Hospital Food Review

Sourcing more local and sustainable food

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Introduction

1.1. "Hospital food is an essential part of patient care. Good food can encourage patients to eat well, giving them the nutrients they need to recover from surgery or illness" – so ran the introduction to the now defunct Better Hospital Food project[1]. But hospital food has long had the reputation for being tasteless, overcooked and unappetising even though the NHS spends around £300 million on food and £500 million on catering overall per year [2].

1.1. As long ago as 1963, an influential report from the Nuffield Trust found that hospital meals were overcooked, poor quality and cold, with little variety and nutritional content, particularly vitamin C[3]. Only 34% of patients in large hospitals described the food as good, and food wastage levels were over 50%. The researchers highlighted poor buildings, the lack of any overall responsibility for patient food, concentration on clinical nutritional needs and cost control as the main contributory factors. Hospital management didn't see food as a method for treating specific diseases, malnutrition and obesity and saw cooking and serving food as a second rate activity.

1.2. In 2007, two in five of hospital patients described the food as 'repulsive' and a fifth of staff (21%) said they would not eat the food they served to patients [4]. Another survey found that 40% of relatives had brought food into hospitals for patients[5]. A recent survey found that nearly half of the main meal items that are given to children in hospital are too unhealthy to be served in schools, exceeding the maximum school food standards for saturated fat or salt[6]. Malnourished patients often do not improve whilst in hospital[7], and 60% of older people are at risk of becoming malnourished or getting worse whilst in hospital[8]. The Government's own figures showed that almost 140,000 patients were discharged with malnutrition, anaemia or another nutritional deficiency in 2006-07 – an increase of 87% in less than 10 years[9]. As a result, artificial nutrition is widespread and very expensive, but more than a quarter of patients receiving artificial nutrition do not need it, or are receiving it inappropriately[10]. All this at a time when the Government has spent more than £54m over the last ten years on initiatives to improve hospital food[11].

1.3. The NHS contributes around 10% to each regional economy and could have a significant impact by using high quality, regionally produced food[12]. However, NHS Supply Chain purchased less indigenous food (i.e. food that can be produced in the UK) from UK sources in 2008-09 than in 2007-08, the proportion dropping from 70% to 64.5%[13]. Whilst all of the 148 food contracts awarded in 2008-09 stipulated nutritional standards, only one required farm assured or organic food and one other followed the Office of Government Commerce's recommendations to use LEAF produce and Red Tractor assured meat.

1.4. The NHS in England produces a quarter of all English public sector emissions making it one of the biggest producers of carbon dioxide, with 59% relating to the procurement of goods and services, of which 3% relates to food and catering[14]. Buying sustainably produced and local food could have a significant economic and environmental impact - creating jobs, reducing food miles and improving patient experience. The previous Government recognised this in their report, *Food Matters*, stating that the public sector

should lead by example in delivering more nutritious and environmentally sustainable food[15].

1.5. It doesn't have to be this way - there are hospital trusts in Britain delivering nourishing, tasty meals using local ingredients and saving money in the process. Nottingham City Hospital and Queen's Medical Centre estimate that they have saved £2.50 per patient per day – or more than £6m a year – just by using fresh local ingredients. Extending those savings across the whole NHS would provide a significant boost for the NHS and the wider economy at a time of austerity[16]. So if it's that simple, why are more hospitals, schools and other public bodies not doing the same?

1.6. This reports attempts to answer that question, looking the barriers that hospital trusts face in increasing the proportion of local and sustainable food used and showing how these have been overcome by other hospitals.

1.7. What do the terms local and sustainable food mean?

1.7.1. At present there is no legal definition of what constitutes environmentally sustainable food and food labelled as British can include food produced overseas but manufactured in this country. Some terms, such as 'organic' or 'Fairtrade', are clearly defined and generally well understood but the definition of local food varies and the term sustainable food is even more nebulous. In this report the term 'local food' is used for food grown or produced in the same or neighbouring county. Sustainable food is defined as food that is produced, processed and traded in ways that:

- Contributes to thriving local economies and sustainable livelihoods – both in the UK and, in the case of imported products, in producer countries.
- Protects the diversity of both plants and animals (and the welfare of farmed and wild species), and avoids damaging natural resources and contributing disproportionately to climate change.

2. Who is responsible for hospital food?

2.1. NHS hospital trusts face confusing and conflicting objectives, with responsibility for hospital food falling between three main Government Departments – DH, Defra and the OGC (Cabinet Office) – but none of these have overall responsibility for hospital food. The previous Government established a Food Strategy Unit as part of the Cabinet office, which published its vision for food, *Food Matters*, in July 2008. The vision was for a more sustainable food system – economically, socially and environmentally. The strategic policy objectives of Food Matters were to secure: fair prices, choice, access to food and food security through open and competitive markets; continuous improvement in the safety of food; a further transition to healthier diets; and a more environmentally sustainable food chain[17].

2.2. Ultimately it is the individual hospital trust that is responsible for the quality of food provided. Although *Food 2030* set a national food strategy, nothing required trusts to provide better quality food. Instead hospitals are bombarded by a myriad of advice, schemes, guidance and initiatives on using more local and ethically produced food from a range of Government Departments.

2.3. Department of Health

2.3.1. The Department of Health (DH) is responsible for the overall direction of health services, in line with the EU's general standards covering food and nutritional care in hospitals[18]. These standards include the simple aim of '*providing and delivering an excellent experience of food service and nutritional care 24 hours a day*.'[19] As such, it sets the commissioning policies for the NHS, including food, developing the *Commissioning Framework for Heath and Well-Being* which put the onus on commissioners to create healthy, safe and sustainable communities as part of their role[20].

2.3.2. DH has attempted to improve hospital food over the years largely without success. For example the Nutrition Guidelines for Hospital Catering, issued by DH in 1995, were largely ignored[21]. The NHS Plan of 2000 stated that '*food is variable in quality, it is not provided in a way which is sufficiently responsive to patients, and too much of it is wasted as a result*'[22] and the Government committed £10m to improving food.

2.3.3. As a result, the Better Hospital Food initiative was launched in May 2001 headed by BBC Masterchef host Loyd Grossman who created 300 restaurant-style recipes for use in hospitals. The DH set a target that all hospitals should introduce at least three new meals promoted by the initiative, but after five years the Hospital Caterers Association estimated that 25 % of NHS trusts had failed to introduce a single dish from the new menus, with less than half only offering three of the choices (from over 20 available recipes)[23]. Caterers found that some of the restaurant style meals were hard to replicate in NHS kitchens under NHS cost constraints, whilst other options were too elaborate for patients who generally prefer plain home-cooked comfort food.

2.3.4. Concerns over malnutrition in hospitals following high profile campaigns by Age Concern, now Age UK, Which? and the Royal College of Nursing led to the development of the Nutrition Action Plan which was launched in 2007 by the Department of Health. The aim was to ensure that health and social care staff and managers were well informed, equipped and supported to provide good nutrition and effective nutritional care. Objectives included raising awareness of the link between diet and good health and to encourage nutritional screening, particularly for vulnerable groups[24].

2.3.5. The implementation of the new Nutrition Action Plan was overseen by the Nutrition Action Plan Delivery Board, whose final report highlighted that 239 patients had died of malnutrition in hospital in 2007, with a total of 2,656 reported to have died since 1997[25],[26]. The Delivery Board also concluded that the effect of malnutrition on mortality rates would be substantially greater as malnutrition predisposes to disease, delays recovery and increases mortality. The group also warned that leadership in the health and social care sectors would be needed to end malnutrition in care homes and hospitals. Despite this high level report, there appears to have been little real progress. A survey of 400 healthcare professionals in 2009 reported in the Nursing Times said nutritional care in hospitals had improved 'not at all' or 'not much'[27] and the Board was disbanded in 2010.

