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Hospital food standards in section 173 of the Health and Care Act 2022: political magic with a soggy bottom

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ABSTRACT

This article argues that section 173 of the Health and Care Act 2022 is a purely symbolic provision that will not effect any positive change to hospital food quality. In order to make this argument, I explore Murray Edelman's work on the symbolic uses of politics and the literature on policy fiascos to explain why section 173 features in the 2022 Act at all. This is followed by a close analysis of what section 173 purports to do, which concludes that there is no substantive change to day-to-day practice as a result. This meets Lasswell's definition of 'political magic'. The article concludes with the argument that the only way to actually improve hospital food is to set aspirational standards and increase the budget to allow institutions to approach food provision in a holistic manner.

Keywords: hospital food; regulation; symbolic uses of law; healthcare.

INTRODUCTION

The quality of NHS hospital food in England and Wales has been the subject of numerous reform attempts and campaigns by celebrity chefs to improve the standard of food served in hospital. In 2013, Sustain – the organisation responsible for the Campaign for Better Hospital Food – published a report on hospital food in the UK.[1] It demonstrated that between 1992 and 2013 there had been 21 voluntary initiatives focused on improving hospital food, many involving celebrity chefs. These had cost £54 million and had resulted in no significant change to the quality of hospital food in the UK. Heston Blumenthal has been involved in several projects to spice up hospital food[2] alongside researchers at the University of Reading. James Martin worked on Operation Hospital Food and produced a toolkit and

1 Sustain, 'Twenty Years of Hospital Food Failure' (2013).

2 H Briggs, 'TV chef takes on hospital food' (*BBC News* 30 April 2010); 'Heston gives taste to hospital meals' (*BBC News* 23 December 2013); 'Heston Blumenthal's children's hospital' (IMDb Documentary January 2011).

recipes to be used in hospital catering.[3] The project was supported by the British Dietetic Association (BDA) and the Campaign for Better Hospital Food. Loyd Grossman, Albert Roux, Mark Hix, John Benson-Smith and Anton Edelmann had all spearheaded projects intended to improve hospital food. Sustain was very clear in its report that nothing less than mandatory standards would improve hospital food.[4]

In 2013, Baroness Cumberlege introduced the Health and Social Care (Amendment) (Food Standards) Bill into the House of Lords. The Bill proposed a panel of experts to be convened to write a set of hospital food standards that would become a condition of continued registration with the Care Quality Commission (CQC). The Bill completed its second reading in the House of Lords and was not taken further in the Commons.[5]

Hospital food standards were put into the legislative framework in England and Wales when the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the 2014 Regulations) included provisions on meeting nutritional and hydration needs.[6] This regulation remains in force today, and is backed by a criminal offence carrying a fine of £50,000 if harm or risk of harm occurs as a result of a breach of the nutrition and hydration standards.

Alongside the standards in regulation 14, there is also a suite of standards that are built into the NHS standard contract that covers all purchases into the NHS in England. For our purposes, this means that all food and food services suppliers must act in compliance with the terms of the NHS standard contract if they wish to retain their contracts. These include four sets of standards that are directly related to improved nutrition for patients:

1 Ten Key Characteristics of Good Nutritional Care (Nutrition Alliance);
2 Nutrition and Hydration Digest (BDA);
3 Malnutrition Universal Screening Tool (MUST) (British Association of Parenteral and Enteral Nutrition); and
4 the Government Buying Standards for Food and Catering Services from the Department of Environment, Food and Rural Affairs (GBS).[7]

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3 Operation Hospital Food (BBC 2011–2014).
4 Sustain, 'Loyd Grossman and celebrity chefs join calls for hospital food standards' (2013).
5 Health and Social Care (Amendment) (Food Standards) Bill [HL] (2013–2014).
6 SI 2014/2396, reg 14.
7 Department of Health and Social Care, Report of the Independent Review of Hospital Food (2020) 59.

The first, second and third sets of standards are largely focused on the infrastructure around eating, rather than the food itself. For example, the *Ten Key Characteristics* require patients to be screened, and personal plans to be put in place. The *Digest* focuses on the role of the dietician. *MUST* is a screening tool which healthcare professionals can use to assess a patient's risk of malnutrition. The *Government Buying Standards* are related to the procurement of food and encourage sustainable procurement and the use of British produce from British farmers.

Contract law ordinarily provides a very strong tool for ensuring that standards are met.[8] However, In 2017, when compliance with these standards was reviewed, it was found that only around half of hospitals were actually compliant.[9] A subsequent review of compliance has not been carried out. It is not known whether any actions in contract have been brought against hospital food suppliers.

This brings us to the heralded changes in section 173 of the Health and Care Act 2022, which put hospital food standards on a statutory footing in England and Wales for the first time, and therefore 'will deliver for the first time, mandatory minimum standards for the provision of good hydration and nutrition in the NHS'.[10]

This article argues that section 173 of the Health and Care Act 2022 is a purely symbolic provision that will not effect any positive change to hospital food quality. In order to make this argument, I explore Murray Edelman's work on the symbolic uses of politics and the literature on policy fiascos to explain why section 173 features in the 2022 Act at all. This is followed by a close analysis of what section 173 purports to do, which concludes that there is no substantive change to day-to-day practice as a result. This meets Lasswell's definition of 'political magic'. The article concludes with the argument that the only way to actually improve hospital food is to set aspirational standards and increase the budget to allow institutions to approach food provision in a holistic manner.

SYMBOLIC USES OF POLITICS AND LEGAL ANALYSIS

When engaging in any type of analysis of legal measures, it is crucial to remember that these are political acts and events. Statutory provisions achieve their final formulation through a political process, hence the

8 T T Arvind, *Contract Law: Unfold the Problem, Reveal the Law, Apply to Life* (Oxford University Press 2017) 4.

9 Department of Health and Social Care (n 7 above).

10 Department of Health and Social Care, Integration and Innovation: Working Together to Improve Health and Social Care for All (White Paper CP 381, 2021) [5.165].

need to examine Hansard. This article is part of a long-established research approach which situates law in its social and political context. It takes the view that the impact of law cannot be properly understood if the social and political aspects are not considered.[11]

A fundamental part of the politics of law is the symbolic effects of the legal change in question. Murray Edelman discusses the value of symbols in law and politics and explains that the condensation symbol is one where the emotions evoked by the political event become synonymous with that event.[12] He suggests that 'every political act that is controversial ... evokes a quiescent or aroused mass response because it symbolises a threat or reassurance'[13] and, particularly in a democracy, 'men may dislike ... a law ... yet be reassured by the forms of the legislature'.[14]

The reassuring effect of a statutory solution is particularly evident in the context of healthcare regulatory changes following policy fiascos. If we look at the recommendations in public inquiries following healthcare policy fiascos, many of them call for legislative change and the use of the criminal law as an enforcement mechanism supporting the provision.

