissioners, about the causes of obesity and the care requirements of obesity, which is really heavily influenced by that perspective of individual responsibility, that people living with obesity are not quite as deserving as people living with other diseases, tied in with all the stigma around people living with obesity."

John Wilding, professor of medicine and honorary consultant physician



## WHAT DO NHS OBESITY SERVICES INVOLVE?

Generally, there are four tiers of weight management services in England

**Tier 1**—Lifestyle advice provided by GPs and practice nurses. This can include signposting of patients to community services.

**Tier 2**—Community based services, often run by local councils, which may offer group classes on lifestyle and diet.

**Tier 3**—Usually based in hospitals, these services can also be run in the community or in primary care and involve patients being seen by a multidisciplinary team, including physicians, physiotherapists, dietitians, and mental health specialists. They can provide patients with weight loss drugs such as semaglutide.

**Tier 4**—Bariatric surgery and bariatric medicine services that offer surgery, post-surgical and annual follow-ups, and more specialist and intensive weight management programmes than those found in tier 3. Often patients will have to go through a tier 3 service before they can access a tier 4 service.

**MINISTERS** estimated that obesity costs the NHS in England around **£6.5bn** a year and is the second biggest preventable cause of cancer, after smoking



BURGER/PHANIE/ALAMY

at Liverpool University, also believes that bias plays a key role in these commissioning decisions. “Obesity services are not deemed a priority,” he told *The BMJ*. “Research has shown that there is an unconscious bias there. I don’t think commissioners are being deliberately difficult, and I don’t think they’re consciously discriminating, but I think there is an unconscious bias which says, ‘This is mostly their fault, so they should just get on with it, go on a diet and lose weight.’ But we know from genetics and other factors that it’s much more complicated than that.”

Wilding has undertaken consultancy work for drug companies and is a commercial trials investigator for Eli Lilly, Novo Nordisk, and Rhythm Pharmaceuticals.

### Bariatric surgery underused

England’s poor provision of weight management services is reflected in the number of bariatric surgeries carried out each year. Around 5000 operations are carried out on the NHS in England every year, far lower than in other high income countries such as France, where around 50 000 bariatric procedures are done annually. Between 2017-18 and 2022-23 the number of bariatric procedures conducted in the NHS in England fell from 6500 to 4900.

The consultant bariatric surgeon Ahmed Ahmed, secretary of the British Obesity and Metabolic Surgery Society, said England had “one of the lowest rates [of bariatric surgery] in the developed world,” despite a 25% prevalence of obesity in adults.

“Bariatric surgery has a strong evidence base showing sustained weight loss, comorbidity resolution, and improved quality of life in those living with severe and complex obesity,” he said.

Ahmed argued that although it would be “logistically and financially impossible for the NHS to treat all two million eligible patients with bariatric surgery,” and that some patients may not choose to undergo such an operation, a “modest increase” from around 5000 to 20 000 procedures a year could be reasonably achieved. This would equate to surgeons carrying out about three each a week, up from less than one a week currently.

Ahmed said that, in addition to the major benefits to patients, investing in better services would be financially beneficial to the NHS and the wider economy. The government estimated that obesity costs the NHS in England around £6.5bn a year and is the second biggest preventable cause of cancer, after smoking.

The high cost of glucagon-like peptide 1 receptor agonists (GLP-1 RAs) such as semaglutide means bariatric surgery may also remain the most cost effective intervention for at least the next decade, said Wilding. “If you look 20 years ahead, we might end up with less surgery. But I think for the next 10 to 15 years it’s very likely we’re going to continue to need to have bariatric surgery, and the provision does need to be expanded,” he said.

**Bariatric surgery is currently more clinically and cost effective than drugs, but this is likely to change in the coming years**

He said that a gastric bypass “is the most clinically effective and the most cost effective” treatment, with a QALY gain of between £2000 and £4000. “For context, the NICE cut-off for cost effectiveness is £20 000 per QALY gained. Now, that’s actually better than a lot of other things that are done. It’s better than implantable defibrillators (cost per QALY around £25 000), and it’s actually close to what you get with a hip replacement (about £7000 to £8000 per QALY),” he explained.

“The cost per QALY gain at the moment with the current prices for GLP-1 RAs is probably somewhere between £16 000 and £20 000, so it’s a lot more. And that’s when we are only giving them for two years.”

However, Wilding thinks this could shift in the future. “What we don’t know is what the long term prices of these drugs are going to be, but it’s likely that they will come down. I remember having these discussions when statins came out. At that time statins were £30 to £40 a month, and we were having exactly the same conversation then. And now, of course, they’re £2 a month and are widely prescribed.”

When asked about the poor provision of weight management services, an NHS England spokesperson said it was “working with the Department of Health to support improvements in the obesity pathway.”

● FEATURE, page 264

**I think there is an unconscious bias which says, “This is mostly the patient’s fault”**

John Wilding



Elisabeth Mahase, *The BMJ*

Cite this as: *BMJ* 2024;386:q1950



2



## THE BIG PICTURE

# Highs and lows of being a drug user

From alcohol and caffeine to ayahuasca and heroin, art has for centuries been used around the world to explore the world of drug cultures.