2.3.6. DH issued a voluntary guide for hospitals on using sustainable food as part of their role in 2009[28] but ultimately the problem with food quality and sustainability persists. One reason is because DH is unable to enforce compliance because the National Health Service (NHS) is responsible for delivery.

2.3.7. In a very recent development, nutrition policy moved from the Food Standards Agency to DH from 1 October 2010. Policies include reducing fat, saturated fat, sugar and portion size as well as food labelling, nutrition surveys and scientific advice on nutrition have been transferred to DH[29].

2.4. NHS Carbon reduction strategy

2.4.1. Environmental issues were the main driver behind the NHS Carbon Reduction Strategy, *Saving Carbon, Improving Health* which aimed to cut NHS carbon emissions by at least 80% by 2050, with a minimum reduction of 26% by 2020 in line with the wider Government commitments. Procurement and food were key areas. The strategy document stated that '*the promotion of sustainable food and nutrition throughout the NHS should become the norm*' and elsewhere that '*local procurement, whole lifecycle costs and the environmental impact of financial decisions should be considered by all NHS organisations*'[30]. Recommendations included the use of seasonally adjusted menus, increased use of sustainably sourced fish and making use of suppliers with lower carbon forms of production and transport.

2.5. Department of Environment, Food and Rural Affairs

2.5.1. Department for Environment Food and Rural Affairs (Defra) covers

sustainable food, but the wider climate change agenda falls under the Department of Energy and Climate Change (DECC). Defra issued the Government's national food strategy, *Food 2030*, and has a key role in co-ordinating food across the public sector and driving forward the sustainability agenda. In particular, Defra was responsible for the Public Sector Food Procurement Initiative (PSFPI) which included a number of initiatives to use more local and sustainable sources of food, including organic food. This scheme, launched by Defra in 2003, encouraged public bodies to buy more food from local and sustainable suppliers when cost effective to do so. It produced a wealth of guidance and an independent evaluation of the scheme by the consultants Deloitte in 2009 showed that PSFPI had a positive impact on public sector procurement, but had not become embedded in the public sector. This was partly because food was given a low priority in many organisations[31]. Particular problems highlighted were the lack of skills to implement the initiative, increased costs in terms of staff time, therefore implementation tended to rely on enthusiastic individuals. PSFPI was shelved in 2009 and the guidance is currently only available on the old Defra website.[32].

2.5.2. Defra was assisted by an independent Council of Food Policy Advisors, providing advice on a wide range of food policy issues. In its second report, *Food: a recipe for a healthy, sustainable and successful future,* the Council stated that the Government should make much more effective use of public sector catering where it can directly influence the choices on offer. The council also felt that standards should be made mandatory because voluntary approaches had not delivered systemic change[33]. The Council of Food Policy Advisors has now been wound up.

2.5.3. In addition, Defra also funded an independent watchdog, the Sustainable Development Commission (SDC), which scrutinised the Government's progress on meeting its sustainability targets. As well as reporting on progress, the SDC highlighted good practice by trusts in local food procurement[34]. In their 2009 report, *Setting the Table*, the Sustainable Development Commission recommended that Government and the Devolved Administrations build on the Food Strategy and develop guidance on sustainable diets in general and particularly for public sector caterers. The Commission highlighted the main priorities as being:

- Consume less food and drink
- Reduce food waste
- Reduce consumption of meat and dairy products
- Reduce consumption of bottled water
- Eat fish from sustainable stocks[35]

2.5.4. The SDC also worked with the NHS and the DH to produce the Good Corporate Citizenship model, enabling NHS organisations to look at how they contribute to the local economy and to become more sustainable[36]. The organisation has now been disbanded[37].

2.6. Office of Government Commerce

2.6.1. Until June 2010, UK public procurement was overseen by the Office of Government Commerce (OGC). The OGC is tasked with obtaining best value from Government spending whilst following the EU's public procurement directives. These directives require open and fair purchasing with no barriers to free trade within the EU, although tenders can cover sustainability issues[38,39]. The OGC developed the Collaborative Food Procurement Programme, a cross-governmental initiative, to promote collaboration in food procurement and increase the use of sustainable food. That programme issued voluntary Food Quality Standards for public sector food, including use of assured produce, such as Red Tractor for meat, Lion Quality Mark for eggs and LEAF for fruit, vegetables and cereals[40]. OGC is now part of the new Efficiency and Reform Group within the Cabinet Office.

2.6.2. The OGC's powers were also limited because strategic health authorities and NHS Trusts are separate contracting authorities, responsible for their own procurement. The local Trust Board controls the food budgets and negotiates contracts locally, although they have to follow the EU public sector procurement rules. Hospitals are encouraged to use the central NHS procurement process, now outsourced to NHS Supply Chain, a private company controlled by DHL.

2.7. Food Standards Agency

2.7.1. Food quality and safety comes within the wide remit of the Food Standards Agency (FSA) to protect public health and consumer interests. The FSA provides information and advice to the Government and to the public but also has a monitoring and enforcement role, carrying out more than 1,200 investigations in 2009[41]. In the past those have included incidents relating to hospital food, such as Listeria found in sandwiches supplied to hospitals and schools in 2007[42].

2.7.2. As already noted, the situation regarding the future of the FSA is fluid as nutrition policy for hospitals moved to the Department of Health on 1 October 2010[43].

2.8. Towards a national food policy

2.8.1. As already noted, health services in the UK are devolved and the PSFPI (Defra) and Better Hospital Food (DH) initiatives only applied to England. The Scottish Government published formal standards for hospital food in 2003, but these concentrated on nutritional standards rather than sustainability[44]. More recently the Scottish Government published a national food and drink policy, planning to adopt sustainable food procurement as part of the objectives for all public sector organisations[45]. This policy is the first comprehensive review of hospital food, assessing compliance with nutritional standards. It showed that the majority of health boards were meeting the standards set[46], but it is still not clear to what extent Scottish hospitals are sourcing food locally or sustainably.

2.8.2. The Welsh Assembly published its *Nutrition and Catering framework* in 2002[47] which established common mandatory standards for Welsh NHS hospitals but which also gave hospitals flexibility to take account of local needs. Those standards did not include any requirements to source food more locally or to adopt a sustainable approach. The Welsh Assembly is due to provide clear standards and guidance on nutrition[48].

2.8.3. Northern Ireland published nursing care standards for hospital food in 2008 called *Get your 10 a day*, which set out a range of requirements for hospital food including assessment, appropriate nutrition plans and dedicated meal times with help if necessary. Standard number ten requires that '*The patient receives food presented in a way that is appealing and appetising*'[49] but again there was no requirement to buy more local or sustainably produced food.

2.8.4. The previous Government attempted to remove these national differences shortly before the May 2010 election by setting out priorities for the UK as a whole in the UK wide food policy, *Food 2030*. This included two aims: that the public sector should lead by example through public food procurement and that it should be easier for small local businesses and social enterprises to access public sector food procurement contracts[50].

2.8.5. In June 2010, Joan Walley MP presented the Public Bodies (Sustainable Food) Bill to Parliament following a campaign led by Sustain[1]. This aimed to introduce mandatory standards for bringing sustainable food into the public sector and had its second reading in November 2010[51],[52]. Unfortunately it was not successful.

2.9. Towards national standards

2.9.1. The previous Government tasked DH and Defra with developing another voluntary initiative, the Healthier Food Mark[53]. The aim was to encourage public sector caterers to increase the proportion of food sourced locally or from fair-trade and organic sources by working towards bronze, silver or gold standards. These covered nutritional content and production methods, i.e. a mix of nutritional and sustainability criteria.