One of the particularly challenging aspects of healthcare fiascos is that they often involve death or serious harm. The more serious fiascos, such as Harold Shipman, Mid Staffordshire, Bristol Heart Surgery, and Alder Hey involved deaths of and serious harm to a lot of people. Harold Shipman was a sole general practitioner (GP) who murdered around 250 of his elderly patients. He was convicted of 15 counts of murder in 2000. This led to significant changes to the oversight of GPs in England and Wales.[15] Both the Mid Staffordshire and the Bristol Heart Surgery fiascos became apparent from increased rates of routine death reporting. In Stafford Hospital, this was a general issue across the whole institution, while Bristol related to increased deaths in babies who had undergone heart surgery. In Mid Staffordshire, the public inquiry[16] found a failure of care at all levels of the organisation including the regulatory body, the Healthcare Commission. This was the driver

11 For further discussion of this theoretical perspective on law, see L Mather, 'Law and society' in K Whittington, R Keleman and G Caldeira (eds), *The Oxford Handbook of Law and Politic* (Oxford University Press 2008) 681–697.

12 M Edelman, *The Symbolic Uses of Politics* (University of Illinois Press 1985) 6.

13 Ibid 7.

14 Ibid 12.

15 Shipman Inquiry, *The Fifth Report – Safeguarding Patients: Lessons from the Past – Proposals for the Future* (9 December 2004).

16 Robert Francis QC, Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive Summary (Stationery Office 2013)

for updated standards for the provision of healthcare.[17] The Bristol public inquiry[18] found that there had been failures in the surgical care of infants and uncovered the generalised practice of retaining tissue and organs from deceased people in England and Wales. A witness in the inquiry, Professor Anderson, commented appreciatively about the extent of the collection of retained organs at Alder Hey Children's Hospital in Liverpool.[19] The revelations were a shock to the general public, and the subsequent inquiry at Alder Hey[20] found that there had been major failings in oversight of practices around hospital-based and coronial-ordered post-mortems. This, along with the Shipman report,[21] led to changes in the regulation of coroners' post-mortems[22] in England and Wales. All of these fiascos involved unexpected and unnecessary deaths, and significant psychological harm to relatives and the wider population. Fiascos or crises of this seriousness are followed by a sense that the public consciousness has been deeply affected. The public outpouring of grief following the crisis evokes a sense of shared trauma for those who are affected, and fear in those who might have been affected. These emotional responses are significant and need to be reconciled so that the public can move forward and so that changes can be made to prevent recurrences. This is one of the motivating factors underpinning the use of Truth Commissions in the aftermath of significant rights abuses.[23] As Allan and Allan highlight, people who have experienced trauma 'need to tell their stories and to have their experiences validated'.[24] Once this collaborative truth-gathering exercise has reached its end, work can be done to offer some redress, and to start the process of ensuring that the events do not occur again. It is no coincidence that the Retained Organs Commission – which was established in 2001[25] to address the revelations from the Alder Hey inquiry that organ retention from deceased bodies without consent was a widespread practice considered to be generally uncontroversial

17 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014/2936.

18 Bristol Royal Infirmary Inquiry, *The Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984–1995: Learning from Bristol* Cm 5207 (Department of Health 2001).

19 Ibid annex C.

20 The Royal Liverpool Children's Inquiry Report (House of Commons 30 January 2001).

21 Shipman Inquiry (n 15 above).

22 Coroners and Justice Act 2009.

23 A Allan and M Allan, 'The South African Truth and Reconciliation Commission as a therapeutic tool' (2000) 18 Behavioural Sciences and Law 459–477.

24 Ibid 462.

25 The Retained Organs Commission Regulations SI 2001/748.

by medical professionals in England and Wales – used a truth and reconciliation model before working on proposed legal changes.[26]

In the context of patient safety, Karen Yeung and Jeremy Horder have argued that legislation and new or strengthened enforcement mechanisms, often using criminal law, create a feeling of safety in the public and a sense that that sort of atrocity or harm cannot happen again. The reassurance offered by the law here is the symbol that the public needs to see in order to feel safe again.[27] Edelman considers the value of this type of symbol creating safety in relation to repealing a law:

> The laws may be repealed in effect by administrative policy, budgetary starvation, or other little publicized means; but the laws as symbols must stand because they satisfy interests that are very strong indeed: interests that politicians fear will be expressed actively if a large number of voters are led to believe that their shield against a threat has been removed.[28]

The stability and longevity of statute law is intertwined with the political barriers to repealing or amending it. A law relating to a controversial issue, such as patient safety, faces significant political barriers in any attempt to repeal or amend it. While the Government might propose a new piece of legislation, it is very likely to remain unchanged after the multiple readings and debates in Parliament. Given this, the symbolism of legislation is made more potent by the symbolism of the legislative and parliamentary processes around enactment.

Where there has been a policy fiasco and people have died or been harmed, the legislation – with its guarantee of longevity – acts as a tombstone to the victims. It has a dual purpose of changing the environment such that the same fiasco will not occur in the future, but also acting as a memorial for the victims of the crisis. Mary Dixon Woods writes of these tombstones 'cast[ing] long shadows'[29] in that they prove difficult to change even where they have become unhelpful in the wider regulatory sense. A classic example of this is the Dangerous Dogs Act 1991,[30] which created a new regulatory approach based on specific breeds of dog being deemed to be dangerous. However, the

26 M Brazier, 'Retained organs: ethics and humanity' (2002) 22 Legal Studies 550.

27 K Yeung and J Horder, 'How can the criminal law support the provision of quality in healthcare?' (2014) 23 British Medical Journal Quality and Safety 519.

28 Edelman (n 12 above) 37.

29 M Dixon Woods, 'The tombstone effect: long shadows and the pursuit of comfort' in R Dixon and M Lodge (eds), *Explorations in Governance: A Collection of Papers in Honour of Christopher Hood* (Institute for Government 2014) 32, 33.

