

Catering for patients

A follow-up report

Prepared for the Auditor General for Scotland

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Auditor General for Scotland

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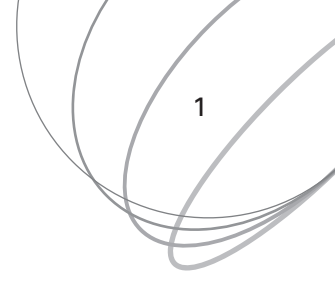
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Part 1. Summary



Catering services are offering patients an improved level of choice but boards still need to do more to ensure patients' nutritional care.

Setting the scene

1. This review of hospital catering follows up the issues from our baseline report which was published in November 2003.¹ The baseline report provided detailed findings and recommendations on nutrition, quality, patient satisfaction, costs and the management of the catering service. This follow-up study assesses the progress made in implementing those recommendations and improving hospital catering services.

Why hospital catering is important

2. Nutritional care is key in helping the recovery of patients in hospital and hospital catering has an important role to play in this.^{2,3} The quality of hospital food is a very important part of ensuring that the patient's experience in hospital is positive. Regular mealtimes perform a significant social role which can promote the general well-being of patients and assist in their recovery.

3. Food safety and hygiene are essential and need to be rigorously monitored to minimise the risk of infection and ensure high-quality patient care.

4. The scale of the costs involved in catering for patients, staff and hospital visitors is also significant. In 2004/05, hospital catering cost the NHS in Scotland £73 million, equivalent to just under one per cent of the total spend on the NHS.⁴ Catering is also a large employer with 3,272 staff involved in producing and serving over 17 million meals each year.^{5,6}

Key findings

- Catering services are offering an improved level of choice to patients, including giving patients the opportunity to order meals less far in advance, offering a range of portion sizes and ensuring that snacks are available to patients outside normal mealtimes.
- Boards still need to do more to ensure the nutritional care of patients. All patients are not yet screened for risk of undernutrition and many hospitals do not have systems in place to ensure a nutritional balance in the meals provided.
- Not all boards are carrying out quarterly patient satisfaction surveys. However, many boards are developing improved ways to get patients' views on catering and use these to improve the services provided.
- Catering costs have risen by a third since the baseline. Catering staff costs have risen due in part to the low pay agreement, whereas the costs of food and beverages per patient day have remained stable.
- Non-patient catering services are still being subsidised but boards are improving their management information systems to allow them to manage this.
- Boards have reduced the amount of food wasted due to unserved meals.

About the study

5. The overall aim of this study was to assess progress against the recommendations reported in the 2003 baseline report. In particular, the study examined whether: processes are in place to provide quality nutritional care to patients; patients are receiving a good quality catering service; catering services have improved their control of costs and wastage; boards have strategies for catering services and are monitoring progress against these strategies.

6. Our baseline report investigated the key areas of the catering service in 2003 and made 31 recommendations for improvement. The key findings of that report are summarised below:

- Nutritional care needed to be given a higher priority by all staff through measures such as nutritional screening, using standardised recipes and nutritional analysis of menus.
- Patient satisfaction with catering services was high but improvements were needed in the amount of choice available to patients and in the ways that patients' views were gathered and used.
- Food wastage at ward level needed to reduce. We recommended that regular monitoring of wastage levels should be introduced with the aim of reducing waste to a target level of ten per cent.

1 *Catering for patients*, Audit Scotland, November 2003. A copy of the baseline report is available to download at www.audit-scotland.gov.uk.

2 *Malnutrition within an Ageing Population: A Call to Action*, European Nutrition for Health Alliance, August 2005.

3 *Nutrition support in adults: oral nutrition support, enteral tube feeding and parenteral nutrition*, National Collaborating Centre for Acute Care, London, February 2006.

4 *Scottish Health Services Costs*, year ended 31 March 2005, Information Services Division (ISD).

5 *Scottish Health Statistics workforce data*, year ended 31 March 2005, ISD.

6 Audit Scotland survey, June-August 2006.

- Spending on catering services varied significantly and services to staff and visitors were being subsidised. We recommended that this could be better controlled by introducing pricing policies, income generation targets and policies on the level and cost of subsidisation.

7. NHS Quality Improvement Scotland (NHS QIS) has produced standards for food, fluid and nutritional care in the NHS in Scotland and has recently reviewed and reported progress against three of the six standards.^{7,8} Audit Scotland has worked closely with NHS QIS to provide a comprehensive picture of work in this area. The complementary approach adopted by both organisations has led to NHS QIS focusing on the nutritional care of patients, while our review has focused on the delivery of catering services. We have drawn on findings from the NHS QIS review as part of this follow-up report.

8. In our study we reviewed progress made at board and hospital level by:

- surveying all NHS boards, two special boards and 149 hospitals that provide catering to patients, staff or visitors
- interviewing catering and finance managers at a sample of boards to follow-up on the recommendations from the baseline study ([Appendix 1](#))
- reviewing supporting evidence supplied by boards and hospitals
- observing mealtime practice in a sample of ten wards to understand the context in which catering is delivered
- using existing documents and findings from other sources (including NHS QIS and the Health Facilities Scotland Catering Group).⁹

9. Fourteen NHS boards, the State Hospital and the Golden Jubilee National Hospital were included in our study.¹⁰ We surveyed 149 hospitals that provide meals to patients, visitors or staff and also carried out more detailed follow-up work in a sample of 33 hospitals which we had reviewed in the baseline study.¹¹ These sample hospitals are listed in [Appendix 1](#) and are referred to in certain exhibits throughout the report where we show the level of progress that has been achieved.

10. Throughout the report we provide data for the 149 hospitals that provide catering services. Where we have reviewed progress at the sample hospitals included in the baseline study, we make this clear in the text of the report. Where it was possible to compare progress we have given the results for 2003 and 2006. However, it was not possible to directly report on progress at trust level since between 2003 and 2006 the NHS in Scotland restructured from trusts to boards.

11. The rest of this report is organised into three parts. [Part 2](#) reports on progress in meeting the needs and preferences of patients. [Part 3](#) reviews how costs and wastage are being managed. And [Part 4](#) looks at what improvements have been made in the strategic management of catering services.

7 *Food, Fluid and Nutritional Care in Hospitals – Clinical Standards*, NHS QIS, September 2003.

8 *Food, Fluid and Nutritional Care in Hospitals – National Overview*, NHS QIS, August 2006.

9 Health Facilities Scotland is a division of National Services Scotland providing operational guidance to NHS Scotland healthcare bodies on non-clinical topics.

10 Our survey was undertaken between June and August 2006. NHS Argyll and Clyde was dissolved in April 2006 but is included in the analysis of information received prior to that date.

11 The baseline report reviewed a sample of 41 hospitals. The follow-up report reviewed 33 of these to monitor progress.

Part 2. Meeting patients' needs and preferences



Key findings

- Patients are not routinely screened for risk of undernutrition on admission to hospital.
- Not all boards have fully developed systems for ensuring the nutritional balance of patient meals.
- Acute hospitals with long-stay beds operate at least a three-week menu cycle to maintain variety in the meal options for these patients.
- Ninety-seven per cent of hospitals offer at least two meal choices at both lunch and dinner.
- Catering services are using flexible approaches which allow patients to order their food nearer to mealtimes and ensure snacks are available outside mealtimes.

Patients are not routinely screened for risk of undernutrition on admission to hospital

2003 Recommendation: Boards should ensure that patients are screened on admission for risk of undernutrition.

2003 Recommendation: Boards should use a validated screening tool and ensure that staff have been trained in the use of this tool.

12. In this section of the report we use findings from the recent NHS QIS review of food, fluid and nutritional care in hospitals.¹² NHS QIS reviewed this area of patient care under standard two of its clinical standards for food, fluid and nutritional care in hospitals.

13. Although NHS QIS found evidence of progress in screening patients for risk of undernutrition on admission to

hospital, it concluded that no boards were complying with the standard of recording all of the required nutritional information within one day of admission for all of their patients.

14. NHS QIS also reported that boards have not yet fully developed processes for nutritionally assessing, screening and care planning for patients. Once developed, these processes need to be fully implemented across all hospitals. This is an essential step in ensuring appropriate nutritional care for patients and NHS QIS has recommended that this is a priority for all boards.

15. The NHS QIS review also found that most boards were not yet using validated screening tools in all ward areas. Only five boards had started to develop a nutrition awareness, education and training programme which would cover training in the use of validated screening tools.¹³

¹² Food, Fluid and Nutritional Care in Hospitals – National Overview, NHS QIS, August 2006.

¹³ NHS Fife, NHS Forth Valley, Golden Jubilee National Hospital, NHS Tayside and NHS Western Isles.

Not all boards have fully developed systems for ensuring the nutritional balance of patient meals

2003 Recommendation: Boards should ensure that catering specifications comply with the model nutritional guidelines for catering specifications in the public sector in Scotland.

2003 Recommendation: The Departmental Implementation Group should develop or commission national catering and nutrition specifications for the NHS in Scotland.

2003 Recommendation: All menus should be nutritionally analysed.

2003 Recommendation: All catering production units should use standard recipes.

The SEHD has not yet produced a national catering and nutrition specification for the NHS in Scotland but plans to do so in 2007

16. The Scottish Executive Health Department (SEHD) set up a Departmental Implementation Group in 2001 to give advice to the NHS on providing nutritional care in hospitals. This group did not produce a national catering and nutrition specification for the NHS in Scotland which we recommended in our baseline report.¹⁴ In April 2006, the SEHD appointed a national Food and Nutrition Adviser from within the NHS whose role is to produce a national catering and nutrition specification. This is due to be published in April 2007.