2.9.2. At the time of the last election, the first pilot phase had been completed and the second stage pilots were in progress. The Government announced that the Healthier Food Mark would not be taken forward as a discrete scheme in July 2010[54]. Instead, the considerable body of evidence and learning from the development of both the nutrition and sustainability criteria would be used to help develop Government Buying Standards for food procurement in the public sector, where there are currently no mandatory standards[55].

2.9.3. The results of self assessment questionnaires from organisations taking part in the pilots were published shortly afterwards in August 2010. Although the scheme is not being taken forward, public sector organisations taking part were positive about the initiative with most planning to make further changes

[1] Sustain: The alliance for better food and farming, www.sustainweb.org

to meet more of the criteria[56]. Of particular interest was the finding that in-house outlets were likely to meet more of the criteria than out-sourced outlets. For example 63% of in house catering teams reported using seasonal fresh produce against only 5% of outside providers.

2.10. The role of NHS Supply Chain

2.10.1. In 2006, the Government estimated that 90% of products purchased by the NHS were delivered through locally negotiated contracts even though there was a central purchasing body for the NHS – NHS Purchasing and Supply Agency (PASA). In 2006 NHS buying was outsourced to a private company, NHS Supply Chain, controlled by DHL. The company sources a wide range of products - from catering supplies to medical equipment - for NHS hospitals and GP surgeries, taking advantage of bulk ordering to reduce prices, with an estimated saving of £1bn to be reinvested in frontline patient services.

2.10.2. NHS Supply Chain suggest that their food contracts use sustainable sources wherever possible and appropriate, implementing ethical sourcing practices and protecting biodiversity[57]. Despite this, NHS Supply Chain purchased less indigenous food (i.e. food that can be produced in the UK) from UK sources in 2008-09 than in 2007-08 – the proportion dropping from 70% to 64.5%[58]. The following table shows how much food is purchased from overseas, but is freely available from the UK.

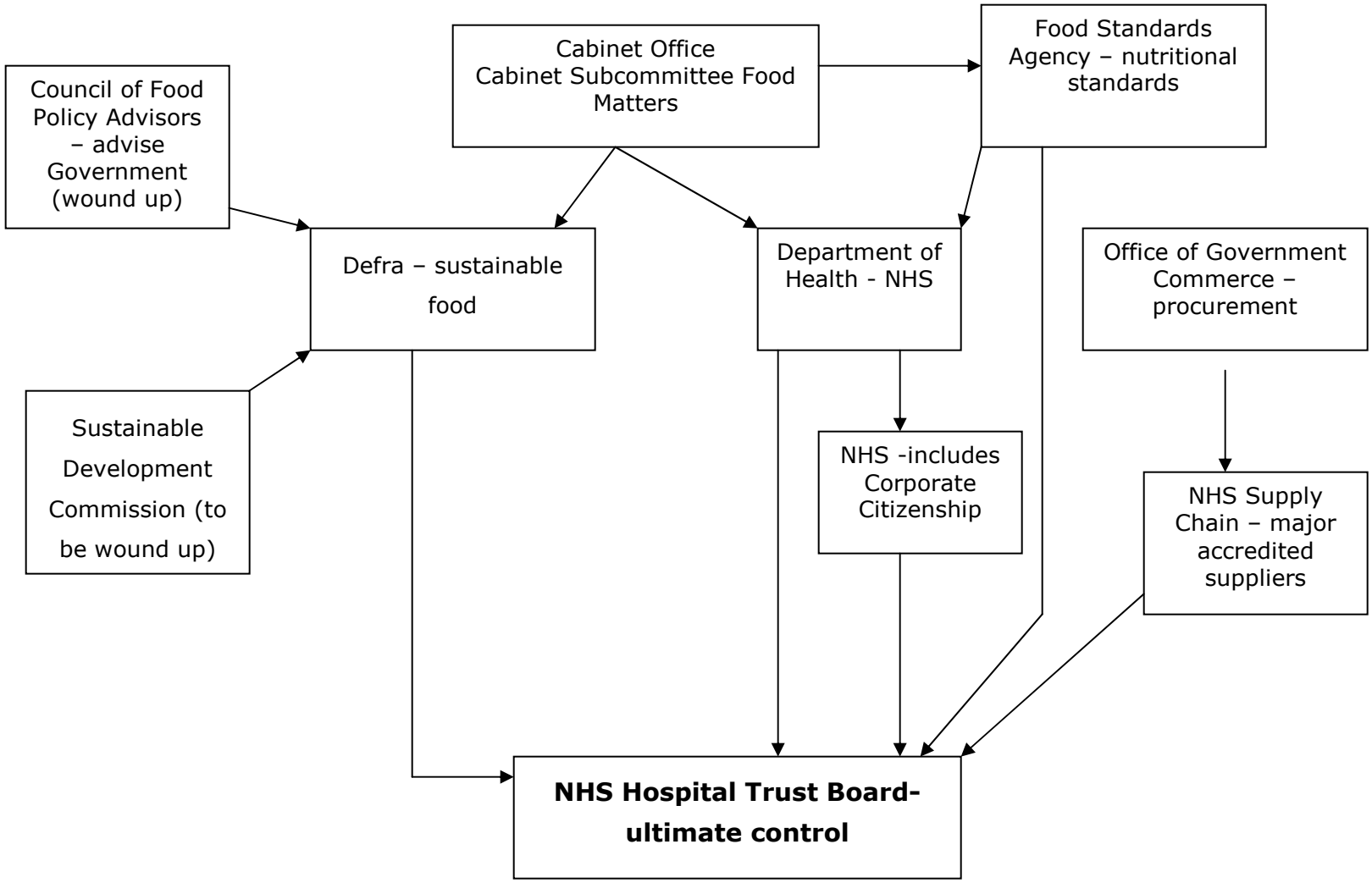
Type of food	Proportion of food purchased from overseas	
	NHS Supply Chain	National average
Processed potatoes	32%	67%
Legumes	7%	49%
Soft fruit	11%	45%
Fish – all from managed sources	5%	52%

2.10.3. Furthermore, whilst all of the 148 food contracts awarded in 2008-09 stipulated nutritional standards, only one specified farm assurance or organic standards and only one other followed the OGC's public sector specifications for LEAF or farm assured meat.

2.11. Conclusion

2.11.1. The most obvious fact that emerges from this review is that there is a myriad of advice, schemes, guidance and initiatives to persuade hospitals to source more local and ethically produced food, but with no single national body taking overall responsibility for hospital food and putting those initiatives into practice. This has been summarised in the following diagram. The push for foundation trust status has handed power and effective responsibility for hospital food back to local hospitals without any real control to ensure that hospitals actively support the Government and NHS commitments to source more local, sustainable, fair-trade and organic

food. The ultimate responsibility for the food served to patients rests with the individual hospital trusts, which face many conflicting objectives with food generally languishing low in the list of priorities.


Council of Food Policy Advisors – advise Government (wound up)
Cabinet Office Cabinet Subcommittee Food Matters
Food Standards Agency – nutritional standards
Defra – sustainable food
Department of Health - NHS
Office of Government Commerce – procurement
Sustainable Development Commission (to be wound up)
NHS -includes Corporate Citizenship
NHS Supply Chain – major accredited suppliers
NHS Hospital Trust Board- ultimate control

3. How bad is hospital food?

3.1. Formal assessments of hospital food

3.1.1. Hospitals are assessed by two main bodies - the Care Quality Commission (CQC) and the Patient Environment Action Teams (PEAT). The CQC set core quality standards, two of which cover food:

C15a Where food is provided, healthcare organisations have systems in place to ensure that patients are provided with a choice and that it is prepared safely and provides a balanced diet.

C15b Where food is provided, healthcare organisations have systems in place to ensure that patients' individual nutritional, personal and clinical dietary requirements are met, including any necessary help with feeding and access to food 24 hours a day[59].