Now the University of East Anglia's Sainsbury Centre is displaying many examples of this art in a six month season of exhibitions asking "Why Do We Take Drugs?"

The five individual series, entitled Power Plants: Intoxicants, Stimulants and Narcotics; Ayahuasca & Art of the Amazon; Heroin Falls; Lindsey Mendick: Hot Mess; and Ivan Morison: Towards the Weird Heart of Things, explore the organised and chaotic use of narcotics and intoxicants in different parts of the world.

Alison Shepherd, *The BMJ*

Cite this as: *BMJ* 2024;386:q1975

3



- 1 Song to Tayaupa, 2022, by Gilberto Gonzales
- 2 Ayahuasca Dream, 1994, Robert Venosa
- 3 Universal Mother, 2015, Martina Hoffmann
- 4 Anteater (Oso Hormiguero), 2020, Celia Vasquez Yui
- 5 Container for snuff or "medicine," late 19th century, Makonde, Tanzania/Mozambique
- 6 Jar, Shipibo-Konibo, Peru, unknown artist



1. BIENAL DE ARTE HUIJCHOL / ARTE YAWI 2. MARTINA HOFFMANN 3. MARTINA HOFFMANN 4. FEDERICO ROMERO GIULIO 5. UEA 6. PRIVATE COLLECTION



# Covid inquiry: the flaws that led to system failure

Without radical reform we are vulnerable to the next pandemic

The first report from the UK's covid-19 inquiry, chaired by Heather Hallett (right), delivered a scathing critique of the country's system of planning for and reacting to health emergencies.<sup>1</sup> Module 1 of the inquiry examined the structures and processes in place for pandemic preparedness, resilience, and response across the UK. In just over 200 pages, the report paints a clear picture of the serious inadequacies that left the UK unprepared for the covid pandemic. Failings identified include a fatally flawed risk assessment process, an outdated and narrow pandemic strategy, not learning from past outbreaks, and a lack of focus on pandemic preparedness. In essence, the report exposes "a lack of adequate leadership, coordination and oversight" in the years before the pandemic.

Perhaps the report's most telling criticism is that, even now, the structures and organisations we rely on to protect us as a country are blind to their inherent fundamental flaws and failings. This dearth of insight, added to the abundant failures of foresight, led the inquiry to make 10 radical and far reaching recommendations. This small number of focused recommendations speaks volumes about the need for precision and clarity in state responsibility, where labyrinthine structures, groupthink, absence of accountability, and the wilful neglect of public health and prevention all contributed to the devastating outcomes of covid-19.

The report's recommendations centre on the UK government, together with the devolved administrations, creating an independent statutory organisation responsible for advice on civil emergency preparedness, resilience, and response. Developing new mechanisms for whole system preparedness would also involve



## Organisations intended to protect are blind to their own failings

constructing a UK-wide civil emergency strategy that would be tested regularly and refreshed at least every three years.

In examining pandemic preparedness, the report identifies many failings in obtaining and using expert advice. The inquiry's suggested solution to the dominant closeted and corralled approach is to use "red teams," an approach developed in military and cybersecurity realms but now applied more widely.<sup>2</sup> It involves creating groups of critical thinkers to identify blind spots and vulnerabilities, challenge orthodoxy, and probe flaws and vulnerabilities.

## Neglect of public health

Unfortunately for the UK population, little or no attention was paid in advance, or during the early phase of the pandemic, to the public health measures that might have prevented or at least delayed the rapid spread of an infectious disease. The report noted the contrast between the approach in the UK and that adopted in (for example) Taiwan and South Korea, where it was understood that the spread of a dangerous infectious disease should and could be stopped. This failure to consider public health measures in the UK is entirely in keeping with the steady marginalisation and diminution of public health in England since 2010.

Although the inquiry catalogued the multiple failures in planning and preparedness, it did not delve into the undoubtedly more complex and

perhaps ideological reasons why they occurred. A little recognised culture war has been waged on public health as part of a broader ideological programme of "state retreat"<sup>3</sup> in England since 2010. This has included the abolition of government offices for the regions, regional development agencies, strategic health authorities, regional resilience forums, and primary care trusts, and the abandonment of conterminous boundaries between NHS and top tier local authorities. It is little surprise that emergency preparedness was so deficient in the absence of any integrating, coordinating, or management function at a regional level in England operating between Whitehall departments and the multiple bodies, often very local, that are charged with implementing government policy.

The hollowing out of England's public health capacity and influence of public health was accompanied by attempts to reinvent the language used. The replacement of "public health" with "health security" in the title of the government's English public health body (from Public Health England to UK Health Security Agency) is just the most prominent example.

Hallett and the inquiry team delivered a report that is an indictment of the system in Westminster and the devolved administrations. The report lays out what needs to be done, and the UK has a new government. There is no time to waste. Another pandemic could emerge at any time, and the World Health Organization's recent declaration of mpox as a public health emergency of international concern is a timely reminder.<sup>4</sup> Until the inquiry recommendations are implemented, we remain vulnerable and unprotected.