Half of boards have catering specifications

17. In the absence of an agreed national specification, boards should still be working to the Scottish Diet Action Plan's recommendation that catering specifications should comply with the model nutritional guidelines for catering specifications in the public sector in Scotland.¹⁵ However, only eight boards have developed catering specifications which comply with the model nutritional guidelines.¹⁶

Three-quarters of hospitals use some standard recipes to provide nutritionally balanced meals

18. Standard recipes ensure that the same ingredients and cooking methods are used each time a menu item is prepared. These should include details of the ingredients to be used, the quantities needed, the method for making the meal and the number of portions of a set size that will be produced.

19. This helps control the costs of ingredients purchased and limits the waste produced in the kitchen. It is also the only way to ensure that the nutritional content of each menu item does not vary from day to day. Standard recipes are therefore necessary to ensure that nutritionally analysed menus deliver balanced nutritional meals to patients.

20. Three-quarters of hospitals are using standard recipes to control the nutritional balance of meals. However, only 58 per cent reported that they used standard recipes for all meals on the menu.

Only seven boards have undertaken a full nutritional analysis of their standard menus

21. Nutritional analysis of menus helps to ensure that patients are provided with nutritionally balanced meals. Half of boards have undertaken an analysis of the nutritional content of each item on the standard menu and seven boards have analysed their entire standard menu to ensure it is nutritionally balanced.¹⁷

22. Nutritional analysis of menus is less likely to have taken place for special diets (Exhibit 1).¹⁸

23. Catering departments and dieticians need to work together to ensure that any changes to menus or recipes are accompanied by an updated nutritional analysis. Boards reported a wide degree of variation in the frequency and accuracy of the nutritional analysis in place. Case study 1 gives an example of the work involved in creating and maintaining nutritionally analysed menus.

Progress is being made but patients' nutritional care is not yet consistently prioritised at ward level

2003 Recommendation: Boards should encourage communication between ward staff and the catering department.

14 A catering and nutrition specification details the service's approach to issues such as nutritional needs, food safety, procurement and menu choice.

15 *Eating for health – A diet action plan for Scotland*, Scottish Office, 1996.

16 NHS Ayrshire and Arran, NHS Dumfries and Galloway, NHS Grampian, NHS Highland, NHS Lanarkshire, NHS Orkney, NHS Shetland and NHS Western Isles have catering specifications which comply with model nutritional guidelines for the public sector.

17 NHS Ayrshire and Arran, NHS Borders, NHS Forth Valley, NHS Grampian, NHS Highland, NHS Lanarkshire, NHS Orkney and the Golden Jubilee National Hospital have undertaken an analysis of each item on their standard menus. These same boards – with the exception of NHS Forth Valley – have also analysed their entire standard menu to ensure it is nutritionally balanced.

18 NHS Highland and NHS Lanarkshire reported that they have fully nutritionally analysed all of their special diet menus.

Exhibit 1

Number of boards with fully nutritionally analysed menus for special diets

Full nutritional analysis of menus is not yet in place across all boards.

Type of menu	Boards with fully analysed menus
Vegetarian	8
Vegan	4
Therapeutic	8
Minority ethnic	5
Children	4
All of the above	2

Source: Audit Scotland survey, June-August 2006¹⁹

Case study 1

NHSTayside

NHSTayside's Nutrition Standards Project was established in 2003 to implement the NHS QIS standards on food, fluid and nutritional care in hospitals. This involved addressing food preparation and producing a core list of dishes for the menu cycles; developing nutritionally analysed dishes from a recipe list with a list of measured ingredients and an explicit method; and seeking the views of staff and patients about the new recipes. A project dietician and a project catering adviser were employed part-time for two years to produce over 600 recipes that were each nutritionally analysed. The recipes were incorporated into individual recipe files for each kitchen in NHSTayside.

Caterers were then asked to use the recipes and feed back their comments to the project team over a three-month period. Patients were also asked to give their views on the meals produced by these recipes by responding to questionnaires. The caterers had difficulties in manually calculating ingredients, resulting in further consultation and testing. The new recipes are due to be implemented by the end of 2006.

Using a dedicated resource to develop the standard recipes was a significant step towards ensuring the use of fully nutritionally analysed menus. However, a number of challenges have been identified:

- Standard recipes involve additional work for chefs to manually calculate ingredients.
- Some areas still prefer established recipes rather than the standard versions which have been tested. However, local variations can be incorporated into the recipe file if they are of acceptable nutritional value.
- Each time a change is made to the ingredients or method of a recipe this requires an updated nutritional analysis to be carried out.
- The nutritional analysis of dishes and menus can only be relied upon if standard recipes are followed by caterers.

¹⁹ The survey included fourteen NHS boards, the State Hospital and the Golden Jubilee National Hospital.

Case study 2

NHS Fife

In addition to a formal protocol for communication between ward and catering staff, NHS Fife catering departments distribute an A-Z directory which covers the main areas of the catering service. The directory gives ward staff an overview of the catering services provided in the hospital. It summarises the main policies and procedures for catering and aims to provide clinical staff with simple to read answers to queries they are likely to have about the catering services.

The directory can be used for training new staff or bank staff and provides a quick reference guide for all staff working on wards.

Communication between ward staff and catering staff has improved

24. The baseline report noted the importance of good communication between ward staff and catering staff as an essential part of providing a quality patient meal service. Our study found that 13 boards have a written protocol for communication between wards and catering departments.²⁰ **Case study 2** gives an example of how catering departments can proactively pass on information to ward staff.

Practices which help patients to eat a nutritious diet while in hospital need to be more widely adopted across all hospitals

25. In 2004, the Hospital Caterers Association and the Royal College of Nursing developed a protected mealtimes policy which recognises the importance of mealtimes and the need to ensure ward staff are able to focus on patients' nutritional care at mealtimes.²¹ The policy recognises the different healthcare environments

and needs at different hospitals but outlines seven objectives for wards adopting the policy:

- to provide mealtimes free from avoidable and unnecessary interruption
- to create a quiet and relaxed atmosphere in which patients have time to enjoy meals, limiting unwanted traffic through the ward during mealtimes, eg, estates work and linen deliveries
- to recognise and support the social aspects of eating
- to provide an environment conducive to eating, that is welcoming, clean and tidy
- to limit ward-based activities, both clinical (eg, drug rounds) and non-clinical (eg, cleaning tasks) to those that are relevant to mealtimes or 'essential' to undertake at that time

- to focus ward activities on the service of food, providing patients with support at mealtimes
- to emphasise to all staff, patients and visitors the importance of mealtimes as part of care and treatment for patients.

26. Less than a quarter of hospitals reported that they are operating protected mealtimes policies. Our ward observations indicated that there is variation in the extent to which they have been implemented at ward level.

27. Difficulty in prioritising the nutritional care of patients was highlighted in a recent survey commissioned by Age Concern.²² This found that nine out of ten nurses reported that they do not always have time to help patients who need assistance with eating. These findings are consistent with our own ward observations and underline the need to ensure that ward managers

20 NHS Shetland, NHS Tayside and the Golden Jubilee National Hospital do not have written protocols for communication between wards and catering departments.

21 <http://www.hospitalcaterers.org/pages/Library/protmealpol.html>.

22 ICM Research interviewed a sample of 500 nurses across Britain between 3-7 August 2006.

schedule enough time to prioritise the nutritional needs of patients.

All boards have systems in place to offer patients choice and to cater for patients with special dietary needs

2003 Recommendation: Acute hospitals with long-stay beds should ensure that they have a three-week menu cycle, at least for these patients.

2003 Recommendation: Menus should be reviewed to ensure that they offer sufficient choice to all patient groups. Where it is necessary, separate menus should be developed for ethnic meals and other special diets.

2003 Recommendation: All menus should be dietary coded to help patients make an informed choice.

Acute hospitals with long-stay beds operate at least a three-week menu cycle to maintain variety in the meal options for these patients

28. In 2000, a report by the Clinical Resource and Audit Group (CRAG) into the nutrition of elderly people in long-term care recommended that elderly patients in long-stay wards should have at least a three-week menu cycle to avoid patients getting bored of the same menu choices on too regular a basis.²³ A report by Age Concern notes that this recommendation should be balanced by the observation that many people enjoy a simple diet at home and may not want to try new meals during their time in hospital.²⁴ As a result, hospitals should provide a long menu cycle to avoid patients facing the same choices too often but also need to be flexible to provide favourite meals in line with patient preferences.

29. Our survey found that 93 per cent of hospitals with long-stay beds were operating a menu cycle of at least three weeks.

Ninety-seven per cent of hospitals offer at least two meal choices at both lunch and dinner

30. Choice is an important factor in encouraging patients to maintain a balanced nutritional diet while in hospital. Ninety-seven per cent of hospitals offer at least two main meal choices at both lunch and dinner for patients ordering from the standard menu.

Boards have systems in place to cater for patients with special dietary needs and preferences

31. Boards reported that they are catering for an increasing number of patients with special diets. Therefore the meals available should provide sufficient choice to meet these dietary needs and preferences. Nine out of ten hospitals provide menu options for vegetarian patients. Half of hospitals offer cultural or religious belief meals from the menu and a third offer a menu option for vegan patients.

32. Although many hospitals do not offer these meals from the daily menus, there was evidence that all hospitals (with the exception of New Craigs Hospital) have systems in place to offer choice to patients with special dietary needs and preferences. A flexible approach has been adopted by hospitals across Scotland to reflect the different demography of the populations served. Many hospitals have developed their systems to reflect their patient populations and do not put menu items for all special diets on the menu every day as this would have implications on cost and waste. This is discussed further in [Part 3](#). However, they have arrangements in

place to ensure that they are able to provide for special diets where these are identified at ward level.