3.1.2. The Commission also manage the new registration scheme for all providers of health and adult social care services introduced in April 2010. Before hospitals can be registered, they have to show that their services meet new quality and safety standards. One such standard is that patients should be '*encouraged and supported to have* ***sufficient food and drink that is nutritional and balanced****, and a choice of food and drink to meet their different needs*' (emphasis added)[60].

3.1.3. The CQC reviews rely on the hospitals' own self assessment of compliance with the standards, and the CQC only visits higher risk organisations, such as those with unusually high death rates, to verify results. Self assessments are not always reliable. For example, none of the 34 NHS trusts that discharged the highest number of patients in an undernourished state in 2006-07 failed core standard C15b[61].

3.1.4. The Patient Environment Action Teams (PEAT) review the quality of hospital food annually. The national figures published in July 2010 suggest that 96% of sites scored 'excellent' or 'good' for quality, choice and availability of patient food. No sites were rated as either unacceptable or poor (compared with 1 and 2 sites respectively in 2009) so the overall picture appears to be improving[62]. That conclusion is supported by the data from the Nuffield report of the 1960s when only 34% of patients rated food as good whereas the proportion is now around 96%[63].

3.1.5. Again though, these are self assessments but without any independent review, and data can be misleading. For example, the PEAT results for 2007 indicated that 63% of hospital food was rated as good or excellent[64] but the Healthcare Commission report published in the same year stated that complaints about food and nutrition were common, and included poor choice or variety in meals, lack of assistance with eating, and food and drinks placed out of reach, particularly for older people[65]. The recent enquiry into failings at Mid Staffordshire Hospital Trust identified a number of problems with hydration and nutrition[66] but food in the hospitals had been rated as good or excellent since 2005[67].

3.1.6. This split between PEAT reviews and patient satisfaction was highlighted by a major survey, carried out in 2006 by the Patient and Public Involvement Forums (PPI). This gave feedback to trusts from patients, their carers and families:

- Over 37% of people had left a meal because it looked, smelt or tasted unappetising but that figure rose to 44% in specialist units and 56% in mental health and elderly care centres.
- 40% of relatives had brought food into hospitals for patients[68].

3.2. Independent patient satisfaction surveys

3.2.1. A number of independent surveys in the past 5 years support the PPI results. The consumer organization, Which? carried out two surveys in 2006 and 2007 which are often used to illustrate problems with hospital food. In 2006, only 42% cent of NHS patients thought hospital food was healthy and just 29% found it appetising. The follow up survey in 2007 showed

- One in three (32%) of recent in-patients were unhappy with the quality of the food served.
- Two thirds (67%) of hospital staff said improvements were needed to food.
- A fifth of staff (21%) would be unhappy to eat the food they serve to patients[69].

3.2.2. The children's cancer charity, CLIC Sargent, is running a Fit to Eat campaign to emphasise the importance of food in cancer treatment for children. Their survey of hospital-based staff revealed huge inconsistencies in the quality of hospital food available to children and young people with cancer, with 41% of staff surveyed reported hospital food to be 'poor' or 'very poor'[70].

3.3. Malnutrition in hospital patients

3.3.1. More seriously, clinical reviews of nutritional quality and malnutrition suggest that Government standards to include effective nutritional screening are not working. The British Association for Parenteral and Enteral Nutrition (BAPEN) carried out two surveys in 2007 and 2008 and is currently planning follow up reviews later in 2010 and 2011. Their 2007 Nutrition survey stated '*Malnutrition in adults on admission to hospitals and care homes affects almost 1 in 3 subjects, who were mostly in the high risk category. Malnutrition is common in all types of care homes and hospitals, all types of wards and diagnostic categories, and all ages. It is also common in mental health units.* Although the report noted that much of the *malnutrition present on admission to institutions originates in the community',* there appeared to be little improvement whilst in hospital[71]*.* The 2008 report shows no significant changes, except in care homes where even higher levels of malnutrition were recorded[72].

3.3.2. Age Concern, now Age UK, issued statistics on nutrition for the elderly in 2006 stating that six out of 10 older people were at risk of becoming malnourished or their situation getting worse in hospital[73]. Data released by

the Government added fuel to the fire - in 2006-7 almost 140,000 patients were discharged with a diagnosis of malnutrition, nutritional anaemia or another nutritional deficiency, up from the 1997-98 total of 75,000[74]. Those figures have continued to rise – in 2007-8 157,175 people were discharged with malnutrition and in 2008-9 those figures increased still further to 185,446[75].

3.3.3. Many patients are given artificial nutrition in an attempt to combat malnutrition or for medical reasons following an operation or intestinal failure. The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report, *A Mixed Bag,* found that more than one in four people (29%) were receiving artificial nutrition inappropriately, while some do not need it at all[76].

3.3.4. Problems with nutrition and hydration were also found during the formal enquiry into failings at Mid Staffordshire NHS Trust by Robert Francis QC[77]. His report raised a wide range of concerns, including:

- lack of menus
- inappropriate food given to patients in light of their condition
- patients not provided with a meal
- patients' meals placed out of reach and taken away even though they have not been touched
- no assistance provided to patients to unwrap a meal or cutlery
- no encouragement to patients to eat
- relatives and other visitors denied access to wards during mealtimes
- visitors having to assist other patients with their meals
- visitors prevented from helping patients with feeding
- no water available at the bedside
- water intake not monitored or encouraged
- problems with drips not addressed adequately
- lack of monitoring and appropriate records of fluid balance and nutritional intake.

3.3.5. A more recent survey found levels of fat and salt that exceed Government recommendations. The work by the Consensus Action on Salt and Health (CASH) and Sustain into children's hospital food found that nearly half of the main meal items reviewed were too unhealthy to be served in schools, exceeding the maximum school food standards for saturated fat or salt[78]. In addition, nearly one in three of all menu items tested would be classified 'red' for saturated fat or salt according to the Food Standards Agency's traffic light labelling scheme.

3.3.6. Finally, one journalist's blog *Notes from a hospital bed* recorded his bad experiences with the hospital food, including a well publicised 'Hospital Food Bingo', in which he encouraged people to guess what his meals were[79]. Although this is anecdotal evidence from one patient, it does suggest that some NHS hospitals still have some way to go in improving patient food.

3.4. NGO food campaigns

3.4.1. As already covered, there are a number of well publicised campaigns run by independent and non-government organizations looking at public sector food and hospital food in particular. These include:

- Royal College of Nursing – Nutrition now – emphasis on malnutrition[80]
- Which? – Patient Experience – general campaign to improve the NHS experience, which included the quality of hospital food[81]
- Age Concern, now Age UK, – has published two major reports, *Hungry to be Heard* in 2006 and *Still Hungry to be Heard* in 2010 – emphasis on nutrition for the elderly[82],[83]
- CLIC Sargent – Fit to Eat – emphasis on children with cancer[84]
- Unison – Food for Good – union representing public sector workers including those working in catering[85]
- Consensus on Salt and Health – high levels of salt and fats in children's hospital food exceeds school meals guidance[86]

3.4.2. In addition, the Soil Association developed its Food for Life campaign including a verification scheme helping caterers to progress towards greater use of fresh, seasonal, local and organic ingredients, high welfare meat and sustainable fish[87]. Over 250,000 meals per day are served to the Food for Life Catering Mark standard in a range of organizations from schools to nurseries, to football clubs. The scheme has three tiers – bronze, silver and gold – and North Bristol Trust and Nottingham University Hospital Trust have achieved the bronze level accreditation.

3.4.3. The Soil Association also supported the Cornwall Food Programme, which transformed menus in several Cornish hospitals by serving increasing amounts of fresh, locally produced and organic food to patients, visitors and staff[88].