30 M Lodge and C Hood, 'Pavlovian policy responses to media feeding frenzies? Dangerous dogs regulation in comparative perspective' (2002) 10 Journal of Contingencies and Crisis Management 1.

new legislative framework could not adapt to a change in problematic dog ownership where dogs were used as weapons. This phenomenon cannot be linked only to breed because it is also affected by training and the relationship between dogs and their owners. This change in practice was not captured by the legislative approach taken in the Act. In the healthcare context, the Human Tissue Act 2004 was the legislative response to the retained organs scandals. This Act created a significant legal and regulatory framework, and a new regulator, the Human Tissue Authority. Its central tenet – that human tissue from the deceased or the living cannot be used without consent – has remained largely unchanged since its enactment, except for consequential amendments to take account of changes made by other legislation, such as the Civil Partnership Act, which adds civil partner to the spouse or partner definition of relatives. The biggest change to the Act was the Organ Donation (Deemed Consent) Act 2019, which gave effect to the new rules relating to opt-out consent for organ donation. The 2019 Act preserves the central tenet that human tissue cannot be used without consent, albeit a slightly different form of consent. The Human Tissue Act 2004 has a significant substantial effect on the legal landscape, but it certainly also has a significant symbolic presence in that it acts as a memorial to all those whose organs were removed without consent, and the relatives who were also affected by this policy. I would argue that the success of the Human Tissue Act is due to its dual substantive and symbolic function. There has to be some substantive effect to show that things have changed in order for the public to continue to believe in the law. Without the substantive aspect of a new legal framework, it is unlikely that the symbolic aspects of the law could carry the public's confidence on its own.

WHY NOW?

Regulatory change in the NHS often follows a policy fiasco. Many of these fiascos are extremely complex, and addressing them takes significant time and energy to unravel the issues and identify how best to prevent them happening again. For example, the retained organs scandal in the late 1990s and early 2000s was addressed through various public inquiries[31] and a new legislative framework in the Human Tissue Act 2004. The Mid Staffordshire scandal was addressed

31 Bristol Royal Infirmary Inquiry (n 18 above); Royal Liverpool Children's Inquiry (n 20 above) (2001); Retained Organs Commission, *Remembering the Past, Looking to the Future: The Final Report of the Retained Organs Commission* (29 March 2004).

through several public inquiries,[32] the Francis Review,[33] and the new standards for care included in the 2014 Regulations. These included the introduction of the duty of candour. This is found in regulation 20 of the 2014 Regulations and requires NHS institutions to explain and apologise for any events which cause or could have caused death or serious harm to a patient. The first prosecution for breach of the duty of candour was brought in September 2020 and related to failures to appropriately disclose details about a patient who died from a perforated oesophagus following an endoscopy.[34]

What these, and other NHS scandals, have in common is the sheer complexity of the situations that have arisen. In most NHS scandals, many people are affected, and there are demonstrable failings at all levels of the service, from the lowest grade member of staff, up to the regulator itself. As such, the process of changing the law in response to these fiascos does not usually follow the classic dangerous dogs knee-jerk response pattern.[35] In these cases, the fiasco is simple – a dog bites a person, often a child. There is a media and public outcry, and a quick legislative solution is brought in, for example, the Dangerous Dogs Act 1991. Everyone agrees that dogs should not be allowed to bite children and that the proposed legislation will solve the problem. In the NHS cases, the complexity of the crisis means that there is not a single focus for any public or media outcry, and there is no simple legislative response that will address all the concerns. Instead, there is often a lengthy public inquiry process which provides time and space for the panel to create substantive recommendations for complex legal change.[36]

In 2019 there was a hospital food safety disaster involving listeria. In April to June 2019, there were nine confirmed cases of listeria originating from sandwiches supplied to a hospital. Seven of these patients died. Listeria is a notifiable illness, and notification triggers an investigation by Public Health England into the source of the outbreak. In this case, Public Health England's report found that the outbreak had originated from a sandwich manufacturer, which sourced

32 There is a comprehensive timeline of inquiries related to Mid Staffordshire published by *The Guardian*. It provides details of the inquiries and the findings. Denis Campbell, 'Mid Staffs hospital scandal: the essential guide' *The Guardian* (London 6 February 2013).

33 Francis (n 16 above).

34 CQC, 'Care Quality Commission prosecutes University Hospitals Plymouth NHS Trust for breaching duty of candour regulation following patient death' (Press Release 23 September 2020).

35 Lodge and Hood (n 30 above).

36 R Stirton, 'The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: a litany of fundamental flaws?' (2017) 80 Modern Law Review 299–324.

its ingredients from another supplier.[37] Following that report, all the sandwiches produced by the relevant manufacturer were withdrawn from sale and use for patients across the whole NHS estate in England, and all 'ready to eat' meat products from the relevant supplier were withdrawn from use across the whole NHS estate in England. The sandwich manufacturer was closed for decontamination and has since ceased trading. The ingredient supplier underwent a voluntary closure and has since ceased trading. Listeria is not a common illness, and it is caused by a food-borne pathogen which grows where there is contamination and inadequate storage. This is why the Public Health England investigation was able to target the source of the outbreak and stop it spreading further.

In legal and political analysis terms, this was a very simple fiasco which shone a light on poor food safety practices in the NHS. It was the NHS equivalent of the 'dog bites child' fiasco. There was a single incident – an outbreak of listeria – and a small number of casualties. There was also a media outcry with a flurry of articles in all the relevant media outlets.[38] The usual response to this sort of fiasco is a knee-jerk legislative change which goes some way to addressing the problem, but can also leave some challenges for the future.[39] Since food safety regulation already applies to suppliers and manufacturers in the hospital catering industry, it would have been a simple response to strengthen it, such that suppliers of food to hospitals faced harsher penalties, or had to meet higher standards. This is something that falls within the remit of the Food Standards Agency. An investigation was carried out, and the Food Standards Agency confirmed in 2022 that all of the suppliers in the chain had ceased trading and that the outbreak had been contained.[40]

It is unlikely that this incident alone would have been sufficient to trigger a change in the law in the Health and Care Act 2022. The existing food safety systems (the Food Standards Agency and Public Health England) and the existing legal obligations were more than adequate to address the problem. However, in addition to the listeria report, in early 2019, the trade union Unison had surveyed its members for their views on hospital food, and the results had made for unpleasant reading: 'More than half of hospital staff in England

37 Public Health England, Investigation into an Outbreak of Listeria Monocytogenes Infections Associated with Hospital-provided Preprepared Sandwiches, UK May to July 2019 (Public Health England 2020).