Cite this as: *BMJ* 2024;386:q1865

Find the full version with references at <http://dx.doi.org/10.1136/bmj.q1865>

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# The Care Quality Commission has lost its way

New leadership then a complete overhaul are needed to get it back on track

There is a profound crisis of confidence in the Care Quality Commission (CQC), the statutory regulator of health and social care services in England. In June, its chief executive, Ian Trenholm, abruptly left the organisation with less than a week's notice, after six years in the role.<sup>1</sup> Less than a month later, the Department of Health and Social Care published a damning report on the CQC's performance from a public body review chaired by Penny Dash.<sup>2</sup> The review had already been established in May as part of an ongoing public body review programme,<sup>3</sup> but the department took the highly unusual step of publishing an interim report after just two months' work. Its final report will follow in the autumn.

The interim report found "significant failings in the internal workings of CQC, which have led to a substantial loss of credibility within the health and social care sectors, a deterioration in the ability of CQC to identify poor performance and support a drive to improved quality—and a direct impact on the capacity and capability of both the social care and the healthcare sectors to deliver much needed improvements in care."<sup>2</sup>

There are many disturbing parallels with the last time the CQC had a very public collapse, in 2012, following highly critical reports from the National Audit Office,<sup>4</sup> the House of Commons Health Select Committee,<sup>5</sup> the Department of Health and Social Care's own performance and capability review,<sup>6</sup> and then the second Francis inquiry report.<sup>7</sup> On that occasion, the senior leadership was replaced, and a completely new strategy and direction was developed by the incoming chief executive, David Behan, with the newly appointed chief inspector for hospitals, Mike Richards.<sup>8</sup>



**Health and social care still needs an effective, credible regulator**

## Not delivering

So, what are the problems for the CQC now, and what needs to be done? The most immediate concern is that the CQC is not delivering its core function. There is a backlog of new provider registrations; the commission is undertaking less than half the number of inspections planned; some organisations have not been assessed for several years; and about 1 in 5 care locations have never been inspected and rated. The CQC's national call centre takes an average of 19 minutes to answer (and between a quarter and a third of callers give up before getting through). There are also problems with its new IT systems.<sup>2</sup>

More fundamentally, the interim report raises questions about whether the "single assessment framework"—which the CQC developed over the past several years and is now trying to implement—is fit for purpose. The framework tries to provide a single set of 34 generic quality statements that can be applied to anything from a small domiciliary care service to a large tertiary acute hospital. It is complex, difficult to understand, and does not explain clearly what represents "good" or "outstanding" performance.

The CQC's inspection teams are also generic, and inspectors do not necessarily have expertise in the sectors or services they inspect. Finally, inspections do not cover all 34 quality statements (typically only about 5-10 are included in each inspection), and the methodology

used for calculating ratings combines statements from current and past inspections (which may be old or out of date) in ways that are obscure and not well understood or trusted by providers.

It is hard to understand how the CQC's board has allowed all this to happen. As the interim chief executive, Kate Terroni, has acknowledged, many providers and CQC staff had raised serious concerns but were not listened to.<sup>9</sup>

The CQC has clearly lost its way. But the health and social care system in England still needs an effective, respected, professionally led, and highly credible regulator. Lessons can be learnt from regulation in other sectors and in other countries (<https://epso-net.eu/>).

We know, for example, that most regulatory impact comes about through self-assessment and voluntary compliance—organisations understanding and complying with regulatory requirements because those requirements are considered legitimate and evidence based; and also because organisations want to be compliant in advance of regulatory interventions such as inspections.<sup>11</sup> So regulators should ensure that their requirements are clear and understandable by providing detailed, sector specific guidance, with exemplars and toolkits to aid implementation.

There are no quick fixes for the CQC, but the first step must be to bring in new leadership with the necessary credibility and expertise in healthcare, social care, and regulation. Then, the regulatory regime needs a complete overhaul, with a relentless focus on regulatory impact, and especially the value that inspections, ratings, and other regulatory interventions deliver for patients and service users.

Cite this as: *BMJ* 2024;386:q1832

Find the full version with references at <http://dx.doi.org/10.1136/bmj.q1832>

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# How do GLP-1 drugs work for weight loss...and everything else?

Scientists are now working to understand how glucagon-like peptide 1 works in the body and, by association, how powerful the likes of Wegovy and Ozempic could be.

**Marianne Guenot** reports

**G**lucagon-like peptide 1 (GLP-1) receptor agonists like semaglutide (Wegovy/Ozempic) are constantly in the news for their staggering slimming effects. But it's becoming clear that there is more to this drug class than weight loss.

GLP-1 receptor agonists were once thought to be simple insulin regulators. Now, they're known to act on the kidneys, heart, liver, brain, and more. "I think it's absolutely fascinating and definitely very unusual that the potential indications are expanding so dramatically," says Lorenzo Leggio, a neurologist and clinical director of the National Institute on Drug Abuse Intramural Research Program in Baltimore.