3.4.4. Sustain, the alliance for better food and farming, ran a project to increase the proportion of local, fresh and organic food provided in London hospitals. The Hospital Food project, which subsequently evolved into Good Food on the Public Plate Project[89]. Sustain is also currently running a campaign aimed at public sector food – Good Food for Our Money, which calls for mandatory standards ensuring that public sector food is healthy, good for the environment and invests in local and sustainable suppliers[90].

3.5. Conclusion

3.5.1. All the survey results suggest that whilst food has improved since the Nuffield Report of 1963, the quality of food served in hospitals is still not good and expensive Government initiatives have had little effect. A recent report from Sustain outlined the lack of progress on improving hospital food over the ten year period from 2000 and estimates that the total sum spent on hospital food initiatives during this period was over £54m[91].

3.5.2. The costs to the NHS are huge – not just in terms of £54m of previous initiatives – BAPEN estimate that malnutrition costs the NHS up to £13 billion

a year[92]. This fact alone means that we have to improve the quality of hospital food and use more local and sustainable food where possible – not only would this have a significant impact on reducing the UK's carbon footprint, it would support local economies and British farming. This review of hospitals also suggests that significant sums of money could be saved across the NHS by making the switch to local and sustainably produced food.

4. Using more local food

'*Local food markets could deliver on all aspects of sustainable development – economic (by providing producers with a profitable route to market), environmental (by cutting down on the pollution associated with food transportation, and by interesting consumers in how the land around them is farmed), and social (by encouraging a sense of community between buyer and seller, town and country).*[93]'
Policy Commission on the Future of Farming and Food (2002)

Locally grown seasonal food is generally seen as better being fresher and riper with less need for chemical preservatives or irradiation to artificially extend shelf life. Moreover, this review shows that there are significant clinical, financial and environmental benefits in using more local, sustainable and better quality food.

4.1. Food as treatment – malnutrition and its impact on other clinical conditions

4.1.1. Surprisingly malnutrition is widespread in the UK, with statistics showing that 40% of adults and 15% of child admissions to hospital show signs of malnutrition. Clearly high quality nutritious food is a vital part of treatment for malnutrition, but it can also have a significant effect on other medical conditions. Patients with malnutrition suffer with impaired mental and physical function and stay in hospital for longer – the average length of hospital stays for malnourished patients is 1.4 days longer[94]. They are also three times as likely to develop complications during surgery and have a higher mortality rate.[95,96] Dr Michael Stroud from the British Association for Parenteral & Enteral Nutrition recently stated '*Patients are more vulnerable to hospital-based infections if they are malnourished, wounds heal less quickly and the kidneys may not excrete salt and water properly if the patient is undernourished*'[97]. For example, malnourished patients are more likely to suffer pressure sores whilst in hospital[98].

4.1.2. Better nutrition in hospitals could also have a major financial impact. Disease related malnutrition costs the UK more than £13 billion annually[99]. Dr Stroud believes that lowering the malnutrition rate by 10% could save £1.3 billion and that as many as 10,000 lives could be saved if every patient was screened on admission to hospital[100].

4.2. Food, incidence of disease and recovery rates in other medical conditions

4.2.1. There is a direct link between food and recovery rates for some medical conditions, particularly cancer and mental illness. For example, finding and treating nutrition based problems early may improve the patient's chance of recovery from some cancers[101].

4.2.2. Use of particular polyunsaturated fats, minerals and vitamins may help to relieve the symptoms of some mental illnesses and either improve the effectiveness of medication for some conditions or at least reduce the

unpleasant side-effects of others[102]. The Mental Health Foundation and Sustain linked diet with ADHD, depression, schizophrenia and Alzheimer's in their report '*Feeding minds: the impact of food on mental health'.* For example depression has been linked to a lack of vitamins B3, B6, C and lack of minerals such as magnesium and zinc. Vitamins B3, B6, C can all be found in fruit and vegetables and minerals such as magnesium and zinc are found in nuts and seeds, fish & seafood.[103] The Mental Health Foundation even suggests that changes to food production and diets in the past century may be partly responsible for the rise in those mental health and behavioural problems over the same period[104].

4.2.3. More generally, better food should improve the patient experience and help rapid recovery. The mental health hospital St Andrews was determined to increase the proportion of locally produced, sustainable, wholesome food. The hospital switched away from cook-chill ready meals, reopened old kitchens and increased the proportion of local food to just under 40%. These moves are reflected in patient feedback – food scores improved rapidly once the changes were made and over 80% of patients consistently rate the food as 'good' or 'excellent' compared with just 55% three years ago[105].

4.3. Saving money

4.3.1. Making changes which benefit the environment could be seen as a desirable rather than a necessary objective for an NHS hospital particularly in times of financial constraint, but providing safe, healthy food at a fair cost has to be of prime importance. As the case studies show, moving to more local food can save significant sums of money – Nottingham City Hospital estimate that they save more then £6m a year by cooking hospital food with fresh local ingredients (see case study)[106]. In another example, Sussex Partnership NHS Foundation Trust found that yoghurts from a local supplier were two thirds of the price of those from their original NHS accredited supplier (see case study). The Deloitte report into the PSFPI backed this up, with local food costing no more and often being cheaper[107].

4.3.2. Even if sustainably produced local food were to cost more, the significant savings from potentially improving the quality of nutrition and cutting the length of hospital stays is likely to more than compensate for any increased costs. As already noted above, BAPEN estimate that lowering the malnutrition rate by 10% would save more than £1.3 billion and even the smallest improvement of 1% could generate £130 million annually.

4.4. Boosting the local economy

4.4.1. Economic benefits are not just limited to the hospital – buying local food boosts the local economy, increases local job creation and helps to support small businesses. A number of the hospitals visited during this study reported that their support has given a definite boost for small farmers and local jobs. For example, one pig farmer turned a profit for the first time in 10 years by gaining the contract to supply Nottingham City hospital with pork, preventing the farm from going under and saving 4 jobs[108].

4.4.2. A wider example comes from an analysis of the Devon Food Links project in 2001. The Devon Food Links project set up 15 farmers' markets, 18 box

schemes and helped 150 hectares of land be converted to organic production, with the result of a net increase of 113 jobs. More farm jobs were created with those producers involved in the local food economy employing on average 3.4 full time staff, compared with a regional average of 2.34 per farm. Some 38% of producers had created new jobs – at an average of 0.5 per farm, resulting in a further 171 new jobs[109].

4.4.3. The respected New Economics Foundation developed a tool, the Local Multiplier Effect (LM3), to measure the impact of changes on the local economy. The Cornwall Hospital Food Programme used LM3 to show that the local spending of £1,131,000 with Cornish suppliers generated additional spending of £910,624 in the local economy[110].

4.5. Better provenance

4.5.1. Another prime objective has to be food safety and provenance – it is often easier to work with a local producer than a national or even international supplier to identify problems and put things right when issues arise. Food poisoning outbreaks in hospital can have disastrous consequences. The Stanley Royd Hospital in Wakefield suffered the worst outbreak of salmonella in the NHS in 1984 when food poisoning affected 355 patients and 106 members of staff, causing or contributing to the death of 19 people. The resulting investigation blamed contaminated chicken and cold roast beef and led to the loss of Crown immunity for hospitals. More recently, eggs from Spain were thought to be at centre of a Salmonella outbreak in 2009 which resulted in deaths of two at a care home in Sunderland and the hospitalisation of five others[111].

4.5.2. Flexibility is also a major benefit for hospitals working closely with smaller local producers. Caterers find that local suppliers are more likely and able to react to changes in supply needs. They will make small deliveries at short notice or change advance orders to meet changing needs.