Three-quarters of hospitals code their menus to help patients with special dietary needs select meals

33. In order to help patients make an informed choice about their meals, menus can be coded to make it clear whether they are suitable for vegetarians, patients on therapeutic diets, patients with allergies, or patients with eating or swallowing difficulties. Three-quarters of hospitals are coding their menus with this information.

Catering services are offering an improved level of choice to patients

2003 Recommendation: Boards should remind all their staff of the procedures for offering, ordering and delivering meals and in particular meals for patients who require a special diet.

2003 Recommendation: All catering services should aim to have patients ordering their meals as close to the meal time as possible and no more than two meals in advance.

Boards ensure that staff are aware of processes for providing meals to patients

34. NHS QIS found that all boards ensure that staff who are in contact with patients' food are aware of: the local protocol or processes for ordering and delivering food and drinks; meal and snack times; and procedures for ordering missed meals. This is achieved through local induction programmes and ward orientation as well as the use of posters, information leaflets and guides which remind staff of this information.²⁵

²³ *The nutrition of elderly people and nutritional aspects of their care in long-term care settings*, Clinical Resource and Audit Group (CRAG), August 2000.

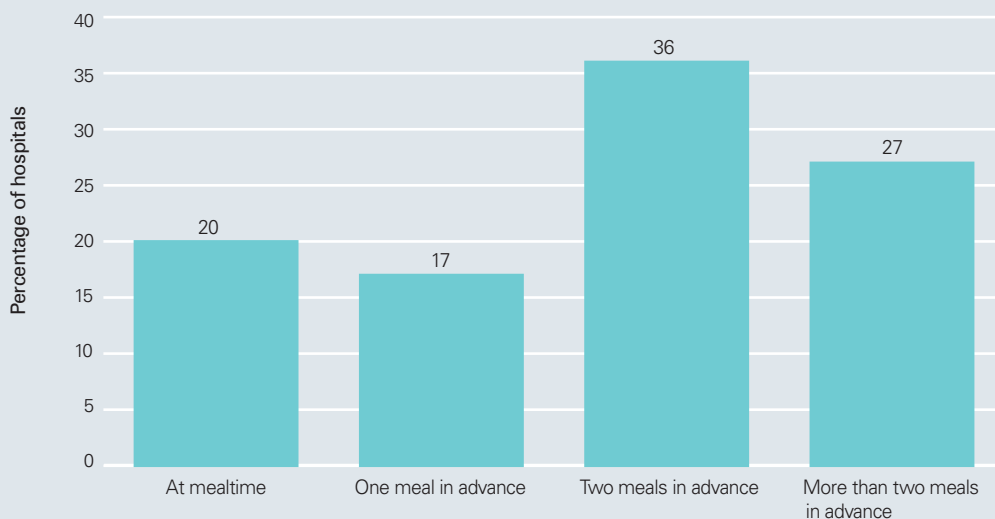
²⁴ *Hungry to be Heard: The scandal of malnourished older people in hospital*, Age Concern, August 2006.

²⁵ *Food, Fluid and Nutritional Care in Hospitals – National Overview*, NHS QIS, August 2006.

Exhibit 2

Percentage of hospitals ordering meals in advance of the mealtime

Three-quarters of hospitals allow patients to order food two meals or less in advance of the mealtime.



Source: Audit Scotland survey, June-August 2006

Almost all hospitals offer patients a range of portion sizes

35. Giving patients the opportunity to pick the amount of food they want increases the choice available and allows them to reflect their normal eating preferences. When at home, some patients would normally have only a light lunch and then have their main meal at dinner time or vice versa. Hospital catering should be flexible to try to match individual eating patterns.

36. Our survey found that all hospitals (with the exception of New Craigs Hospital) offer a range of portion sizes for menu items. This gives each patient the opportunity to choose an amount of food to match his or her appetite. The range of portion sizes available to patients should be quantified in all standard recipes and nutritional analysis of menu items (discussed in paragraphs 18-23) to ensure that these analyses provide an accurate assessment of nutritional intake.

37. If portion sizes are selected and ordered in advance then catering departments can produce the correct amount of food, but patients' appetites may change between ordering the food and the mealtime. This can result in more food being left uneaten by patients (plate wastage). However, if portion size is selected at the mealtime then catering departments will not know how many patients want large portions and will have to estimate how much food will be needed. This can result in surplus food being sent to wards to ensure that all patients are given a choice (wastage in unserved meals). Therefore, giving choice to patients over the size of the portion they want can also affect the level of wastage.

Snacks are available to patients outside normal mealtimes

38. Due to clinical activity taking place throughout the day, some patients will miss mealtimes. Similarly, medication may affect patients' appetite or clinical symptoms may mean that patients

are not able to eat at regular mealtimes. It is therefore important that hospitals respond to these needs and are flexible about providing snacks outwith normal mealtimes.

39. In 95 per cent of hospitals, wards are able to provide snacks for patients either to supplement mealtimes or to compensate where meals have been missed. We also found that 85 per cent of hospitals were able to offer patients snacks prepared in the catering department outwith normal mealtimes.

Patients in three-quarters of hospitals can order their meals two meals or less in advance

40. Our baseline report recommended that patients should be given the chance to order their meals no more than two meals in advance of the mealtime.²⁶ Exhibit 2 shows that 73 per cent of hospitals are now achieving this, with 20 per cent providing choice as the meal is served. Less than half of the hospitals reviewed in 2003 were operating in this way.

Boards have some processes in place to seek patients' views on catering services

2003 Recommendation: Boards should ensure that they obtain patients' views on the catering service through the introduction of regular (at least quarterly) patient satisfaction surveys.

A standard survey has been developed by the Health Facilities Scotland Catering Group

41. In January 2006, the Health Facilities Scotland Catering Group agreed the format of a patient satisfaction questionnaire. This aimed to standardise the questions asked in each board and allow better comparison of information on patient satisfaction. All boards have made a commitment to carry out the survey annually and share the results.

Only 30 per cent of hospitals are regularly monitoring patient satisfaction with hospital catering through patient surveys

42. The progress made in developing a standard survey for all boards is not yet reflected in a coordinated approach at hospital level. Almost a fifth of hospitals are not using patient satisfaction surveys at all. In the hospitals that are using patient surveys, the frequency of gaining patient feedback varies widely ([Exhibit 3, overleaf](#)). Regular monitoring of patient satisfaction is essential if patients' views are to be used to improve service delivery. But only 30 per cent of hospitals are meeting our baseline recommendation that patient satisfaction surveys should take place at least once every three months.

43. However, we did find areas of good practice where boards are developing comprehensive systems for gaining patient feedback and using this to

improve the quality of services both in kitchens and on wards. An example of this is given in [Case study 3 \(overleaf\)](#).

44. A variety of other patient feedback systems are in place at local level. Four-fifths of hospitals are using other systems such as patient forums or individual interviews in place of a patient survey or to supplement their findings. But 11 hospitals (seven per cent) do not have any systems in place to gather or act on patients' views on hospital catering.²⁷

45. Another indicator of patient satisfaction is the amount of food returned uneaten on patients' plates. This measure can be influenced by a number of factors, such as loss of appetite caused by medication or symptoms of illness, but could be linked with other patient feedback systems to provide a more complete picture of the level of satisfaction with the food provided.

Some hospitals are exploring innovative ways of encouraging all patient groups to be able to give their views on hospital food

46. Some boards have undertaken innovative work to ensure that the methods used to record patients' views are appropriate to the client group. For example, patients with learning difficulties may find it difficult to complete a questionnaire but trained staff can discuss satisfaction levels with patients in an informal way in order to get their views on catering.

47. We also found examples of patients in long-stay hospitals being encouraged to join catering groups, where patients meet with catering staff on a regular basis to raise and discuss issues with the service ([Case study 4, overleaf](#)). Patients are encouraged to raise issues by putting concerns on the agenda for these

meetings and then discussing these directly with catering staff. The minutes of these meetings record where actions are agreed to improve services as a result of the issues raised.

Recommendations

- Nutritional screening of all patients on admission to hospital should be a priority for all boards.
- Boards should put protected mealtimes policies in place to ensure that mealtimes are free from non-essential clinical activity and that there are enough staff on wards to help all patients eat a nutritious diet while in hospital.
- The SEHD should ensure that the catering and nutrition specification is published in 2007 as planned.
- All boards should ensure that standard recipes are used for all meals. These should detail ingredients, quantities, cooking method and the expected number of portions. The SEHD should consider developing a national database of standard recipes for the NHS in Scotland to promote this.
- Catering departments and dieticians should work together to ensure that all menus are fully nutritionally analysed and updated whenever any changes are made to recipes or menus.
- All boards should regularly monitor patient feedback and use this as part of quality improvement. This can be achieved through methods such as patient satisfaction surveys, monitoring plate wastage and reviewing feedback from carers.

27 Arbroath Infirmary, Blairgowrie Community Hospital, Crieff Community Hospital, Irvine Memorial Hospital, Little Cairnie Hospital, Royal Dundee Liff Hospital, Royal Victoria Hospital, St Margaret's Hospital, Stracathro Hospital, Strathmartine Hospital and Whitehalls Health & Community Care Centre do not have systems to gather patients' views on catering services.

Exhibit 3

Frequency of gathering patient feedback through surveys

Thirty per cent of hospitals are gathering patient feedback through surveys at least four times each year.

Frequency of patient satisfaction surveys	Number of hospitals
At least once every three months	45
Once every six months	14
Once every 12 months	30
No set frequency	33
Never	27

Source: Audit Scotland survey, June-August 2006

Case study 3

NHS Lanarkshire

The Property Support Services Department has worked with the Dietetics, Patient Affairs and Clinical Effectiveness departments to develop a patient catering opinion survey. The survey is issued quarterly and covers all 17 hospitals including both acute and primary care. The survey analyses quality in three key areas: patient meals; service; and therapeutic and special diet meals.