38 'Hospital patients die in sandwich listeria outbreak' (*BBC News* 7 June 2019); 'Sixth person dies from listeria outbreak linked to NHS sandwiches' *The Guardian* (London 1 August 2019).

39 Lodge and Hood (n 30 above).

40 'Update on investigation into food supply chain linked to listeria' (Food Standards Agency 9 May 2022).

wouldn't eat food served to patients because it's unhealthy and of poor quality.'[41] The survey also raised concerns about the provision of food to staff who referred to inadequate preparation areas, a lack of healthy food, and food that did not allow for religious and cultural needs. With the listeria outbreak following the Unison statement that over half of NHS staff would not eat the food served to patients, it is perhaps more understandable why Matt Hancock, then Secretary of State for Health, announced an independent review of hospital food,[42] which reported in October 2020.[43] By offering up the whole NHS food provision system for review, Matt Hancock demonstrated a commitment to addressing the wider problems in hospital food that have been rumbling on since the early 1990s.

The review panel advisor was Prue Leith, well known for her roles in *The Great British Menu* and *The Great British Bake Off*. The final report from the review panel made recommendations in relation to eight areas. However, for our purposes the most important of these recommendations was that there should be:

a) Ambitious NHS food and drink standards for patients, staff and visitors to be put on a statutory footing and inspected by the CQC, with appropriate resources for the CQC to be able to do so.
b) Standards to apply to patient, staff and visitor food, food manufacturers, food retailers and vending machines; including requirements for appropriate facilities to support patients and staff to eat well 24/7 when in the hospital environment.[44]

This recommendation was addressed in section 173 of the Health and Care Act 2022. Legally and substantively, food safety and nutrition are wholly distinct, in that there is already a very strong regulatory framework around safety. However, in this instance, I would argue that the substantive situation was less important than the optics. Patients in hospital have no real choice whether to eat the food that is provided to them. The listeria outbreak put many patients at unnecessary risk of serious harm or death. This was combined with a damning statement from people who could choose not to eat this food. In this fiasco, the safety and nutrition issues have become intertwined. The fact that the proposed solution focused on the nutritional aspects of the problem is a reflection of the strength and robustness of the food safety regulation.

41 Unison, 'Hospital staff say patient meals not fit to eat' (Press Release 9 April 2019).

42 Department of Health and Social Care, 'Hospital food review announced by government' (23 August 2019).

43 Department of Health and Social Care (n 7 above).

44 Ibid 9, recommendations 6a, 6b.

SECTION 173 – DOES IT HAVE A SOGGY BOTTOM?

A favourite criticism of Prue Leith in pastry week on *The Great British Bake Off*[45] is that of the 'soggy bottom'. For those who are not avid fans of the show, the soggy bottom is a problem with pies. The pie might look beautiful from the top, but once a piece has been removed, and the bottom pastry crust can be inspected, the fear is that the bottom piece will be soggy and damp, rather than the beautiful crisp pastry that is expected. For a Great British Baker, the 'soggy bottom' is a devastating blow to their chances of success in the competition.

The authors of the Report of the Independent Review of Hospital Food[46] devoted chapter 6 to their vision of the hospital food and drink standards that they wanted enshrined in statute. However, the report did not clearly set out what the 'ambitious standards' would be. Instead, the recommendation was for the establishment of an expert group to work on the appropriate standards. The main focus of chapter 6 was on the existing standards currently found in the standard contract for supplying food and food services to the NHS in England. As noted above, these are: the Ten Key Characteristics of Good Nutritional Care; the Nutrition and Hydration Digest; the MUST; and the GBS. With the first, second and third focused on the infrastructure around eating and the fourth[47] on procurement.

The panel's concerns about these sets of standards does not seem to have been their content, but rather the lack of compliance with and the poor monitoring of compliance with the standards. The aim of the recommendation around hospital food standards was to increase compliance, hence the recommendation of statutory force.

Given these expectations, there is no doubt that section 173, the heralded statutory hospital food standards, has a very soggy bottom. Section 173 amends section 20 of the Health and Social Care Act 2008 (the 2008 Act) to enable the Secretary of State to:

> (a) Impose requirements in connection with food or drink provided or made available to any person on hospital premises in England …;
> (b)(a) Specify nutritional standards, or other nutritional requirements, which must be complied with;
> (b)(b) require that specified descriptions of food or drink are not to be provided or made available.

It is merely an enabling provision which allows the Secretary of State to make whatever regulations they so choose. However, section 20 of the

45 See *The Great British Bake Off*.

46 Department of Health and Social Care (n 7 above).

47 Department for Environment, Food and Rural Affairs, 'Sustainable procurement: the GBS for food and catering services' (1 July 2014).

2008 Act already offered a wide discretion to the Secretary of State to make regulations applying in England and Wales relating to food and nutrition. Section 20 enabled the Secretary of State to 'make provision as to the manner in which a regulated activity is carried on',[48] and 'make provision as to the fitness of premises'.[49] The regulations that are already in force, having been made under the authority granted in section 20, are the 2014 Regulations. Regulation 14 provides that 'the nutritional and hydration needs of service users must be met'. These regulations are to remain in force until 31 March 2025.[50]

Section 173 of the Health and Social Care Act 2022 makes no substantive change to the law. Hospitals in England and Wales must meet the nutritional and hydration needs of their patients, by virtue of regulation 14. This is one of the fundamental standards that a hospital must demonstrate that it is meeting in order to remain a registered provider of healthcare services.[51] If a hospital were found not to be meeting the fundamental standards, then there is a range of enforcement actions that the CQC can use to ensure improved performance including criminal penalties as necessary and, ultimately, the withdrawal of registration to continue providing healthcare services. These standards were strengthened, as were the enforcement actions, in the 2014 Regulations, which were enacted after the Mid Staffordshire crisis, and the Francis Inquiry.[52]

If we look at the White Paper relating to the Health and Care Act 2022, we can see the rationale for including the provisions that became section 173, even though they make no substantive change to the law. Paragraphs 5.165 to 5.167 explain that 'statutory standards will … instil greater confidence in the public that the NHS is committed to deliver appropriate levels of nutrition and hydration, as well as good quality food'.[53] What is particularly striking here is that there is not even any attempt to sugar-coat this. The purpose of section 173 is not to improve hydration and nutrition, or to increase the quality of hospital food. Instead, it is to *instil confidence in the public* that the NHS is committed to providing appropriate levels of nutrition.