4.6. Climate change

4.6.1. The Climate Change Act committed the UK to reducing greenhouse gas emissions by 80% by 2050, with a 34% cut by 2030. Using local or sustainable food can make significant moves towards those targets by driving changes in farming and production methods.

4.6.2. Using local food reduces the distance that food travels to the consumer – generally referred to as food miles. A detailed review of the Cornwall Food Programme, which awarded all contracts for fruit, vegetables, meat, fresh milk, eggs and dried goods to Cornish businesses, showed that the new contract trimmed 111,000 road miles from a year's deliveries[112].

4.6.3. Although this can be a blunt tool for measuring reduction in carbon footprint, there is no doubt that reducing food miles will make a contribution to meeting environmental targets with 25% of heavy goods vehicle movements related to food and drink[113]. Reducing food miles would also help to cut traffic congestion and accidents and improve air quality[114].

4.6.4. Some have argued that using local food is not always best for reducing

greenhouse gases, arguing that a range of factors, such as the need for refrigeration and storage, have to be taken into account. However, an academic review suggested that local can still be better: for example greenhouse gas emissions from growing apples in the UK and refrigerating for a year round would be less than those required to transport applies from overseas[115]. A switch to seasonal field grown fruit and vegetables would have an even more dramatic effect on greenhouse gas emissions as artificial heating of greenhouses and refrigeration of fruit and vegetables would fall.

4.7. Wider ecological impacts of using more sustainable food

4.7.1. There are wider ecological benefits from using local and sustainable food that have to be taken into account. For example, changes to more organic and less intensive farming methods increase biodiversity. Defra's organic action plan for England states that organic farming results in higher levels of biodiversity, lower pesticide pollution, less waste and a reduction in carbon dioxide emissions through lower energy use[116].

4.7.2. Even small changes in farming practice to a more sustainable approach can have a significant effect on biodiversity. Research published in 2005 by ADAS, the independent farming and rural consultancy, showed that leaving undrilled patches and field margins increased the number and diversity of invertebrates and native plants, which in turn increased the number of birds[117].

4.7.3. We have to recognise that it may not be possible, or even desirable, to source all food locally, particularly for more tropical crops. For example, it might be more environmentally friendly for tomatoes to be grown in Spain and transported to the UK than for the same tomatoes to be grown in greenhouses in the UK which require electricity to light and heat them. On the other hand, it may be more sensible to support the growers of traditional greenhouse areas, such as the Channel Islands, switch to eating seasonally or to develop alternative low impact energy sources, such as solar, geothermal or wind.

4.8. Conclusion

4.8.1. Patients, visitors and NHS staff are far more interested now than at any other time in where their food comes from and how it is produced. Using locally produced sustainable food has significant medical and economic benefits, and indeed can save significant sums of money. There will be times though when using local food is not necessarily a better option. Where local food is either not available or environmentally undesirable, hospitals should be looking at using more fair trade or ecologically sound products that protect natural environments and habitats.

5. Soil Association Hospital case studies

The Soil Association has been involved with the campaign to improve public food catering, including that in hospitals, for a number of years. This began with the Cornwall Food Programme, and its subsequent report: *A fresh approach to hospital food*, for which HRH The Prince of Wales wrote the forward, in his role as patron of the Soil Association.

Following publication of the report, the Prince of Wales convened a seminar of NHS Chief Executives who were interested in or were already actively involved with initiatives to improve the quality of their food. We have followed the progress of those trusts in their attempts to improve food quality and use more local and sustainable produce, and outline examples of good practice in the following case studies. We have also used those trusts to look at the problems that trusts face in making the switch to more local and sustainable food, and outline their solutions to those problems.

5.1. Summary of progress

5.1.1. Of the 19 trusts attending the seminar with the Prince of Wales, seven have made direct changes to their food provision and are using more local suppliers. Six were already involved in local food initiatives, making a total of 13, or 68%, who are trying to source more food from local suppliers. The remaining trusts do not appear to have made any real moves to use more local food, but some have been affected by other major more pressing issues, such as mergers or were tied into contracts with external caterers so had little opportunity to change.

5.1.2. Most of those making changes have relied heavily on enthusiastic catering staff within the trusts to drive the process. However, catering teams also need support from a range of organisations and networks to find local suppliers, such as:

- Local food networks, such as South East Food and Drink
- Non Government Organisations, particularly the Soil Association and Sustain
- Other local hospitals, particularly via local branches of the Hospital Caterers Association.

6. Why hospitals don't use local or sustainable food

Even though the arguments for using local and sustainable food in hospitals are strong, Defra's report on the proportion of UK food used by the NHS suggests that not many do so, with only 65% of indigenous food purchased from UK sources in 2008-09[118], let alone from the local region. Where hospitals do use a significant proportion of local food, they rely on enthusiastic catering teams and/or senior NHS

staff to drive the changes.

This section examines some of the reasons given by hospitals for not using more local food. Its draws on a combination of interviews with the hospital staff who attended the seminar run by The Prince of Wales and a wider literature and internet review.

6.1. Confusing responsibilities and failed initiatives

6.1.1. NHS hospital trusts face confusing and conflicting objectives regarding food sourcing. Responsibility for hospital food falls between three main Government Departments – DH, Defra and the OGC (Cabinet Office) – but none of these have overall responsibility for hospital food. Although there is a national food strategy, nothing requires hospitals to provide better quality food. All of the information provided by Government Departments to improve the quality of hospital food is voluntary and the final decision on food purchasing rests with individual NHS trusts.

6.1.2. Successive Governments have introduced plans to improve the quality of hospital food, but as our historical review shows these have had little real impact. Our hospitals were critical of some of the measures and guidance from previous schemes. For example, recommendations made in the Better Hospital Food project were developed by chefs with little or no understanding of the NHS limitations – both in terms of budgets and types of kitchens available. Our review found that some menus were not popular with patients because they were too complex or used ingredients that were not generally popular, such as rhubarb. Hospitals were expected to include 'Chef Specials' but found some were too complex to prepare in NHS kitchens. When the scheme was shelved, many hospitals either simplified those recipes to make them more palatable and easier to produce or simply removed the meals from the menus altogether. Others reported that outside suppliers used the requirement to include the Chef's Specials as a way of increasing prices. Under these circumstances it is no surprise that take up was piecemeal at best with others refusing to follow the guidance altogether.

6.2. Standards are voluntary

6.2.1. As already identified none of the standards or schemes to increase the proportion of local and sustainable food are mandatory, so hospitals are not required to follow them. A number of bodies, including Defra's Council of Food Policy Advisors and Sustain, have suggested that mandatory standards should be imposed for food provided by the public sector, including hospitals[119,120].

6.2.2. We found that there was mixed support for this during our review, with some agreeing that mandatory standards would stop external contractors from providing poor quality food, citing the improvement in school meals as an example of mandatory standards in practice. Others questioned the morality of removing choice from adults by enforcing mandatory food standards, including one hospital visited which has an adolescent unit and already has to apply the mandatory standards in the school food regulations.

6.3. Catering is not a priority in hospitals

6.3.1. Devolved budgets coupled with assessment based primarily on clinical criteria mean that catering is generally not seen as a priority in hospitals. Even where hospitals have a good reputation for food, clinical matters dominate and catering is a poor cousin with less financial support. Deloitte's evaluation of the PSFPI highlighted that only 29% of organisations rated the key objectives of promoting healthy food and protecting the environment as being 'very important'. Instead the majority regarded it as a 'necessary consideration'[121].

6.3.2. The Care Quality Commission proposals for 2010-11 suggested conducting a review of basic good practice for hospital food[122] and any increase in assessment would mean that trusts would have to devote more time to their catering provision. It is not clear if this proposal will be implemented, in either the current or the next reporting period.