"In today's era of drug development, which is often largely driven by genetics, GLP-1 doesn't stand out genetically," says Daniel Drucker, professor of medicine at the Lunenfeld Tanenbaum Research Institute Mount Sinai Hospital in Toronto and one of the discoverers of GLP-1's first actions (for diabetes) in the 1980s. "We're lucky to have the [unusual] pharmacology of GLP-1."

GLP-1 agonists have been in the clinic since the early 2000s. But it's only over the past few years, with the advent of the more powerful semaglutide and tirzepatide, that the drug class's effects have truly started to be unpacked—and they are plentiful.



**GLP-1 seems to be a major actor in our body regulating metabolic pathways**  
Lorenzo Leggio



**The health gains far outweighed what would have been expected from the amount of weight loss**  
Katherine Saunders



## Wealth of uses

Following successful clinical trials, semaglutide was approved by the US Food and Drug Administration in the first quarter of 2024 to reduce the risk of cardiovascular death, heart attack, and stroke. The UK Medicines and Healthcare Products Regulatory Agency followed suit in July, approving the drug's use in people with a BMI higher than or equal to 27 and with established cardiovascular disease.

The drugs also seem to be able to protect the brain, with dozens of trials under way to explore GLP-1 receptor agonists as potential treatments for Alzheimer's and Parkinson's diseases, including two large scale phase 3 clinical trials, Evoke and Evoke+, run by Novo Nordisk. GLP-1 agonists might act on kidney disease too. The Flow trial sponsored by Novo Nordisk looking at once weekly semaglutide for people with type 2 diabetes, showed a 24% reduction in major kidney disease events. The agonists are also showing promise against non-alcoholic fatty liver disease.

Drucker thinks that more indications are probably around the corner. Patients are approaching him, claiming that these drugs helped alleviate the symptoms of their chronic pain, rheumatoid arthritis, atherosclerosis, and even chronic fatigue and long covid brain fog. "The reason we are seeing all this is that GLP-1 seems to be a major actor in

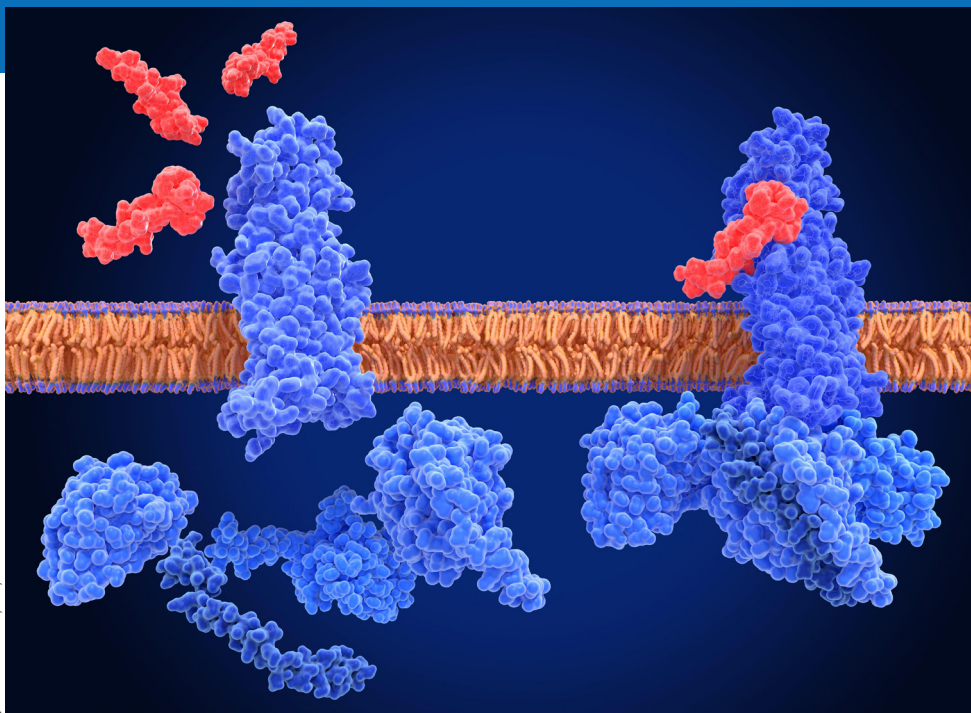
our body—including in the brain—regulating metabolic pathways," says Leggio. Yet we still don't really know what these pathways are.

## Whole body regulatory mechanism

One of the obvious health benefits of GLP-1 agonists is the staggering amount of weight loss they trigger. That is in part because GLP-1 is an incretin, a group of hormones released by the gut after a meal that modulate the release of insulin. GLP-1 is also known to reduce gut motility and delay gastric emptying, which brings a feeling of satiety more quickly after a meal is started. This has beneficial knock-on effects on the body. Weight loss reduces insulin resistance, tissue inflammation, and fat accumulation in the liver and other organs, which helps protect organs from damage, Drucker says.