This is an explicit engagement of Cass Sunstein's expressive function of law.[54] Theoretically, statutory provisions combined with enforcement action should work together to improve standards overall.

48 S 20(3)(b).
49 S 20(b)(e).
50 SI 2022/179.
51 2008 Act, ch 2.
52 For a detailed discussion of these changes see Stirton (n 36 above).
53 Department of Health and Social Care (n 10 above).
54 C Sunstein, 'On the expressive function of law' (1996) University of Pennsylvania Law Review 2021.

Elsewhere, in relation to hospital food provision, I have argued that this is entirely unlikely to be a successful strategy.[55] The reason for this position is the chronic underfunding of the NHS, and of its regulator, the CQC. The imperative to cost-save while still providing good quality healthcare to patients is a powerful factor in budget allocation at the hospital level. Food provision is a 'safe' place to conserve budgets in the wider business of the hospital. It is much safer to reduce food budgets than it is to reduce cardiac surgery services, for example. This position was recognised in the parliamentary debates about section 173 when Alex Norris asked how the Government intended to resource the changes: 'We do not want pressure on hospital settings … to make cuts elsewhere. It would be a pyrrhic victory if the clause led to better nutrition but worse care.'[56]

Edward Argar, the Health Minister speaking on behalf of the Government in this debate, did not address the question of resourcing section 173, instead saying that 'giving the Secretary of State powers to place hospital food standards on a statutory footing sends a clear message about the importance of standards for the provision of good hydration and nutrition in the NHS'.[57] He went on to say that section 173 is 'a key part of our policy to improve public confidence in hospital food'. The Government has continued to push the position laid out in the White Paper, that the aim of section 173 is to send a message to the public, to demonstrate that hospital food is important. This is not the same as saying that hospital food quality is important and should be improved.

There were further attempts to amend section 173 in the House of Lords. Lord Hunt of Kings Heath, who is also president of the Hospital Caterers Association, made a very astute point that 'lip service has always been paid to good standards of hospital food and nutrition, unfortunately the boards of NHS organisations have often found it difficult to provide the resources to enable that to happen'.[58] Lord Hunt's proposed amendment would have required a board-level director to ensure that the nutrition and hydration standards were properly implemented at their hospital. He also proposed additional training requirements for staff involved in hospital food service. Ultimately, it is this resources point that seems to carry the arguments. Appointing a board member responsible for food provision costs money. Implementing training standards across the sector costs money. This money is not available from the ordinary sources. Lord Hunt withdrew his proposed amendments after the

55 Stirton (n 36 above).

56 Health and Care Bill HC Deb 26 October 2021, vol 702, col 680, Alex Norris.

57 Ibid col 681, Edward Argar.

58 HL Deb 7 March 2022, vol 819, col 1230, Lord Hunt.

response from Baroness Penn on behalf of the Government, who said that the Government was working with NHS England on updating the food standards – those currently included in the NHS standard contract – and that those standards would include a requirement that a hospital board member must have responsibility for food provision.

NHS England published its updated hospital food standards on 3 November 2022.[59] The first of the eight standards in section one requires organisations to have a board member responsible for food and drink and for reporting on compliance with the standards to be a standing agenda item at board meetings.

Ultimately, despite these attempts to add substance, section 173 has retained the *status quo* as regards hospital food standards. It enables the Secretary of State to make regulations about nutrition and hydration – a power that was already provided in the 2008 Act, and had already been made use of in the 2014 Regulations. The only difference is that nutrition and hydration are explicitly included in statute, rather than being hidden away in secondary legislation and the NHS standard contract.

ACTUAL CHANGE OR POLITICAL MAGIC?

In 1960, Harold Lasswell wrote: 'The number of statutes which pass the legislature … but which change nothing in the permanent practices of society, is a rough index of the role of magic in politics.'[60]

I have argued that the only change that has happened as a result of section 173 is that the nutrition and hydration standards currently included in the NHS standard contract have been moved into the legislative and regulatory framework.

The new standards for healthcare food and drink are in four separate sections. All NHS organisations in England must comply with sections 1 (all healthcare food and drink) and 4 (sustainable procurement and food waste). Section 2 covers patient food and drink while section 3 deals with staff, visitor and retail provision.[61] Section 1 includes eight standards requiring that NHS organisations in England must:

1. have a board member responsible for compliance and reports at every board meeting;
2. have a food and drink strategy;
3. consider input from a named food service dietician;

59 NHS England, National standards for healthcare food and drink (3 November 2022).

60 H Lasswell, *Psychopathology and Politics* (University of Chicago Press 1960) 195.

61 Sections 3 and 4 are outside the scope of this article because they do not relate specifically to patient nutrition and hydration.

4 have a food safety specialist;
5 have a high-calibre workforce and properly remunerated chefs and food service teams;
6 demonstrate that they have a training and development programme for food service staff;
7 monitor and reduce waste; and
8 demonstrate an appropriate 24/7 food service provision.

While these map closely on to the recommendations of the Independent Review of Hospital Food,[62] it is worth looking closely at the impact assessment to identify whether these standards are expected to make substantive change. Seven of the eight standards are described as having no cost *because the provision should already be in place*. The evidence for this conclusion has not been provided, but the fact that the Independent Review of Hospital Food made specific recommendations relating to several of these standards suggests they are not already in place across the board. The only expected change is around monitoring food waste.

Section 2 of the new standards requires NHS organisations in England to demonstrate their compliance in five areas:

1 the Ten Key Characteristics of good nutrition and hydration care;
2 the BDA's Nutrition and Hydration Digest;
3 implementation of a digital ordering system aligning with patient care plans and dietary information;
4 a ward-based quality assurance system; and
5 a nutrition and hydration quality improvement programme.