6.4. Costs and lack of commercial expertise

6.4.1. The NHS is driven by short term costs and in absence of a clear responsibility; cost tends to become the major driver in procurement. Budgets for food are very low in comparison with the domestic household's spending on food - the average hospital food budget in 2007[123], covering breakfast, lunch, dinner, drinks and snacks (excluding staff and other ancillary costs) was £2.65 per patient per day, similar to figures of £2.31 for prisons[124] and lower than the armed forces budget of £3.45 a day[125]. It is important to remember though that local trusts set their own budgets and the actual costs vary widely – in our project, amounts spent ranged from £2.10 to just over £4 per day. The obvious conclusion here is that budget allocations in the NHS are low and at this level it is not surprising that cost is a major factor for hospital executives and catering teams.

6.4.2. There is a common perception that local and sustainably produced food will cost more, so hospitals tend not to source it routinely. But Deloitte's review of the PSFPI found that UK, regional, seasonal, farm assured and small/local supplier produce does not generally cost more, and can often cost less, but organic and fair trade produce was more expensive [126].

6.4.3. Most of the hospitals visited in this study support this conclusion, reporting that careful negotiation and benchmarking of prices can lead to savings. However one hospital in our study reported that local food was more expensive, having spent considerable time investigating sustainable sources and identifying local suppliers. They looked at products that other trusts had

found easily – organic milk, locally made ice-cream, yoghurts, locally-grown vegetables and locally caught sustainable fish. In most cases local products were more expensive and not viable within the food budget of £2.10 per patient per day – the lowest found during the project. However, even that hospital changed to some local seasonal vegetables and local eggs and would use more local food if possible.

6.4.4. We found that other hospitals have been able to use more local food by adopting more commercial practices, either to control costs or to generate more income to cover any budget increases.

6.5. Controlling costs

6.5.1. One route is to take a commercial approach to procurement – using careful negotiation and careful benchmarking of prices with similar organisations to make sure that the trusts are always getting the best deal.

- North Bristol Trust has a lower than average budget at £2.20 per patient per day but has been able to find local milk, ice-cream, farm-assured meat, ham, cheese and free-range eggs, gaining the Bronze level Food for Life mark in the process.

- Sussex Partnership Trust found local yoghurts that were one third cheaper.

- Nottingham City Hospital and Queen's Medical Centre highlight savings of £2.50 per patient per day – or more than £6m a year – just by using fresh local ingredients.[127]

- Tendering in Barnsley for local sandwiches produced 9% savings in costs[128].

6.5.2. There are however dangers in keeping prices down artificially – one local dairy commented that the trust's procurement department were keeping prices so low that there was no profit in supplying the hospital. The farmers in this example only continue with the contract for the publicity value.

6.5.3. A similar conclusion was drawn by the report into failings at Mid Staffordshire NHS trust, which highlighted the dangers of excessive financial restriction:

*If one lesson is to be learned from the Stafford experience, it is that changes made or demanded in haste can be inimical to good patient care. This is not to exempt the NHS from the prioritisation and re-allocation of resources that any government must consider. However, safe and consistent care cannot be delivered unless change is properly planned and risk assessed, with proper engagement of the staff whose duty it is to deliver that care***. Finance, in the sense of the resource made available to the Trust, must always be the servant of the Trust's purpose – the delivery of good and safe care – and not the master which dictates the standard of delivery, however poor** (emphasis added)[129].

6.6. Income generation

6.6.1. Other hospitals actively encourage out-patients and visitors to use the food outlets, generating significant income to cover any cost increases or are looking at new ways of generating income from their catering facilities.

- Bedford Hospital has a top class restaurant and coffee shop with a Sunday Carvery that is very popular with local people, generating annual income more than £1m.
- Darlington Memorial Hospital recently successfully tendered in an open competition to provide meals to another local hospital.
- Many hospitals have opened or refurbished their own coffee shops to generate income, rather than outsourcing to major chains. Nottingham took this one stage further by using dead space, including an empty lift shaft, for its own chain of Coffee City outlets. These generate £150,000 profit on 20% margin, covering inflationary cost increases for the last 8 years. The trust has also been able to save money by cutting the opening hours for the main restaurant as the outlets are able to provide food in the evenings and at weekends.

6.6.2. Some of the more commercial catering teams felt that there is a general lack of commercial understanding in hospitals, particularly of value of the existing retail sites and the income generating potential of dead space in hospitals. Whilst some hospitals have opened their own coffee bars, others do not appear to see the potential. When Nottingham offered the Coffee City brand to other local NHS hospitals only Shrewsbury took the idea on.

6.7. Outsourcing and use of private contractors

6.7.1. 34% of all hospitals now buy in ready meals, compared with fewer than 10% two years ago and the market is growing at 15% a year[130]. Many contracts have no sustainable or local food provision, are long term and are often difficult to change; giving trusts little opportunity to use more local food in the short term. Even if there is some flexibility in existing contracts, requests to include more local food can result in unacceptable price rises from suppliers.

6.7.2. NHS trusts choose external contractors for many reasons, but the most common factor quoted for the switch is cost. Although costs per meal are similar to in-house kitchens, contracts are often based on a high level of capacity, when in practice the numbers of patients eating meals fluctuates dramatically due to operations or short term empty beds. Nottingham City Hospital saved significant sums by moving to in-house provision. The catering manager estimates that the hospital has saved £6m, which could translate into savings of £400m annually across the NHS as a whole[131].

6.7.3. Outsourcing intrinsically means a loss of control over the catering function. Commercial organisations have a corporate view and profit generating motive, giving local catering managers little ability to change suppliers and use more sustainable food. One catering manager with experience of contracting commented '*Where catering staff are not part of the hospital, they are bound by what is best for their employer – which tends to be profit. Where staff are part of the hospital staff, they are more likely to want what is best for the hospital and the patients*'.

6.7.4. Feedback from catering managers who have taken catering back from a contractor suggests that contractors provide little training for staff to keep costs down. Others reported that contractors had 'stripped' kitchen facilities or don't keep on site facilities up to standard, making it more difficult for a hospital to go back to in house provision. For example, one hospital reported that the outside contractor had forced catering staff to use goods lifts for eight years by not repairing the dedicated catering lifts. As a result, food took a longer time to get to patients with a potential increased risk of cross infection.

6.7.5. A number of catering managers also raised concerns over poor quality of food from outside contractors. Several mentioned the Channel 4 investigation into one major supplier, which filmed workers over a period of eight weeks allegedly mishandling food; coughing and sneezing while preparing food; eating from the production line; and dipping ungloved fingers into vats of cooked food. Another highlighted that academic research into a microwaved meal system where meals are cooked offsite and microwaved at the hospital. The research suggested that patient intake did not meet requirements and that patients were likely to loose weight if they relied solely on hospital food[132].

6.8. Lack of kitchen facilities

6.8.1. The trend towards outsourcing means that many older hospitals no longer have fully functioning kitchens whilst some newer Private Finance Initiative (PFI) hospitals only have industrial microwaves[133]. Others have full kitchen facilities but food will be provided by an external contractor as part of the PFI deal[134].

6.8.2. There are parallels here with schools where new schools also suffered from the same problem[135]. A report in 2005 by Steve Davis of Cardiff University stated '*far too many PFI school projects exclude the provision of full production kitchens, relying instead on "regeneration" kitchens*'[136]. For example the state-of-the-art schools constructed by Mowlem in 2005 as part of the £35 million Leeds 7 Schools Project were built without kitchens, with pre-cooked, frozen food being shipped from Mowlem's catering facilities at a hospital near Middlesbrough[137]. Similarly, PFI schools in Merton were built without proper kitchens[138]

6.8.3. The previous Government established mandatory standards for food and nutrition in schools after research showed that children did not make healthy food choices at lunch time and that school meals did not meet their nutritional needs[139]. At the same time two major strategic programmes, Building Schools for the Future for secondary schools, and the Primary Capital Programme for primary schools, made an extra £150m available specifically to build new or refurbish kitchens and dining areas[140]. Whilst those schemes have been cut significantly, some planned projects will still go ahead[141].