Patients can comment on breakfast, lunch and evening meals. A detailed analysis of responses allows for targeted service improvement in each of these three areas.

As the system continues to be developed, in conjunction with the Clinical Effectiveness Department, the results of the surveys will be made available to staff via the Intranet. Information will be available to be viewed at ward or hospital level enabling managers, catering staff, dieticians and ward staff to analyse the results relevant to their work.

Case study 4

The State Hospital

At the State Hospital, members of the catering and dietetic staff meet with patient representatives on a regular basis in a subgroup of the Patient Partnership Group. This group gives patients an opportunity to raise concerns about meals provided and discuss ideas for improvement.

Topics discussed by the group include the quality of particular menu items, the availability of fresh fruit, the provision of kosher diets and the size of food portions. Catering and dietetic staff give a direct response to the issues raised and either change the services provided to take account of these or else explain why this is not possible.

The minutes of these meetings record agreement on any further action that is needed to resolve the issues discussed. This enables patients who attend the group to monitor progress against the commitments made to service improvement.

Part 3. Financial management



Key findings

- Catering costs have risen by a third since the baseline. Catering staff costs have risen due in part to the low pay agreement, whereas the costs of food and beverages per patient day have remained stable.
- Hospital catering costs have risen more slowly than other operating costs. There remains wide variation in the amount spent on catering services across boards.
- Catering services for NHS staff and visitors are not breaking even.
- Boards have reduced the number of unserved meals that are wasted.

Hospital catering costs have risen more slowly than other operating costs

2003 Recommendation: Boards should ensure that they have appropriate financial information on the catering service to allow informed decision-making.

2003 Recommendation: Boards should base their catering budgets on the most recent, relevant and accurate information available.

Spending on catering has risen by a third since our baseline report

48. In 2004/05, the NHS spent £73 million on catering services in Scottish hospitals.²⁸ Spending on catering services has risen by 33 per cent since the baseline report. **Exhibit 4 (overleaf)** shows that most of this increase took place between 2002/03 and 2003/04 and is due in part to the low pay agreement introduced at that time.²⁹

49. Catering costs have risen more slowly than other operating costs. Between 2003/04 and 2004/05, spending on catering rose by 1.8 per cent (this was less than the rate of inflation).³⁰ Over the same period the total operating costs for the hospital sector rose by 11.1 per cent.³¹

There remains wide variation in the amount spent on catering services

50. The average catering costs per inpatient week vary from £42 in NHS Highland to £280 at the Golden Jubilee National Hospital. **Exhibit 5 (overleaf)** shows that catering costs per inpatient week are much higher in Orkney, Shetland and the Golden Jubilee than in the other boards but this is due in part to the smaller amount of inpatient activity in these areas. In the other 14 boards where inpatient activity is higher, the catering costs per inpatient week still vary from £42 to £68.

28 *Scottish Health Services Costs*, year ended 31 March 2005, ISD.

29 *NHSScotland – Low Pay Agreement*, SEHD HDL (2003) 15.

30 *Hospital & Community Health Services pay and price index*, Department of Health, 2006.

31 *Scottish Health Services Costs*, years ending 31 March 2004 and 31 March 2005, ISD.

Exhibit 4

Catering services costs between 2001/02 and 2004/05

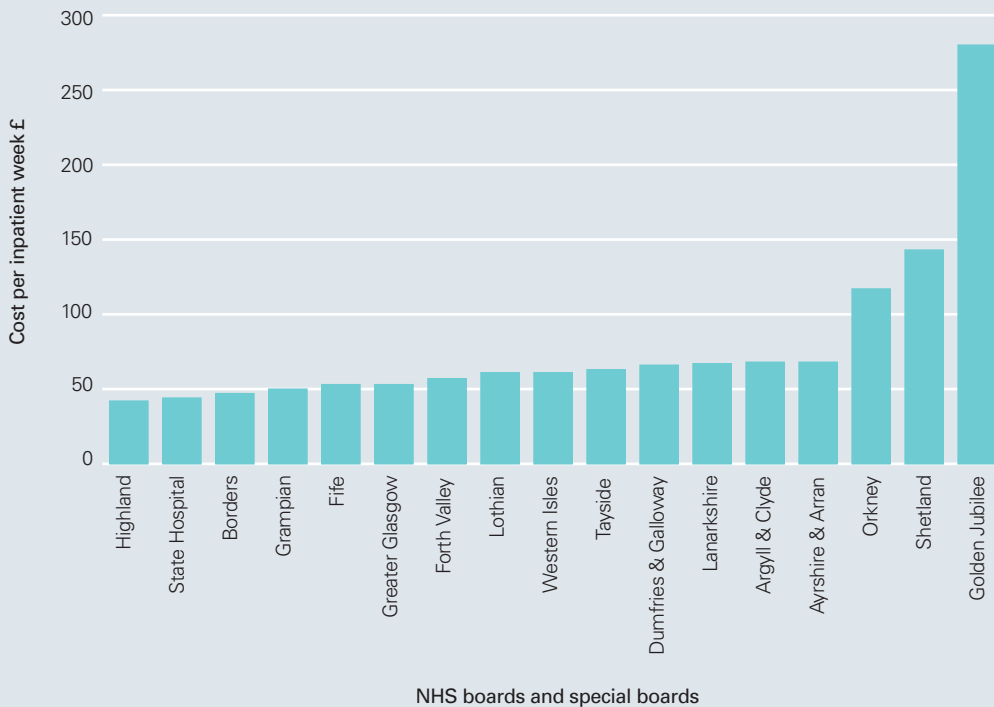
Year	Spending (£000)	Number of patient consumer weeks	Cost per patient consumer week (£)
2001-02	54,717	1,350,623	40.5
2002-03	59,249	1,304,046	45
2003-04	71,742	1,281,093	56
2004-05	73,017	1,234,322	59

Source: *Scottish Health Services Costs*, ISD

Exhibit 5

Boards' catering costs per inpatient week, 2004/05

Costs per inpatient week vary across boards.



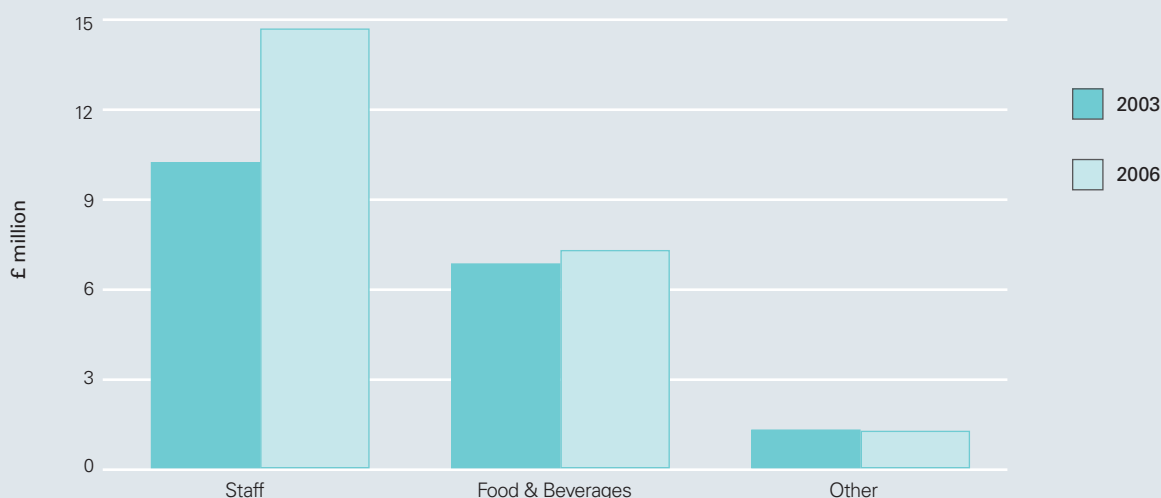
Source: *Scottish Health Services Costs*, year ended 31 March 2005, ISD³²

32 An error in NHS Lanarkshire's accounts meant that the catering costs for 2004/05 were overstated by £554,000 at Monklands Hospital. The revised figure for NHS Lanarkshire would be £62 per inpatient week.

Exhibit 6

Comparison of components of total cost 2001/02 and 2005/06

Catering staff costs have increased more quickly than the costs of food and beverages.



Source: Audit Scotland survey, June-August 2006³³

Catering staff costs have risen more quickly than the costs of food and beverages

51. In the small sample of hospitals we reviewed, staffing accounts for the largest part of catering costs. Since our baseline report, their catering staff costs have risen by 44 per cent, due mainly to the introduction of the low pay agreement. Over the same period, spending on food and beverages increased by seven per cent. The actual changes in costs for the sample hospitals reviewed are shown in Exhibit 6.

52. The number of staff employed in catering departments has remained relatively constant at around 2,150 whole time equivalent (WTE) between 2001/02 and 2004/05. One factor that increased catering staff costs was the introduction of the low pay agreement in 2003. Under this no NHS employee would earn less than £5.18 per hour and overtime rates took effect after

37.5 hours instead of 39 hours.³⁴ However, any increase in staff costs due to the new terms and conditions for staff currently being implemented under Agenda for Change are not yet included in these figures.³⁵

There has been little change in the cost of food and beverages per patient day

53. The cost of patients' food and beverages per patient day in the sample of hospitals we reviewed has remained the same. Exhibit 7 (overleaf) shows the cost of patients' food and beverages per patient day in 2005/06 for 21 of the sample hospitals reviewed. Although these costs vary among hospitals, the average level for the sample hospitals where we can compare across both years rose from £2.23 in 2001/02 to £2.34 in 2005/06.³⁶ This rise is lower than the rate of inflation over the same period.³⁷

54. Boards reported that the continued use of national contracts

to purchase food and beverages played a key role in managing the increase in these costs.