The first two of these areas were already included in the previous standards, and therefore amount to no substantive change. However, areas three, four and five are new and do require the development of new processes with accountability and improvement built in at the level of ward staff. This is where the responsible board member will have new work to do to explore how to develop and implement these frameworks.

MUST, mentioned above, should still be used in accordance with the NICE guidance on nutrition support for adults, and the GBS, mentioned above, are included in section 4 of the new standards.

Although relatively small, this substantive change to the standards should be welcomed. It aims to ensure that there is greater accountability within NHS organisations in England in relation to food provision. It has been just over one year since these standards were published, so it is too early to see evidence of the impact of any shift in practice. It is

62 Department of Health and Social Care (n 7 above).

clear that there is scope for change and improvement around patient food provision.

Although there has been a minor substantive change, it is crucial to consider whether the change in enforcement mechanism – from contract law to regulatory enforcement by the CQC – amounts to an actual change to the law, or political magic. In addition, given that the Hospital Food Review Report was particularly concerned about increasing compliance with the standards, there is a second question about whether this change can increase compliance, or whether section 173 does in fact have a soggy bottom.

Monitoring compliance

Decent information-gathering mechanisms are a fundamental component of an effective regulatory framework. It is essential to know whether the standards are being complied with in order to make any subsequent decision about undertaking enforcement action.

Prior to section 173, when the hospital food standards were contained within the NHS standard contract, compliance was monitored under the Patient Led Assessments of the Care Environment (PLACE)[63] scheme. The Hospital Food Review Report indicates concern that 'current monitoring processes have become a "tickbox" process for some trusts and may not accurately reflect reality, and not all the food standards are included in PLACE'.[64] PLACE is an assessment mechanism which involves an internal assessment of the relevant site. At least 50 per cent of the assessment team must be patient assessors. One of the domains that an institution is inspected against is 'nutrition and hydration'. The approach taken in the 2018 PLACE report relied on by the Hospital Food Review[65] was to ask whether the institution had assessed its compliance with specific standards. In relation to the nutrition and hydration standards, only 49 per cent of the 53 institutions inspected were fully compliant with the BDA's Nutrition and Hydration Digest. This is standard 2 in the list of nutrition standards in the NHS contract. This means that approximately 24 institutions were fully compliant with the Digest, which has been a mandatory standard since 2014.[66] The PLACE scheme has undergone a review since the 2018 publication, and the 2019 report presents the data in a different way. The most important change is that many more inspections are carried out – 1068 institutions were included in the 2019 assessment. However, the

63 NHS Digital, 'Patient-led assessments of the care environment (PLACE)' (2023).
64 Department of Health and Social Care (n 7 above) 59.
65 Ibid 60.
66 Department of Health and Age UK, 'The Hospital Food Standards Panel's report on standards for food and drink in NHS hospitals' (2014).

2019 assessment still only considers compliance with MUST (92%), the Ten Key Characteristics (91%) and the Nutrition and Hydration Digest (88%).[67] While this is an improvement on the previous PLACE model, it still only asks for compliance information on three of the four standards relevant to food for patients. This does present a much rosier picture of compliance with the mandatory standards than the 2018 PLACE assessment because it offers a more complete picture, and it asks whether the institution is compliant with the relevant standards rather than whether the institution has assessed its compliance. While PLACE was carried out in 2022, there has been no significant change to the model used, and the data collection and results were affected by the Covid-19 pandemic. Given these factors, it is more appropriate to focus on the 2019 results.

However, compliance with these standards has been mandatory since 2014. While some settling-in issues are to be expected, one would also expect that five years after compliance was made mandatory, the rates of compliance would be closer to 100 per cent rather than 90 per cent. It is even more concerning when we consider that these are not high standards. They are not aspirational standards, they are baseline standards.

A significant criticism of PLACE is that it is self-reported data,[68] and, while there have been changes to PLACE for the 2019 assessments onwards, it is still self-reported data by an internal assessment team. The problem with self-reported data is that it is difficult to ensure that the report matches the patient experience in the institution. There is a recommendation that an independent person is included in the assessment team, and this offers some guarantee that the questionnaire is answered honestly, however, the accuracy of the data is largely dependent on the integrity and knowledge of the assessment team. To use Baldwin's taxonomy of regulatees, teams which are ill-intentioned or ill-informed may inflate the reporting of their compliance with mandatory standards.[69] There is no way of knowing how many of the 1068 assessment teams are either ill-intentioned or ill-informed. As such, there is no way of verifying the veracity of the data.

Section 173 moves the compliance monitoring for hospital food standards into the purview of the CQC. The CQC has a team of inspectors who travel around the country making announced and unannounced inspections of registered institutions. The inspectors will gather information from patients, staff and other service users. They will collect data from comment cards and will review documentation,

67 NHS Digital, 'Patient led assessments of the care environment (PLACE) 2019 England' (2020).

68 Department of Health and Social Care (n 7 above) 61.

69 R Baldwin, *Rules and Government* (Clarendon Press 1995) 148.

including patient notes, at an institution. The inspectors will also undertake observations of the activities in the registered institution.[70] The purpose of the inspection is to consider whether the service is safe, effective, caring, responsive to people's needs and well-led.[71] Each of the five questions is rated as outstanding, good, requires improvement or inadequate, and the institution is given an overall rating, which it must share publicly.[72] The CQC writes a report, which is made available on its website, and publicises the ratings given.

It is worth exploring how regulation 14, the existing nutrition and hydration standards, is currently inspected in order to consider how the CQC might inspect in relation to the standards newly added to its remit. In relation to each of the five overall questions, there are several sub-questions which relate to specific regulations. One aspect of the nutrition standards is their responsiveness to patients' cultural needs. This forms part of the 'caring' question. The main space where nutrition is addressed is in the effectiveness part of the inspection, in which the inspectors consider this question: 'E1.5 How are people's nutrition and hydration needs (including those related to culture and religion) identified, monitored and met? Where relevant, what access is there to dietary and nutritional specialists to assist in this?'[73] This is an extremely broad question that gives the inspectors scope to explore the application of regulation 14, which provides that nutrition and hydration needs must be met. The relevant needs include 'suitable and nutritious food … adequate to sustain life and good health', parenteral nutrition and dietary supplements as necessary, the meeting of any cultural or religious needs, and support with eating where necessary.[74]