6.9. Lack of time, enthusiasm or high level support

6.9.1. All our case study hospitals rely on the enthusiasm, drive and commitment of the catering teams to use more local food. Working with small local suppliers can be more time consuming initially as many need help with accreditation and process. Even where hospitals work with accredited wholesalers, catering teams found that they still needed to spend more time up front to find local suppliers.

6.9.2. It is therefore essential that the catering teams have high level support from senior managers and the trust board to make the switch to more local and sustainable food.

6.9.3. Catering and procurement managers also need confidence to challenge national suppliers and make changes. Those with experience outside the NHS seem more willing to make changes and draw on their external experience to challenge existing practices and adopt more effective methods from the private sector and the armed forces.

6.10. Risk and accreditation

6.10.1. Accreditation and food safety is paramount in hospitals and trusts may prefer to use NHS Suppliers to cover those risks. Many smaller local suppliers do not have the appropriate accreditation, such as STS, and are therefore not considered by trusts when reviewing tenders.

6.10.2. However, there are organisations able to help both trusts and suppliers. London based hospitals found support from Sustain's Good Food on Public Plate programme invaluable in helping to find the right type of supplier.

6.10.3. Hospitals outside London found a variety of organisations able to help, such as local food networks, Local Authorities and NGOs, particularly the Soil Association and Sustain. The caterers own professional body, the Hospital Caterers Association, is another major source of help, publishing guidance on sustainability and finding local suppliers on their website. The Association's local branch meetings are also a vital way of building links with other local hospitals, and many of our hospitals used those contacts to help find local suppliers. For example, North Bristol's local ice-cream producer now supplies a number of other local hospitals in the area as a result of the positive feedback from the trusts catering manager.

6.10.4. The North Bristol Trust and Darlington Memorial hospital found that they were able to cover most of these issues by working with their existing accredited wholesalers to identify local suppliers and producers with the wholesaler taking responsibility for the necessary accreditation and review.

6.11. Availability of products

6.11.1. Almost all the hospitals visited reported some difficultly in getting all the products they need from the UK at the right quality and price because local suppliers cannot always guarantee supply. As already noted, Sussex Partnership Trust has worked with local farmers to develop a pool of suppliers better able to supply the volumes they need.

6.11.2. The diversity of British agriculture also means that not all produce can be grown or farmed in every area of the UK, so some items will always have to be supplied nationally. The case study hospitals have responded by becoming more flexible, with different summer or winter menus. Bedford hospital just has 'seasonal vegetables' on the menu, to take advantage of surpluses without having to change menus.

6.12. Changing cooking techniques and reducing food waste

6.12.1. The nature of the patient population means that Sussex Partnership NHS Foundation Trust is not in a position to develop its retail outlets but has worked on improving kitchen efficiency, again using commercial food manufacturing methods to keep costs under control. Food waste is also carefully controlled and reviewed as another measure to keep costs under control.

6.12.2. Other trusts commented that reducing food waste is a major way to keep within budget. Reducing food waste nationally in hospitals would have a significant financial impact as more than a third of patients have abandoned their food at some point and 40% have had food brought in by visitors[142].

7. Recommendations for the future

Hospitals should use more local and sustainable food to improve the quality of food they provide, boost local economies and minimise their carbon impact whilst achieving long term savings for the public purse. The Government is committed to encouraging sustainable food production and ensure that food procured by the public sector will meet British standards of production, where this can be achieved without increasing overall cost[143]. We recommend that the following measures should be taken to translate this commitment into action:

- The Government should establish a clear responsibility for hospital food at Government level with a single body with overall responsibility and accountability for food and catering in hospitals.

- The Government should make food a much higher priority in hospitals and develop clear practical standards for the hospital sector, using existing expertise in the NHS, Government and NGOs.

- Hospital trusts should recognise the importance of food as treatment and make it a priority in their trust, actively engaging their catering teams in a drive to source more food locally.

- Trusts should work with existing wholesale suppliers, NGOs, local food networks, the Hospital Caterers Association and other local hospitals to identify suitable local growers and producers:
  - eggs, milk and bread are easier to source locally
  - fish from sustainable sources is generally cheaper
  - use local in-season ingredients where possible.

- Trusts should adopt a more commercial approach to catering provision:
  - benchmark costs against other local NHS trusts, public sector bodies and commercial organisations
  - Use existing food outlets more effectively to generate more income
  - Develop new retail outlets for income generation

- The Government should work with NHS Supply Chain to purchase more indigenous food and include more sustainable supply clauses in contracts.

- New hospitals, whether built under the PFI initiative or not, should be built with full kitchen facilities so that hospitals can cook fresh food on site for patients and preferably for staff and visitors too.

The following websites contain a wealth of guidance for hospitals wanting to increase the proportion of local food served to patients.

Sustainable food - *A guide for hospitals*
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098881[144]

NHS Corporate Citizen and Sustainable Development Unit – these offer wide range of resources covering travel, procurement, facilities management, workforce and buildings. http://www.corporatecitizen.nhs.uk/resources.php[145]

South East Food Group Partnership has produced Getting Started, a guide to buying more sustainable food in the public sector
http://www.southeastenglandfoodanddrink.co.uk/display.aspx?id=667[146]

Food Vision – information portal for local authorities but includes some useful case studies and toolkits http://www.foodvision.gov.uk/ - viewed 4 June 2010

Hospital Caterers Association – includes a detailed resources section, with tips and practical advice, on sustainable food as well as still holding useful information from the Better Hospital Food initiative
http://www.hospitalcaterers.org/national_day/excellence/tips.html[147]
http://www.hospitalcaterers.org/better-hospital-food/nutrition.php[148]

The Soil Association - charity campaigning for planet-friendly organic food and farming able to offer a wide range of support to caterers and producers, including

General resources
http://www.soilassociation.org/[149]

Food for Life Catering Mark - accreditation scheme to help caterers provide customers with reassurance that their food is fresh, honest and additive-free and takes account animal welfare and climate change[150]
http://www.sacert.org/Gettingcertified/Whatwedo/Restaurantscatering/tabid/1056/language/en-GB/Default.aspx

Resources for farmers and growers[151]
http://www.soilassociation.org/Farmersgrowers/tabid/80/Default.aspx

Sustain – the alliance for better food and farming has a wide range of resources and publications, including
general resources
http://www.sustainweb.org/goodfoodpublicplate/useful_information/[152]

Useful guide to developing contract terms
http://www.sustainweb.org/pdf/fluk_sustainable_food_procurement_June06.pdf
[153]

Local Food Finder to help caterers identify suppliers of sustainable produce in and around London
http://www.sustainweb.org/londonfoodlink/local_food_finder/[154]

Royal College of Nursing campaign – Nutrition Now – general background http://www.rcn.org.uk/newsevents/campaigns/nutritionnow/tools_and_resources/other_resources[155]

Social Care Institute for Excellence (SCIE) Guide 15: Dignity in Care. This is a detailed resource guide to support the wider Dignity in Care initiative from Dept of Health. http://www.scie.org.uk/publications/guides/guide15/index.asp[156]

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[4] http://www.which.co.uk/documents/pdf/impatient-for-change-hospital-food--which---briefing-paper--176985.pdf - viewed 24 May 2010

[5] PPI Forum (2006) *Food Watch* http://www.hospitalcaterers.org/documents/ppi_report.pdf - viewed 1 June 2010 http://www.hospitalcaterers.org/documents/ppi_report.pdf - viewed 19 May 2010

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