Catering services for NHS staff and visitors are not breaking even

2003 Recommendation: All catering departments should have systems in place which allow them to accurately calculate the costs of providing patient and non-patient catering.

2003 Recommendation: Boards should set pricing policies and income generation targets that aim to at least break even on non-patient catering activities or have a clear stated policy on the level and cost of subsidisation.

The extent to which boards are subsidising non-patient catering is becoming more transparent

55. Most hospitals provide catering for NHS staff and visitors – this is known

³³ These results are based on a sample of 15 hospitals which provided financial information for 2001/02 and 2005/06.

³⁴ *NHSScotland – Low Pay Agreement*, SEHD HDL (2003) 15.

³⁵ Once boards have implemented new terms and conditions under Agenda for Change, these will be backdated to October 2004.

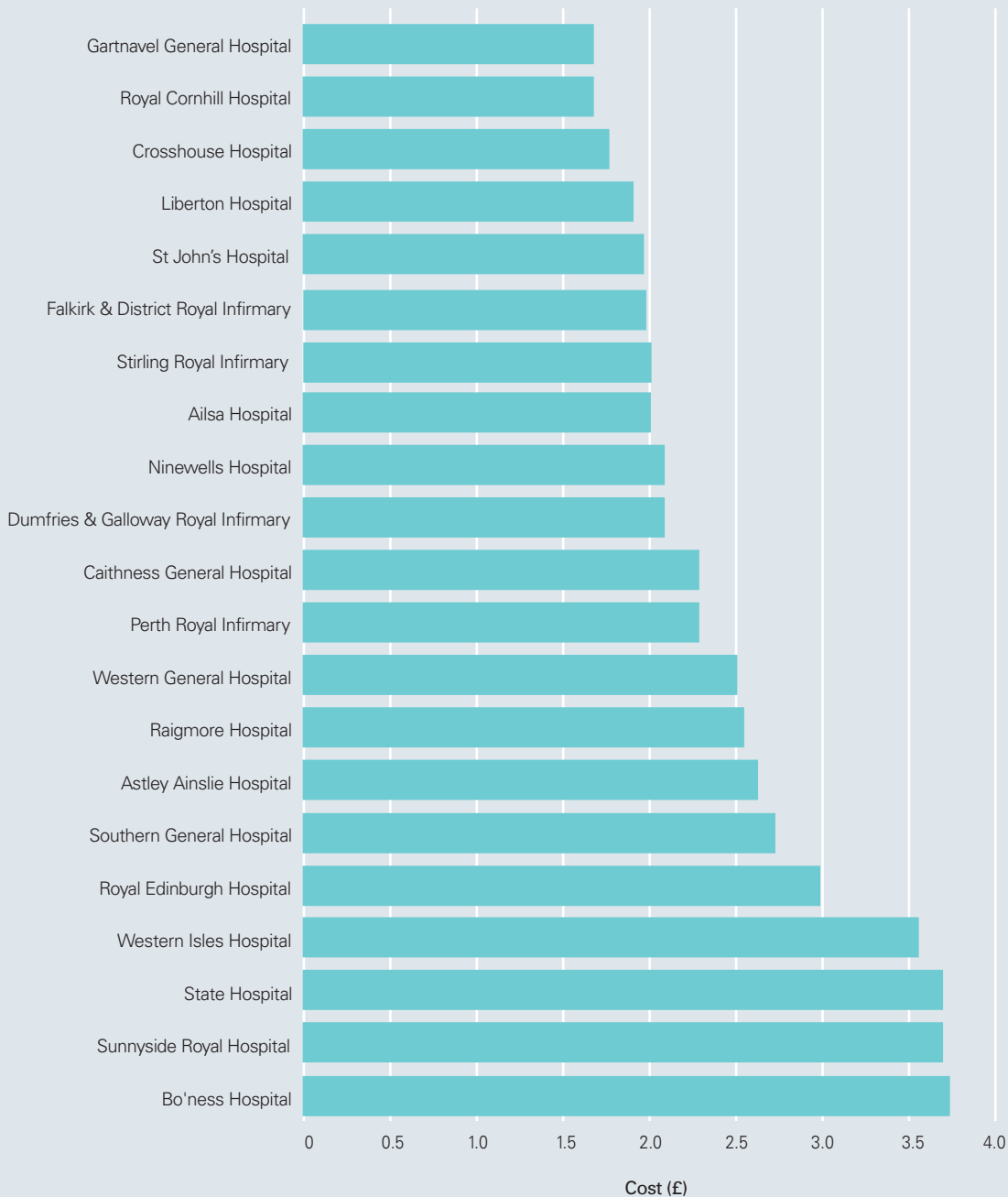
³⁶ Based on 19 of the sample hospitals which returned this information for 2001/02 and 2005/06.

³⁷ *Hospital & Community Health Services pay and price index*, Department of Health, 2006. This reports a non-pay price increase of 5.5 per cent over this period.

Exhibit 7

Cost of patients' food and beverages per patient day, 2005/06

Spending on patients' food and beverages varies among hospitals.



Source: Audit Scotland survey, June-August 2006

as non-patient catering. In July 2005, the SEHD issued guidance which requires that non-patient catering activities must now at least break even or NHS bodies should have a clear, written policy on the level and costs of subsidisation.³⁸ The guidance requires boards to produce trading accounts in 2006/07 for each catering department showing if non-patient catering is:

- breaking even against the budget
- budgeting for anticipated wage increases
- contributing to overhead costs such as training, travel, hardware and crockery
- being subsidised, and if so to provide clear justification for subsidisation.

56. We found that half of boards are operating trading accounts for all their catering departments.³⁹ Eighty-nine hospitals reported that they could split the costs of patient and non-patient catering services. Of these, 40 hospitals reported that they were subsidising non-patient meals and 32 hospitals reported that they were not subsidising non-patient meals. Fourteen hospitals reported that they did not know if they were subsidising non-patient catering services and three hospitals used private contractors who would not provide this information.

Boards are still subsidising non-patient services

57. A year after the SEHD issued its guidance, half of boards have a policy on subsidisation of non-patient catering services.⁴⁰ Only seven boards

have clearly defined pricing policies and income generation targets which aim to at least break even.⁴¹ Exhibit 8 (overleaf) shows the level of contribution or subsidy achieved in 2005/06 for the sample of hospitals who returned this information.

58. Boards reported that price increases will be necessary to reduce these subsidy levels. However, they also reported that where prices had been increased too quickly this had resulted in opposition from Partnership Forums or a reduction in the number of staff using hospital catering facilities.

Boards have reduced wastage due to unserved meals

2003 Recommendation: All hospitals should aim to reduce the level of ward wastage (unserved meals) to ten per cent.

Two-thirds of hospitals are monitoring wastage against targets

59. Food waste has an effect on the cost of catering services and unnecessary waste should therefore be kept to a minimum. Since the baseline report, boards have been required to have waste management procedures to monitor and reduce waste.⁴² However, wastage is also linked to the amount of choice available to patients. It can be affected by the number of options on the menu as well as how far in advance meals are ordered. For example, allowing patients to choose their meal at the mealtime rather than 24 hours in advance should mean that the meal will better reflect their preference at that time. But in order to provide that level of choice, extra meals have to be produced to give all patients choice.

Wastage levels need to be managed to balance the cost implications with the quality of the service offered.

60. Wastage can occur in production (kitchen wastage), in the wards (unserved meals), or in uneaten food left by patients (plate wastage). Monitoring wastage levels at these three stages provides hospitals with useful information to help control costs and understand patients' preferences. Twelve boards have set wastage targets ranging from zero per cent to 12 per cent and two-thirds of hospitals are monitoring wastage against these targets.

There has been a significant reduction in wastage due to unserved meals

61. Exhibit 9 (page 19) shows the change in wastage levels recorded for unserved meals for the hospitals reviewed in 2003 compared with 2006. Seventy-five per cent of the hospitals in this sample have reduced their wastage levels and 21 of the 24 have achieved the recommended target wastage level of ten per cent.

Recommendations

- Boards should set pricing policies and income generation targets that aim to at least break even on non-patient catering activities or have a clear stated policy on the level and cost of subsidisation.
- All boards should continue to monitor and control wastage. All hospitals should reduce or maintain ward wastage at below ten per cent.

38 *NHSScotland: Guidance on charging for non-patient catering and the production of catering trading accounts*, SEHD HDL (2005) 31.

39 NHS Ayrshire and Arran, NHS Fife, NHS Grampian, NHS Orkney, NHS Tayside, NHS Western Isles, the Golden Jubilee National Hospital and the State Hospital are operating trading accounts for all their catering departments.

40 NHS Ayrshire and Arran, NHS Dumfries and Galloway, NHS Grampian, NHS Greater Glasgow and Clyde, NHS Lanarkshire, NHS Orkney, NHS Western Isles and the Golden Jubilee National Hospital have policies on the subsidisation of non-patient catering services.