One of the issues about regulation is that framing is everything. The way that standards are framed affects the decision about how to gather information about those standards, and how to enforce the standards. John and Valerie Braithwaite demonstrated this very clearly with their nursing home research comparing Australia and the United States.[75] If the standards are written in a 'closed' manner, ie, 'Are the beds changed daily?' or 'Is a MUST assessment carried out on every patient?' then the answers are yes or no. This is a tickbox exercise. Collecting this information does not require an inspection team to observe practices on a ward. The best way to collect this information is to provide a

70 CQC, 'What we do on an inspection' (25 August 2022).
71 CQC, 'The five key questions we ask' (25 August 2022).
72 CQC, 'Ratings' (5 April 2023).
73 CQC, 'Assessing needs and delivering evidence-based treatment (healthcare services)' (12 May 2022).
74 2014 Regulations 14(4).
75 J Braithwaite and V Braithwaite, 'The politics of legalism: rules versus standards in nursing-home regulation' (1995) 4 Social and Legal Studies 307.

questionnaire for someone internal to the organisation to complete. They are in the best place to know the answers to the questions and, also, in the best place to do something if the answers are no. These roles are already present in NHS institutions. The Quality and Governance Teams have compliance roles. For example, the Compliance Manager at an NHS Foundation Trust is expected to:

> lead the organisation in ensuring all services are registered correctly with the Care Quality Commission (CQC) and ensure processes are in place to continuously monitor compliance. You will be the Trust link with CQC and co-ordinate all correspondence to and from them.[76]

A member of the compliance team would be best placed to answer the questionnaire regarding compliance with the standards previously assessed through PLACE.

Unless the hospital food standards are significantly rewritten, in such a way that they are 'open' rather than closed statements, the information-gathering exercise will remain the same, albeit under the authority of a different organisation – the CQC rather than PLACE, which is administered by NHS Digital. The best way to get this information is from self-reporting because the compliance team, or similar, are best placed to know the information. The expectation of the Hospital Food Review Panel that enshrining the standards in law would change the monitoring framework seems to have been misguided. In that respect, it seems that section 173 is an example of political magic.

Enforcement practices

Once again, the decisions around enforcement practices are connected to the manner in which the standards are formulated[77] as well as the types of regulatees affected by the rules.[78] Since the Hospital Food Review Panel was concerned that the incentives and penalties for non-compliance were not working,[79] it might have been a more useful exercise to scrutinise why they were not working before recommending that statutory enforcement would be more effective.

When considering the optimal nature of law enforcement, Steven Shavell argued that the stage at which the legal intervention occurs is a fundamental dimension of enforcement.[80] The advantage of

76 Quote taken from a job description advertised on NHS Jobs. These adverts are removed when the closing date has passed but similar job descriptions are available. See NHS Jobs.

77 See R Baldwin, M Cave and M Lodge, *Understanding Regulation: Theory, Strategy and Practice* (Oxford University Press 2011) 230.

78 Baldwin (n 69 above)

79 Department of Health and Social Care (n 7 above) 61.

80 Steven Shavell, 'The optimal structure of law enforcement' (1993) 36 Journal of Law and Economics 255, 257.

the NHS Standard Contract as an enforcement mechanism is that it plays both a preventative role and a restorative role. The contract is a preventative measure because the parties to the contract have to sign it in advance, with knowledge of its contents. The consequences of breaching a contract are sufficiently significant that no serious commercial enterprise would sign a contract that it did not intend to abide by. In that sense, the contracting process works as a filtering system. Non-professional enterprises would not get to the stage of even signing the contract to provide food, or any other services, to the NHS. Given that the NHS Standard Contract for 2022–2023 has 81 pages of service conditions, and 53 pages of particulars, as well as any additional local particulars which are agreed with the local Commissioners,[81] it is inconceivable that any food preparation company would sign the contract without seeking proper legal advice on the obligations it would be accepting.

In relation to quality of service, paragraph 3.3 of the service conditions provides that where a contracting party has fallen below the expected national quality thresholds, the Commissioners can enforce performance without the need to appear in court. They may issue a contract performance notice, which requires the service provider to comply with the quality standards. Alternatively, they can remove any or all patients from that provider's care. There is no requirement to start with a performance notice, so the Commissioners can go straight to full removal. In the context of food provision, this means that the food supplier would be removed from the NHS estate, and the contract would in essence be cancelled. This is what happened in the case of the listeria-contaminated sandwiches. The Public Health England inquiry demonstrated that companies in question were non-compliant with food safety law. Compliance with the law is another term of the NHS Standard Contract in paragraph 1.1 of the service conditions. Their contracts were withdrawn, and they are no longer able to supply food to the NHS.

Supplying products to the NHS is likely to be a significant revenue stream for any food company. The consequences of the withdrawal of that contract are dramatic. For example, both companies implicated in the listeria outbreak have ceased trading completely. As a preventative enforcement mechanism, contract law has considerable symbolic power, and, in the case of an actual breach of the contract, it has considerable substantive power as well.

The contract is a powerful mechanism for protecting the rights of those who have been affected by a breach of that contract. The other contracting party, in these cases, the NHS Commissioners, can

81 NHS, 'NHS Standard Contract 2022/23 Particulars, Service Conditions and the General Conditions' (2 March 2022).

withdraw the contract without the need to appear in court. This keeps costs down and means that breaches can be remedied quickly. This is both a restorative intervention after a breach has occurred, but also a deterrence symbol for other organisations considering taking on NHS contracts. As an enforcement mechanism, I would argue that the NHS contract is a very powerful tool.

How do the CQC enforcement practices measure up to the power of the contract? The 2014 Regulations changed the enforcement measures available to the CQC and made it easier for their enforcement team to choose the appropriate enforcement mechanism for the regulatory failure in question. The 2014 Regulations also removed the previous formality requirements so that inspectors were not bound by waiting periods or a need to provide a warning notice alongside an improvement period before a prosecution could be brought.[82] However, as I have argued elsewhere, the 2014 Regulations pushed the CQC into a deterrence approach to enforcement – the need to use the more significant penalties in order to deter regulatees from non-compliance. This created a mismatch between the role of CQC inspectors in maintaining ongoing relationships with the institutions they inspect, and support through any period of change and improvement.[83]

Two significant differences between the CQC enforcement actions and the NHS contractual enforcement mechanisms is the speed with which action can be taken, and the entity at which the enforcement action is targeted. These are intertwined. Most food service and provision is contracted out to private companies. If, on inspection, hospital food provision was found to fall below the standards required by regulation 14, then the CQC inspectors would start with some informal negotiations about improvement, or one of the enforcement notices requiring significant improvement. This would include a time period over which the improvement would have to take place, and possibly a second inspection would be carried out. Crucially though, these actions would be taken against the regulated institution – the hospital – not against the food provider or supplier, which would fall outside the CQC's remit. It would then be up to the hospital to decide how to approach the deficit. Would it work with the food supplier to improve standards, or could the hospital simply withdraw the contract? If the contract were to be withdrawn, this is the same result as the contractual enforcement mechanism, but it has taken longer because the CQC report can only be addressed to the hospital. It adds an additional layer of bureaucracy that must be navigated for the same outcome.