But several clues indicate that GLP-1 acts on more than body weight. One is that GLP-1 receptors are found all over the body—in the heart, blood vessels, kidneys, immune cells in the liver, neurons in the brain, and more. A further clue comes from the Select trial that studied semaglutide effects on heart disease and stroke in patients with overweight or obesity, also run by Novo Nordisk.

This found a 20% reduction in major adverse cardiovascular events among participants treated with semaglutide. The scale of these



health gains far outweighed what would have been expected from the amount of weight loss observed, says Katherine Saunders, a spokesperson for the Obesity Society and professor of medicine at Weill Cornell Medicine.

Preclinical and early clinical data provide insight into how this could be happening. Studies indicate that GLP-1 reduces apoptosis, which could help protect organs from damage. GLP-1 might also have a strong anti-inflammatory effect, although the data to support this idea are only starting to emerge.

“All of the diseases that we’ve just discussed—kidney disease, heart disease, strokes, Alzheimer’s, Parkinson’s, metabolic liver disease, atherosclerosis—they’re all characterised by excess inflammation,” Drucker says. His team recently showed that one dose of semaglutide given to mice reduced inflammation throughout the body. And importantly, this happened only when GLP-1 receptors in the brain were active.

### GLP-1 in the brain

The brain likely plays a big part in how GLP-1 tweaks the body’s mechanisms. Studies have shown that GLP-1 can change neural plasticity, modulate brain metabolism, and reduce neural inflammation—which might be how it could act on Alzheimer’s and Parkinson’s diseases. It has been suggested to change the

**GLP-1 receptors are found all over the body—in the heart, blood vessels, kidneys, immune cells in the liver, neurons in the brain, and more**

levels of mood boosting molecules too, such as dopamine, serotonin, and glutamate, which might affect our moods. GLP-1 is also thought to reduce appetite by interacting with the hypothalamus, which contributes to weight loss.

This lines up with incidental evidence coming from patients who take GLP-1 drugs. According to Drucker, several have said that they feel the treatment made it easier to control their drug, smoking, alcohol, and even shopping addictions. Saunders also testifies to this. “I have one patient who is a very successful businessman, but he has never been able to control his gambling addiction. He is now on Mounjaro [a brand name for tirzepatide] and couldn’t be happier that he can finally manage the gambling.”

This remains anecdotal—clinical trial data on GLP-1 agonists for the treatment of addiction are scarce. Still, studies are starting to emerge. A study on electronic health records, for example, published on 30 July in *Annals of Internal Medicine*, found a significantly lower risk of seeking medical advice for tobacco use in patients with diabetes treated with semaglutide compared with other diabetes medications. But experts including Rachel Richardson, the Cochrane methods support unit manager, have said that this tentative association would need to be confirmed in a randomised controlled trial.



**The drugs show promise but clinicians should be mindful of managing expectations**  
Daniel Drucker

Leggio, who has conducted early laboratory studies on GLP-1 agonists and addiction, thinks the preclinical evidence is exciting. “I’m talking about 10 plus years of evidence with alcohol, nicotine, opioid stimulants” in animal models, Leggio tells *The BMJ*.

This hints at a major problem around these drugs right now: hype. Drucker cautions that, although the drugs show some promise, clinicians should be mindful of managing people’s expectations, particularly as they are barraged by stories and commentary about the medicines on mainstream and social media.

Notably, the drugs come with substantial side effects, including nausea and gastric discomfort, which can limit a person’s ability to take the drug long term. GLP-1 receptor agonists can also increase the risk of gallstone and biliary disease. Early studies indicated that it could raise the risk of pancreatic and thyroid cancer, although to date, there is no clear evidence for this association. For Drucker, one avenue for drug development going forward will be to find formulations that alleviate these side effects.

“If you’re asking me to look through my crystal ball, I think metabolic liver disease has got a reasonable likelihood of success,” says Drucker. But when it comes to Alzheimer’s and Parkinson’s diseases, he takes a “wait and see” approach pending large scale clinical trials. “We know how difficult it is to have a positive impact on slowing down the development of cognitive dysfunction,” he adds. Still, the fact that GLP-1 agonists have long been used—with around 20 years of safety data—means that they could be quick to roll out.

“It’s already an amazing story to have medicines that reduce heart attack, strokes, cardiovascular death, and kidney disease, are really good therapies for diabetes, and have unprecedented efficacy for weight loss,” Drucker admits. “If we can extend the benefits of GLP-1 to those [neurodegenerative] conditions, I would be willing to consider the term ‘wonder drug.’”

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Cite this as: *BMJ* 2024;386:q1767



MALCOLM WILLETT (APOLOGUES TO MICHAEL CRAIG-MARTIN)

## BMJ INVESTIGATION

# Government's nutrition advisers are paid by world's largest food companies, BMJ analysis reveals

Campaigners say food experts' conflicts of interest are detrimental to public health, but defenders say they reflect the lack of research funding. **Sophie Borland** reports

**M**ore than half of the experts on the UK government's advisory panel on nutrition have links to the food industry, a BMJ analysis has found. At least 11 of the 17 members of the Scientific Advisory Committee on Nutrition (SACN) have conflicts of interest with the likes of Nestlé, sugar manufacturer Tate and Lyle, and the world's largest ice cream producer, Unilever.