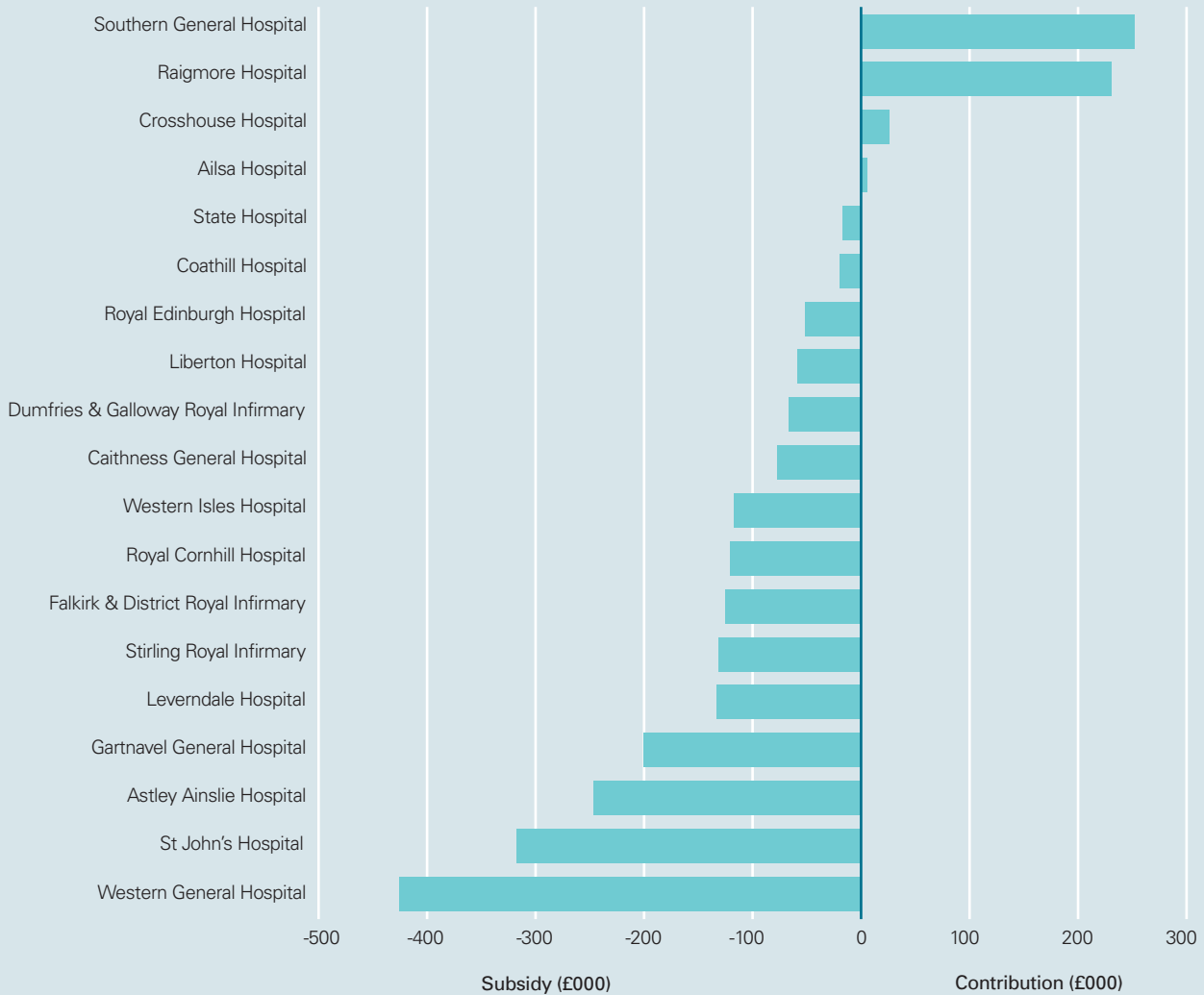
41 NHS Ayrshire and Arran, NHS Borders, NHS Greater Glasgow and Clyde, NHS Highland, NHS Lanarkshire, NHS Lothian and NHS Western Isles have clearly defined pricing policies and income generation targets which aim to at least break even.

42 *NHSScotland: Guidance on charging for non-patient catering and the production of catering trading accounts*, SEHD HDL (2005) 31.

Exhibit 8

Contribution or subsidy level of non-patient catering services, 2005/06

Nearly two-thirds of the sample hospitals are still subsidising non-patient catering.



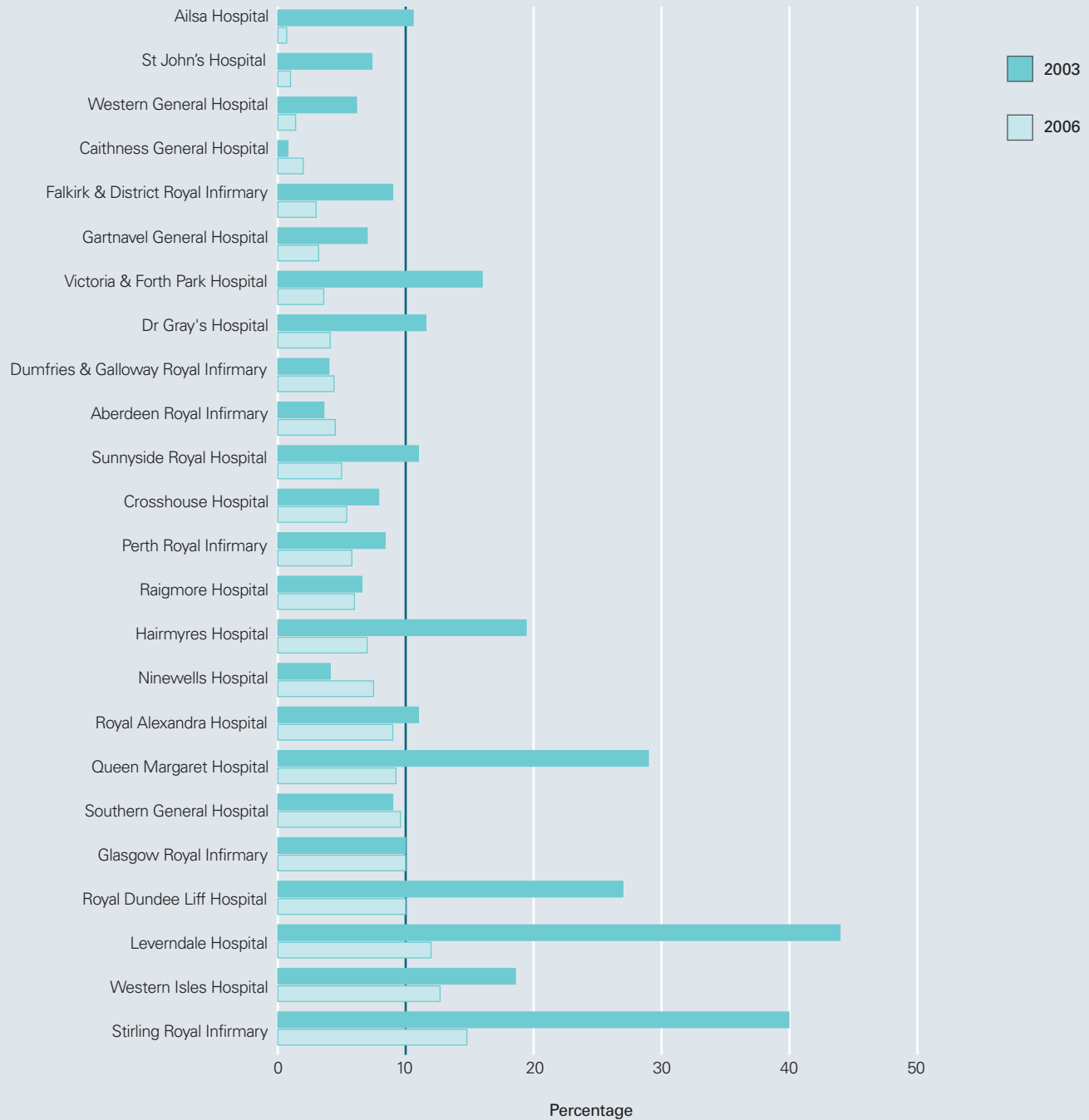
Source: Audit Scotland survey, June-August 2006⁴³

43 Based on 19 of the sample hospitals which returned this information.

Exhibit 9

Comparison of wastage measured in unserved meals on wards in 2003 and 2006

The level of wastage measured in unserved meals has reduced.



Source: Audit Scotland survey, June-August 2006⁴⁴

44 Based on 24 of the sample hospitals who returned this information in both 2003 and 2006.

Part 4. Strategic management



Key findings

- Catering services are becoming a higher strategic priority for boards.
- Catering staff vacancy rates remain high.
- Agenda for Change has not resulted in standard job descriptions or pay grades for catering staff in different boards.
- A fully functioning national eProcurement system for catering is not yet in place across the NHS in Scotland.

Catering services are becoming more of a strategic priority at board level

2003 Recommendation: Boards should ensure that a clear strategy has been approved for the future provision of catering services where other services are being reconfigured.

2003 Recommendation: All boards should have a food and health policy in line with the Diet Action Plan for Scotland.

Eight boards have a clear written strategy for the future provision of catering

62. There has been an increase in the number of boards with a catering strategy since the baseline report. Eight boards now have a catering strategy, although only seven are

monitoring progress against their strategies.⁴⁵ Five boards have still to develop a food and health policy in line with the Diet Action Plan for Scotland.⁴⁶

63. In 2000, the government gave most public authorities in Britain a legal duty to promote race equality. As part of this duty, public bodies, including NHS boards, should assess and monitor policies for any effects they might have on people from different racial groups.⁴⁷ A race equality impact assessment systematically assesses the possible effects that a policy may have on people depending on their racial group. Although boards showed evidence of responsiveness to equality issues at an operational level, only four had carried out an equality impact assessment of their board's strategic catering documents.⁴⁸

45 NHS Ayrshire and Arran, NHS Dumfries and Galloway, NHS Forth Valley, NHS Grampian, NHS Lanarkshire, NHS Shetland, NHS Western Isles and the State Hospital have catering strategies (the State Hospital is not yet monitoring progress against their strategy).

46 NHS Dumfries and Galloway, NHS Forth Valley, NHS Highland, NHS Tayside and the Golden Jubilee National Hospital do not have food and health policies in line with the Diet Action Plan for Scotland.