82 Stirton (n 36 above) 317.
83 Ibid 319.

Putting these mechanisms side by side, it is clear that there is no substantive change to the potential outcomes of enforcement action. A food supply contractor can still have its contract withdrawn. But under the CQC enforcement model this takes longer than it does under the contractual model. I would argue that the move to CQC enforcement is likely to be less effective than the enforcement mechanisms inherent in the NHS contract.

CONCLUSION: A TRIUMPH OF SYMBOLISM OVER SUBSTANCE

This argument has moved from the expressive functions of law, and symbolic uses of political acts such as law-making. It has traversed the heady issues of political magic and soggy bottoms. One conclusion to reach from this discussion is that the symbolism of a legal or political act is important in its own right, irrespective of whether there is also a substantive effect of that same act. In the case of hospital food, statutory standards have been the 'prize' that all eyes have been on since the early 1990s with the Campaign for Better Hospital Food's work. Now this has been achieved, there is a sense from the activist groups that the work is complete. Sustain has archived its Campaign for Better Hospital Food website.[84] In that sense, the symbolism means something.

This might be that it provides concrete evidence that the Government supports improvement and development of hospital food. This has been supported by public commitments from the then Prime Minister Boris Johnson that the Government would improve hospital food when the review was announced.[85] However, these commitments were made when Matt Hancock was Health Secretary, and, as the minister who ordered the Hospital Food Review, there was some demonstrable commitment to improving hospital food at least at that stage. Matt Hancock resigned his office before the Health and Care Bill was introduced to Parliament, and Sajid Javid replaced him. This role has since been transferred to Steve Barclay and Thérèse Coffey. Victoria Atkins became the Secretary of State for Health and Social Care in November 2023. While a change in minister does not automatically mean a change in priorities, it is worth noting that the public-facing discussion about the food provisions in the Health and Care Bill at the time focused on the food advertising provisions:

84 Sustain, 'Campaign for better hospital food'.

85 See this video of Prue Leith and Boris Johnson discussing the aims of the hospital food review.

> Supporting the introduction of new requirements about calorie labelling on food and drink packaging and the advertising of junk food before the 9pm watershed to level up health across the country. The pandemic has shown the impact of inequalities on public health outcomes and the need for government to act.[86]

When the Health and Care Act 2022 received royal assent the press release mentioned food advertising and tackling obesity through regulating food advertising, but nothing else.[87] The first statutory hospital food standards provisions did not merit public comment.

I have argued that a closer look at the impact of the hospital food standards provision in section 173 indicates that there is likely to be no change at all to compliance monitoring practices, and if there is a change in enforcement it is likely to be for the worse rather than the better. This is because the CQC enforcement practices are much more complex than the enforcement of the NHS Standard Contract. It is also crucial to recognise that adding additional responsibilities onto the CQC will necessitate an increase in funding to support its work. It is far from clear that this will be forthcoming. Harold Lasswell's political magic that makes no change to day-to-day practices is the better case scenario here.

Ultimately, the problem with hospital food is that it is often unappetising and of low quality. It is cheap food. This is an entrenched problem that activists have been fighting for at least 20 years. There is no quick fix to this. It is all very well having a symbolic legal provision that demonstrates the government's commitment to improvement, but this is just the latest in a long line of symbolic acts to address the problem. Every time a celebrity chef gets involved, there is a flurry of government and media interest in improving the situation, but ultimately, nothing really changes.

There are two elements that need to be addressed if there is a genuine commitment to improving hospital food. First, the current standards are extremely low. They are baseline standards that providers should not fall below. If we want improvements in hospital food, then the content of these standards needs to be explored and changed. One option would be to create high standards that organisations need to work to meet. The recommendations in the Hospital Food Report offer a holistic and aspirational set of measures that would, if implemented, improve hospital food. The recommendations include things such as training requirements, improved grading of hospital food staff and

86 Department of Health and Social Care, NHS England, Rt Hon Sajid Javid MP, 'Health and Care Bill introduced to Parliament' (6 July 2021).

87 Department of Health and Social Care, Rt Hon Sajid Javid MP, 'Health and Care Bill granted Royal Assent in milestone for healthcare recovery and reform' (28 April 2022).

technological solutions. Interestingly, one of the panel's focuses was on knowledge throughout the organisation. The report suggested that 'it is important that boards and chief executives are regularly eating the same meal as patients'.[88] This is a really simple way of ensuring that those at the top of the institution know what is happening for their service users. If the standards are written in a way that requires implementation of these recommendations then it is possible that hospital food will improve. The enforcement mechanisms need to be written around the standards. The form of enforcement measures are related to the content and the form of the standard being enforced. Ensuring that the two match up is an important part of regulatory success.

The other aspect of improving hospital food is funding. Currently, the median spend per patient meal is £4.56.[89] This includes all overheads. This amounted to 0.6 per cent of the total NHS budget in 2018–2019.[90] When we consider the number of people involved in food provision, and the cost of kitchens and utilities, this is a tiny amount of money. Combined with increasing the substance of the standards, it is essential to increase the budget allocated to food provision.

Unless these two things are addressed properly – substantive change to the standards, and increased budget – there is only a very slim possibility that hospital food will improve. If section 173 does not lead to these changes, then the only conclusion it is possible to reach is that it is political magic with a soggy bottom.

88 Department of Health and Social Care (n 7 above) 14.

89 NHS Digital, 'Estates Returns Information Collection Summary page and dataset for ERIC 2018/19' (17 October 2019).

90 Department of Health and Social Care (n 7 above) 9.