SACN is a powerful group of people appointed as independent experts that provides advice to the government—which in turn influences policy. Since its establishment

in 2000 it has produced high profile guidelines on daily salt and sugar intake, vitamin D supplements, and feeding babies.

But there is concern that both SACN and the previous governments reviewing its recommendations have not done enough to curb rising rates of obesity and food related ill health. Currently, 28.3% of women and 26.9% of men in the UK are obese, up from 13.8% and 10.7%, respectively, three decades ago. Deaths from premature heart disease in England are at their highest in 14 years, and diabetes cases in the UK are at record levels.

Campaigners say that these conflicts of interests at the heart of policy making are

detrimental to public health. Others say that they reflect the lack of funding for nutrition research and that removing experts with industry links from SACN would “diminish” its expertise.

## Money changes minds

*The BMJ* looked at the interests declared by members of SACN—in publicly available documents published on the government website—in the past three years.

Among its members is David Mela, a retired senior scientist from Unilever, who has done consultancy work for the firm that earned him over £5000 last year. He also has shares in Unilever worth over £5000. He has done consultancy work for Tate and Lyle, Coca-Cola's Israel franchise CBC Israel, and Cargill, which produces cocoa and chocolate products among other things.

Another SACN member, Julie Lovegrove, is the chair of an expert group at the International Life Sciences Institute Europe, based in Brussels. Its member companies include PepsiCo, Cadbury's US owner Mondelez, and General Mills, the American firm behind Cheerios and Haagen Dazs.

Member Kevin Whelan has worked for Nestlé Health Science (owned by Nestlé), Danone, Alpro, Yakult, and the Dairy Council. He has received research grants from the International Nut and Dried Fruit Council and the Almond Board of California.

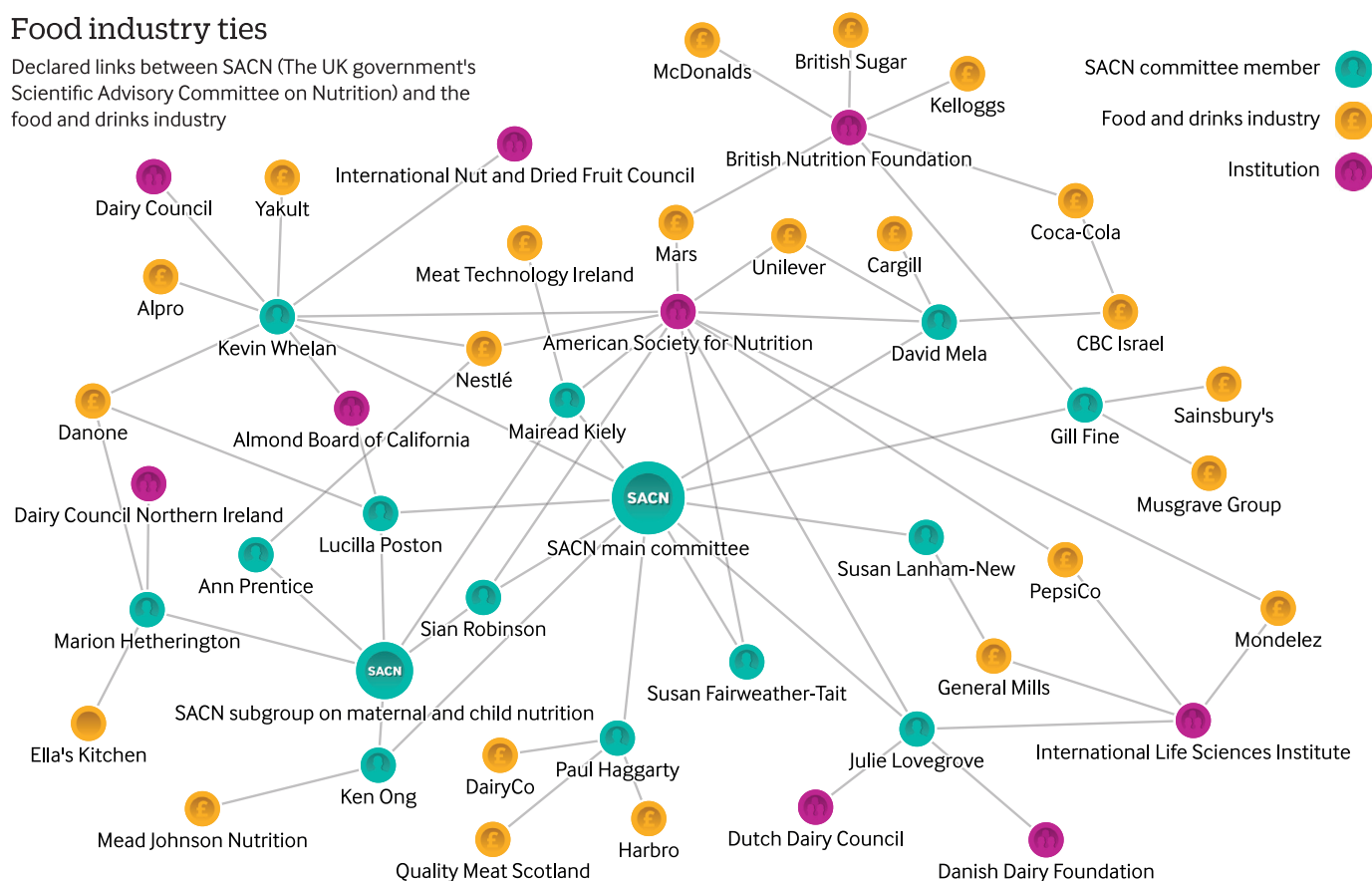
Gill Fine is a shareholder at Sainsbury's, and Paul Haggarty is head of lifelong health at the University of Aberdeen's Rowett Institute, which receives funding from the red meat and dairy industries. “I have no role in the administration of external funding in this position, and I am not familiar with these particular projects, which may be carried out in themes other than lifelong health at Rowett,” Haggarty told *The BMJ*. “My own research is not funded by industry as a personal choice, and this is reflected in my declarations.”