47 The Race Relations Act 1976, as amended by the Race Relations (Amendment) Act 2000, gives public authorities a statutory general duty to promote race equality.

48 NHS Ayrshire and Arran, NHS Dumfries and Galloway, NHS Shetland and NHS Western Isles have carried out an equality impact assessment on their catering strategy.

64. Boards have developed work on catering strategies alongside, or as part of, nutritional care strategies. NHS QIS found that three-quarters of boards had started the process of developing and implementing a nutritional care policy and strategic plan. While progress has been slow, all boards now have nutritional care groups in place which are central to the further development and implementation of catering and nutritional care at a strategic level.⁴⁹

Catering staff vacancy rates and sickness absence rates remain high

2003 Recommendation: Boards should monitor staff vacancy and turnover rates on a regular basis.

2003 Recommendation: Staff vacancy and turnover rates are high in some areas. Where this is the case, boards should take action to address these issues.

Staff vacancy rates have reduced but remain high

65. All boards except NHS Grampian are formally monitoring sickness absence and staff vacancy rates for catering staff. Catering staff vacancy rates across the sample hospitals are on average two per cent lower than in 2001/02 but remain high at 7.8 per cent. [Exhibit 10 \(overleaf\)](#) shows that there are large differences in vacancy levels among the sample hospitals. Some boards reported that vacancies were being held open to allow for future flexibility in staff changes without the need for redundancies. Boards also reported that high turnover rates were closely linked to unsociable hours worked on backshift and to the repetitive nature of some of the jobs involved.

Catering staff sickness absence rates are still high

66. The average level of sickness absence in the sample of hospitals we reviewed has remained at the same level as it was three years ago (7.2 per cent). [Exhibit 11 \(page 23\)](#) shows there have been large changes in sickness absence levels in some of these hospitals but this may be due to the small number of staff employed in some catering departments. Where sickness levels are high, boards reported that long-term sickness absence was a contributing factor. Some boards have introduced more robust sickness absence policies accompanied by return-to-work interviews to manage sickness absence rates.

A Facilities Management System which aims to provide managers with regular monitoring reports on catering services is being piloted in Tayside

67. In 2005, NHS Tayside received £220,000 from the SEHD to develop a national Facilities Management System (FMS) for the NHS in Scotland. The first phase of the system, covering financial and operational key performance indicators (KPIs), is due to be rolled out in NHS Tayside in November 2006. The FMS provides access to management information on the intranet, via NHSnet, allowing service managers, board directors and the SEHD to access and analyse information at an appropriate level. Monthly monitoring of the KPIs such as financial reports, sickness absence, overtime, headcount, staff turnover and vacancy can be compared against previous years and benchmarked against other hospitals. The benchmarking tool is dependent on the successful roll-out of the FMS across Scotland.

68. The FMS is a potential tool for managers to use to systematically analyse many of the key indicators reported in this review. The system has the potential to assist in the regular monitoring of performance to improve decision-making at an operational and strategic level. However, it will be dependent on the quality of the data recorded in other computer systems such as the Scottish Workforce Information Standard System (SWISS) and PECOS.⁵⁰

Implementation of Agenda for Change varies among boards

69. Catering staff are being given new terms and conditions under the Agenda for Change review. The new terms and conditions cover standard hours, overtime payments, annual leave and basic pay. It also introduces the NHS Knowledge and Skills Framework which links education and development with career and pay progression.

70. NHS Ayrshire and Arran, NHS Orkney, and the State Hospital have not yet changed the terms and conditions of catering staff in line with Agenda for Change. Other boards have changed terms and conditions for catering staff but have not yet evaluated the job descriptions for management, or clerical and administrative staff involved in catering.

71. A benchmarking exercise carried out by the Health Facilities Scotland Catering Group confirmed the results of our interviews which found that Agenda for Change has not resulted in standard job descriptions or pay grades for catering staff across different board areas. For example, head cooks' pay bands vary among boards.

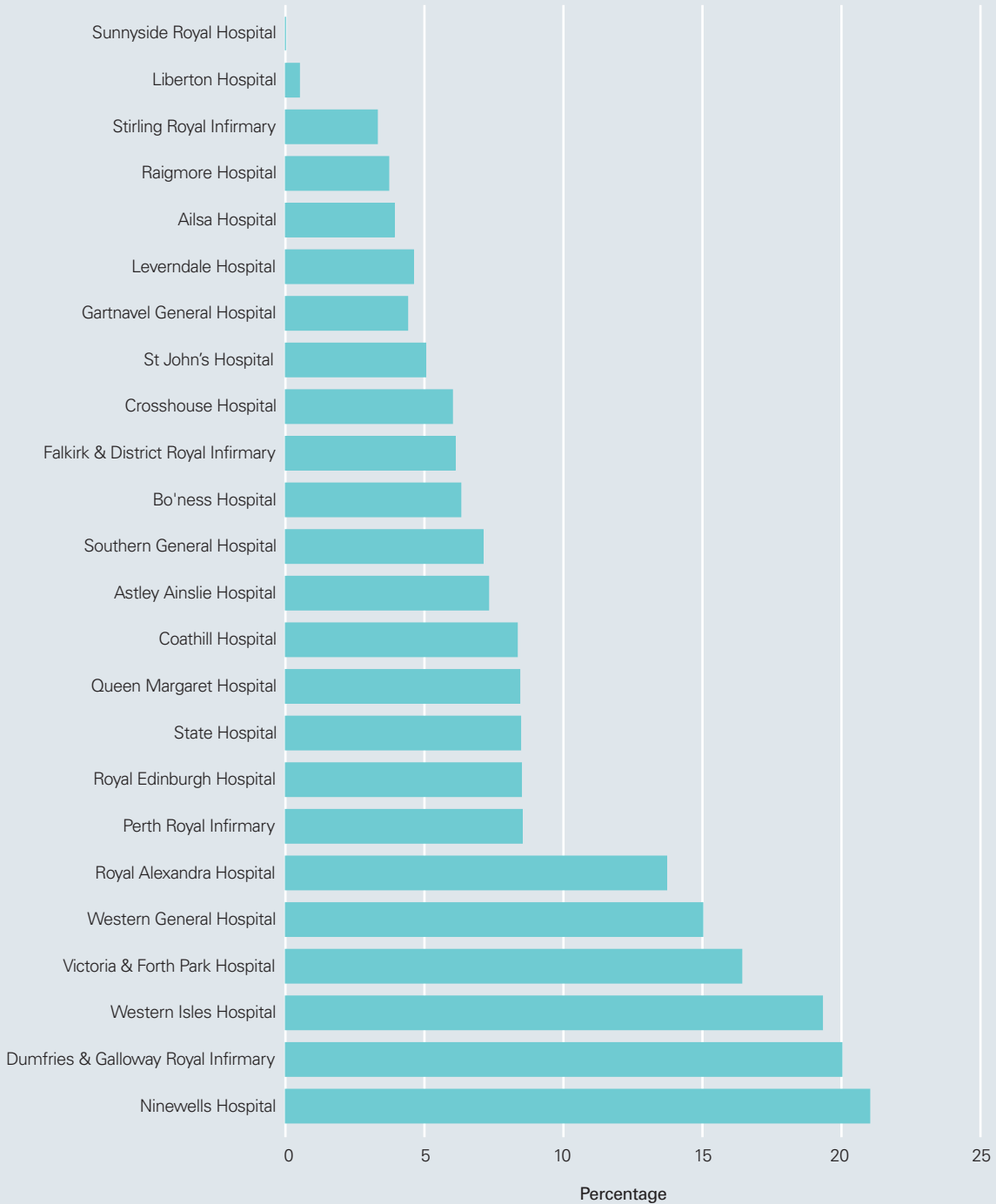
49 *Food, Fluid and Nutritional Care in Hospitals – National Overview*, NHS QIS, August 2006.

50 Professional Electronic Commerce On-line System (PECOS) is an electronic procurement system.

Exhibit 10

Catering staff vacancy rates for 2005/06

Vacancy rates vary among sample hospitals.