The Department of Health and Social Care (DHSC) responded on behalf of SACN and all members named in this article, saying that SACN members are required to confirm existing potential conflicts of interest annually and to declare new ones at the first appropriate committee meeting, which are included in the minutes and published on the SACN website.

Chris van Tulleken, associate professor at University College London and the author of a bestselling book on ultraprocessed food, told *The BMJ*: “Even small financial conflicts affect behaviour and beliefs in subtle or

## Food industry ties

Declared links between SACN (The UK government's Scientific Advisory Committee on Nutrition) and the food and drinks industry



unconscious ways—we have data from food and pharma research showing this. This means that declaring conflicts doesn't mitigate them.

“Conflicts in SACN damage the reputation and credibility of the committee. How can someone who claims to have an interest in public health have any links to companies like Coca-Cola or Unilever? We have known for decades about the harm caused by the products that companies like these make. Some companies make slightly less harmful products, but all are controlled and constrained by the same financial incentives, which mean they can't self-regulate.”

### Undermining public health

Six members of SACN are members of the American Society for Nutrition, which is funded by Mars, Mondelez, Nestlé, PepsiCo, and the Sugar Association, among others. These include Whelan, Mela, and Lovegrove; the other three are Sian Robinson, Susan Fairweather-Tait, and Mairéad Kiely. Others have financial links to Danone, the infant formula manufacturer Mead Johnson Nutrition, and General Mills (Lucilla Poston, Ken Ong, and Susan Lanham-New, respectively).

Rob Percival, head of policy at the Soil Association, a charity aiming to

### Six SACN members are members of the American Society for Nutrition, funded by Mars, Nestlé, PepsiCo, and others

transform the way we eat, farm, and care for the natural world, told *The BMJ*: “We're concerned that the committee and its integrity might be undermined by those ties to the food industry. That's not to say that individual scientists have been corrupted; the challenge is systemic. There's now really good evidence that conflicts of interest at the interface of science and policy can skew either specific policies or public narratives in favour of the food industry in ways which undermine public health.”

SACN's current work includes reviewing the evidence over ultraprocessed foods, artificial sweeteners, and plant based food and drink. Last July the committee issued a statement on ultraprocessed foods that warned that increased consumption was “associated with increased risks of adverse health outcomes,” adding that there were “uncertainties around the quality of evidence available.”

Experts including van Tulkeken and Percival say that SACN did not do enough to present the case for tougher regulation on ultraprocessed foods. The UK is behind countries in Latin America that have introduced warning labels on products high in sugar, salt, and fat.

A spokesperson for DHSC told *The BMJ*: “No members of the committee are directly employed by the food and drink industry, and all have a duty to act in the public interest and to be independent and impartial.”

### Lack of research funding

Katharine Jenner, director of the Obesity Health Alliance, a coalition of more than 50 organisations, told *The BMJ* that SACN members' ties to the food industry are partly a result of the lack of money in relevant research. “Nutrition funding is notoriously underfunded. So many of the studies are industry funded as the people who have got a particular interest are the research and development teams of the companies. It really is a very poorly funded world, and that just invites more industry funding.”

Alison Tedstone, former chief nutritionist at Public Health England, which was replaced by the Office for Health Improvement and Disparities, adds that several experts on SACN are in receipt of research grants from the food industry and that this practice is “expected” by a key national funding body. She says that in her experience applications for nutrition research to the Biotechnology and Biological Sciences Research Council (BBSRC) are more likely to be successful if there is partnership funding from food businesses. That can range

from supplying products to be used in studies to funding part of the study.

A BBSRC spokesperson told *The BMJ* that, although “collaborations with industry and other stakeholders are encouraged, it is not expected.” They point to organisational guidance for researchers, which the spokesperson says includes managing and making explicit any conflicts of interest. They say, “The BBSRC encourages the researchers it funds to build strategic partnerships with industry and broader stakeholders, such as government and charities, to accelerate the translation of research into public benefit.”