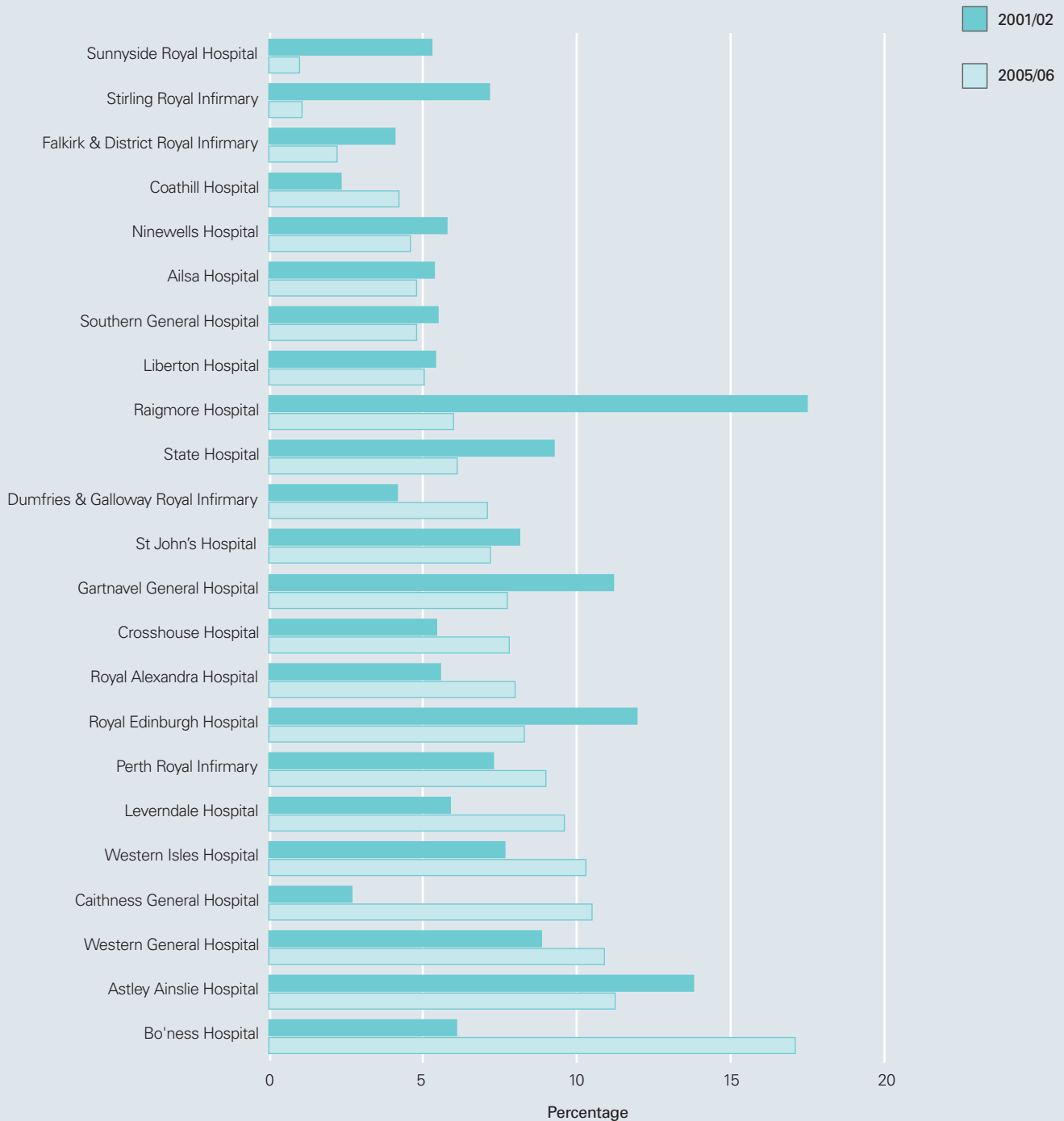


Source: Audit Scotland survey, June-August 2006

Exhibit 11

Catering staff sickness absence rates for 2001/02 and 2005/06

Sickness absence rates remain high.



Source: Audit Scotland survey, June-August 2006⁵¹

51 This is based on 23 of the sample hospitals who returned this information for 2001/02 and 2005/06.

Boards reported that this is affecting staff morale and could lead to further difficulties in recruitment and retention.

Boards have found it difficult to plan for the financial impact of changes to catering staff's terms and conditions under Agenda for Change

72. The financial management of Agenda for Change has been problematic. Boards have had to earmark funding in the knowledge that the Agenda for Change review will alter the pay rates of some staff but without good information on the costs involved.

A fully functioning national eProcurement system for catering is not yet in place across the NHS in Scotland

73. The SEHD has selected eProcurement Scotland as the common procurement service for NHS Scotland. The software Professional Electronic Commerce On-line System (PECOS) is intended to provide users with tools to support procurement with intended benefits including:

- making it easier to monitor contracts
- monitoring performance and spend patterns
- improving the accuracy and ease of maintaining contract items, prices and other data in a secure environment
- reducing costs and process cycle times.

74. However, boards have reported a number of limitations with PECOS which have delayed its progress in

being rolled out across Scotland. Concerns include:

- the slow speed at which the system operated
- problems in using the system which initially could not deal with decimal points
- incomplete and out-of-date lists of suppliers on the system.

75. The intended roll-out of PECOS will have cost implications for boards, therefore, many boards are waiting until the problems have been resolved before making any further investment. As a result, boards are still using different procurement systems and some boards are operating more than one system at different hospitals. This means that many of the intended benefits of PECOS are not yet being realised.

76. Some boards are developing links between their electronic systems for recipes, menus, procurement and finance to provide a more coordinated delivery of catering services. These aim to improve the speed and accuracy of management information.

Boards have the required food safety and hygiene control systems in place

Boards have Hazard Analysis Critical Control Points systems to minimise risks to food safety

77. Hazard Analysis Critical Control Points (HACCP) is a food safety system that identifies the critical control points in food production and preparation processes, and monitors these to ensure that food is safe for consumption. Boards must have HACCP systems in place and the

12 boards that we visited were able to provide evidence of how these systems are operating to manage the risks in areas such as temperature control and food hygiene.

Boards are continuing to meet their statutory requirements in health and safety and food hygiene training

78. NHS QIS found that all boards provide staff who are in contact with patients' food with training in health and safety issues, and food hygiene commensurate with their duties. However, they also reported that difficulties in releasing staff from their duties could reduce the attendance rates on these courses. Overall, boards were meeting their statutory requirements in health and safety and food hygiene training.⁵²

Ninety per cent of boards have food safety manuals and infection control policies which include catering services

79. Our survey found that catering services were included in the food safety manuals and infection control policies of most boards. NHS Lothian and NHS Tayside reported that they do not have a food safety manual in place. And NHS Grampian and NHS Shetland are the only two boards that do not have an infection control policy that covers catering services.⁵³

Boards work with Environmental Health Officers through a programme of regular visits to ensure food safety and hygiene standards are being met

80. Our survey showed that most hospitals are inspected annually by Environmental Health Officers, but where concerns have arisen, the frequency of visits rose in order to ensure that the hospital was taking action to resolve problems.

52 *Food, Fluid and Nutritional Care in Hospitals – National Overview*, NHS QIS, August 2006.

53 NHS Shetland uses private contractors to provide catering services so does not cover catering in its infection control policy.

Recommendations

- Boards should ensure that they have approved a clear strategy for the future provision of catering services.
- All boards should have a food and health policy in line with the Diet Action Plan for Scotland.
- Boards should take action to address issues where catering staff vacancy rates are high.

Part 5. Summary of recommendations



Part 2. Meeting patients' needs and preferences

81. Nutritional screening of all patients on admission to hospital should be a priority for all boards.

82. Boards should put protected mealtimes policies in place to ensure that mealtimes are free from non-essential clinical activity and that there are enough staff on wards to help all patients eat a nutritious diet while in hospital.

83. The SEHD should ensure that the catering and nutrition specification is published in 2007 as planned.

84. All boards should ensure that standard recipes are used for all meals. These should detail ingredients, quantities, cooking method and the expected number of portions. The SEHD should consider developing a national database of standard recipes for the NHS in Scotland to promote this.

85. Catering departments and dieticians should work together to ensure that all menus are fully nutritionally analysed and updated whenever any changes are made to recipes or menus.

86. All boards should regularly monitor patient feedback and use this as part of quality improvement. This can be achieved through methods such as patient satisfaction surveys, monitoring plate wastage and reviewing feedback from carers.

Part 3. Financial management

87. Boards should set pricing policies and income generation targets that aim to at least break even on non-patient catering activities or have a clear stated policy on the level and cost of subsidisation.

88. All boards should continue to monitor and control wastage. All hospitals should reduce or maintain ward wastage at below ten per cent.

Part 4. Strategic management

89. Boards should ensure that they have approved a clear strategy for the future provision of catering services.

90. All boards should have a food and health policy in line with the Diet Action Plan for Scotland.

91. Boards should take action to address issues where catering staff vacancy rates are high.

Appendix 1. Boards and hospitals followed up from baseline

Board	Hospital
NHS Ayrshire & Arran	Crosshouse Hospital Ailsa Hospital
NHS Dumfries & Galloway	Dumfries & Galloway Royal Infirmary
NHS Fife	Queen Margaret Hospital Victoria & Forth Park Hospital
NHS Forth Valley	Stirling Royal Infirmary Falkirk & District Royal Infirmary Bo'ness Hospital
NHS Grampian	Royal Cornhill Hospital Dr Gray's Hospital Aberdeen Royal Infirmary
NHS Greater Glasgow & Clyde	Leverndale Hospital Gartnavel General Hospital Glasgow Royal Infirmary Royal Alexandra Hospital Southern General Hospital
NHS Highland	Raigmore Hospital New Craigs Hospital Caithness General Hospital
NHS Lanarkshire	Wishaw General Hospital Hairmyres Hospital Coathill Hospital
NHS Lothian	Astley Ainslie Hospital Royal Edinburgh Hospital Liberton Hospital Western General Hospital St John's Hospital
State Hospital	State Hospital
NHS Tayside	Royal Dundee Liff Hospital Sunnyside Royal Hospital Perth Royal Infirmary Ninewells Hospital
NHS Western Isles	Western Isles Hospital

Appendix 2. Study advisory group

Members sat on the group in a personal capacity

Kenneth Birrell	Project Manager, NHS Forth Valley Bid Team and Chairperson of the West of Scotland Hospital Caterers Association
David Browning	General Manager, Property and Support Services, NHS Lanarkshire
Lynne Cameron	Section Manager, Scottish Healthcare Supplies, NHS National Services Scotland
Helen Davidson	NHS Scotland Food and Nutrition Adviser, Scottish Executive Health Department
Janice Gillan	Catering Manager, Crosshouse Hospital, NHS Ayrshire & Arran and Co-ordinator of the Catering Sub group of Health Facilities Scotland
Anne Hanley	Review Manager, NHS Quality Improvement Scotland
Caroline Hubbard	Project Dietician, Nutrition Standards Project, NHS Tayside
Myra Keenan	FM Quality Manager, NHS Lothian and Chairperson of the Catering Sub group of Health Facilities Scotland
George Reid	Catering Manager, NHS Grampian
Imran Shariff	Project Manager, Race Equality, NHS Greater Glasgow & Clyde
Derek Walker	Finance Manager, NHS Grampian

Catering for patients

A follow-up report



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