## Excluding conflicted members

*The BMJ*'s findings come amid growing awareness over the importance of conflicts of interest in the food industry. Last year researchers from the Centre for Food Policy at City, University of London, and the Science Policy Research Unit, University of Sussex Business School, warned that conflicts of interest in food regulation were putting public health at risk. *The BMJ* has previously reported on conflicts of interest at the Science Media Centre—an organisation that facilitates health and science reporting—which has received money from Nestlé, Coca-Cola, and Tate and Lyle.

Experts tell *The BMJ* that the composition of SACN needs to be reviewed, in light of members' ties to the food industry. Percival says that we should “learn from the precedent set internationally” by organisations such as the World Health Organization (WHO), where members with conflicts of interest are excluded from key decisions.

DHSC told *The BMJ* that, when members have a direct interest on a specific topic or issue, it is handled under the SACN code of practice and that those members “may be” excluded from the discussion. SACN membership includes those with technical industry expertise “to ensure a broad range of skills, expertise, and experience are available during discussions,” it adds. “SACN's conclusions reflect the considerations of the whole of SACN and are not influenced by any individual members of the committee.”

Van Tulleken says that SACN should ensure that five years from now there are no members with recent industry ties.



## Formula milk and baby food links

*The BMJ*'s analysis has found that at least six of the 11 members in SACN's subgroup on maternal and child nutrition have ties to food companies, including baby food manufacturers and formula milk brands.

Ann Prentice is a council member of the Nestlé Foundation, a body founded from a donation from Nestlé to support research in lower income countries, and Marion Hetherington has undertaken work for Danone and Ella's Kitchen, the latter on an unpaid basis. The group's chair, Ken Ong, has received research funding worth more than £5000 a year from Mead Johnston Nutrition, which makes formula milk.

Last July the subgroup produced guidelines on feeding young children aged 1 to 5 years. Some experts think that it held back on recommending the benefits of home cooked food over ready made baby food and on spelling out that “growing up” formula milk was entirely unnecessary.

Nestlé and Danone are two of the world's largest infant milk providers, and Ella's Kitchen is the most popular baby food brand in the UK. “It raises the question—if you're working for and supporting a commercial baby food company, and then you're also sitting on a committee that's making public health recommendations—how can you be expected to give an independent view around how babies should be fed?” asks Vicky Sibson, director of First Steps Nutrition Trust, a public health nutrition charity.

“I also think certain conflicts should be red lined—so we should not have anyone who works with the formula industry sitting on a subcommittee of SACN and making recommendations for how you feed babies,” she says. “That should be a red line. I think it should be the same for commercial baby foods. This is a very important committee; it's very influential.”

The DHSC responded on behalf of SACN and all members named in this article. A spokesperson says: “No members of the committee are directly employed by the food and drink industry, and all have a duty to act in the public interest and to be independent and impartial.”

## One of my big worries is somebody might think they've solved the nation's nutrition problems by deleting SACN

Alison Tedstone

He says that any “industry representative” should be removed immediately. “The first, necessary—but absolutely insufficient—step to getting control of the UK's epidemic of diet related disease is to deconflict SACN. That is the most important thing that must happen. It will send a clear message that there is an intention to regulate the food industry. This is what happened with tobacco, and it must happen with food.”

Tedstone, however, who now is a member of the WHO Nutrition Guidance Expert Advisory Group subgroup on policy actions—and also advises them on obesity related projects—as well as the Obesity Health Alliance, says that refusing to allow experts with industry ties on SACN would “diminish” its expertise.

“WHO has made a decision to take nobody who takes any research money from industry, and that has left them in a position where they have people who are not research active. It's harder to get people who are thinking about the subject, actively researching about the subject.”

Tedstone, who was chief nutritionist

at Public Health England at the time SACN was making recommendations on daily sugar intake in 2015, adds: “I've never seen any conflicts within SACN. One of my big worries about SACN is that somebody . . . [might] think they've solved the nation's nutrition problems by deleting SACN and all that did was delay future legislation. It's important but there are more important conflicts that go on in the food chain and policy.”

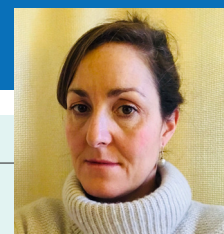
Former health secretary Victoria Atkins is married to former managing director of British Sugar, Paul Kenward; these two posts coincided. The Conservative government was also criticised for failing to release lobbying letters from food and advertising companies ahead of proposed advertising restrictions on unhealthy products. On SACN, Tedstone adds: “This is tricky, and there are these interests—but where's the evidence of bias?”

Van Tulleken insists: “Despite two decades of work from a conflicted SACN there has been an explosion of suffering and death from diet related disease in the UK, so I don't think it's credible to claim that the committee has been very effective. There are some excellent independent experts, but they are a minority, and in my view their work has been hampered by conflicts of interest with the industry that has created this health crisis.

“SACN must become independent of the food industry.”

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Cite this as: *BMJ* 2024;386:q1909



**We should not have anyone who works with the formula industry sitting on a SACN subcommittee**

Vicky Sibson