A REVIEW OF HOSPITAL CATERING

King Edward's Hospital Fund for London

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FOREWORD

The Hospital Caterers Association has been pressing for a review of hospital catering for several years. Since the last, 30 years ago, there have been substantial changes in the provision of catering services; the service has become more complex; higher standards are demanded and new technology has necessitated the introduction of new skills. The Association was hopeful that the DHSS would carry out the review. Regretfully we were informed in the Autumn of 1983 that it would be unable to undertake this work.

The Association was anxious that such a review be undertaken. It looked to other prominent bodies, whose views were respected, to support the venture and was delighted when King Edward's Hospital Fund for London agreed to support the venture with a grant, thus enabling an independent committee to be established under the chairmanship of Lady Margaret McCarthy.

The committee, which comprised a cross section of people with interests in or allied to catering in general and the NHS in particular, began its work in late 1984. They have worked with enthusiasm to produce the review and this is reflected in the constructive recommendations made.

The Association recognises that not everyone will agree with all the recommendations. But we have in the following pages a balanced independent review of hospital catering that identifies the need for a change in the approach to the catering service and makes recommendations as to how these changes may be effected.

We wish to place on record our appreciation to the King Edward's Hospital Fund for London for having the foresight to fund the review; to Lady Margaret McCarthy for chairing the review committee so ably; to the members of the committee for their individual contributions; to Miss Amanda Millard for acting as secretary to the committee, and to all those who have contributed in any way to the work of the review committee.

The Association commends the report to authorities and managers in the NHS. They hope it will be used to look afresh at the catering service being provided so that present operations can be reviewed and the quality of service to the customer improved.

Hospital Caterers Association, September 1986

INTRODUCTION

We were invited by the Hospital Caterers' Association (HCA) to undertake a review of hospital catering*. Our terms of reference were:

> Within the framework of an economic and cost effective Catering service, to investigate and report on the perceived needs of patients and staff, with special reference to:
>
> a) nutrition and dietary education
> b) elimination of unnecessary waste
> c) varied and attractive menus
> d) a pleasing and healthy environment

We have had 12 meetings and have made a number of visits to hospitals. Our main source of information has been a questionnaire which was sent to all districts with a request that it should be completed. We received 250 replies, a 25 per cent response which we believe is a sufficiently large sample to be meaningful. The replies covered all regions of the country (with the exception of Northern Ireland), although the percentage of replies received varied considerably from region to region.

The largest single number of questionnaires returned came from Trent which returned 11 per cent; Yorkshire and the West Midlands 9 per cent; North West Thames and the Special Health Authorities 8 per cent; North Western 7 per cent; Oxford and South Western 6 per cent. The other regions returned 5 per cent or less. A copy of the questionnaire is shown at Appendix II.

Our report is divided into two sections. The first is concerned with the catering services provided for patients and staff. The second considers the finance and management systems to support these services. The relevant recommendations of the report are listed at the end of each section. They will, we hope, be seen in the context of our terms of reference.

The review committee received invaluable help and advice in compiling this report from the co-opted advisors whose names appear at Appendix I. The final report and recommendations were drafted by the independent members, and do not necessarily

* Membership of the committee is listed at Appendix I.

reflect the opinions of our advisors. We should like to thank them for all their work. We should particularly like to record our thanks to Amanda Millard who acted as secretary to the committee.

As we were finishing our work and drafting our report, the Report of the Committee of Enquiry into an Outbreak of Food Poisoning at Stanley Royd Hospital was published.* Much of the report does not concern us directly since it relates to specific events at the hospital.

However, the management and financial context in which the particular incidents occurred provides a very clear example of the weaknesses at present in the management of catering, at which we have directed our report. The failures of management are sufficiently well documented for us not to have to repeat them in detail. But it is obvious that there was lack of supervision and training for staff. There was a lack of commitment on the part of management. The Stanley Royd committee indeed make specific comments about the apparent gulf between management and those who work in the kitchen.

It is difficult to see where final responsibility for the catering services lay. The report makes specific mention of the District Catering Advisor's role, pointing out that, since the abolition of functional management at district level, 'his position approached the unenviable one of having responsibilities without power', and that he had lost 'any expenditure power'. The low priority which health authorities give to catering is demonstrated by the way in which the requests for capital to up-grade the kitchen were treated. Such attitudes are demotivating for catering staff and make the provision of good catering services much more difficult to achieve. We think that our report should be read in the context of the Stanley Royd report, since looking broadly at the management of catering in the NHS we have reached many of the same conclusions.

With the growth of 'consumerism' in the NHS, the increasing attention to quality assurance and the publication of the Stanley Royd enquiry there will certainly be more pressure on catering services – whether directly managed or contracted out – to im-

* HMSO 9716, January 1986.

prove their standards. The pressure for improved quality may well lead to answering demands for increased capital and revenue to be spent on kitchen buildings and equipment and for catering managers to be paid a salary which reflects rather more closely comparative rates in the private catering and hotel trade. District health authorities have frequently been reluctant to spend scarce capital on modernising kitchen equipment and up-grading buildings, using as a reason the needs of 'direct patient services'. We would exphasise that catering is a direct patient service and we hope that, with the changing attitudes to quality which we have mentioned, this will be recognised.

Those reading this report will not find any revolutionary ideas, although we hope that they will find much that is useful. Many of our recommendations are, virtually, costless. Many of the actions which we advocate are already part of normal procedures for some health authorities. We do not believe that any health authority is doing everything that we suggest.

We have sought for some published up-to-date guidance to health authorities which will help them to judge the quality of the catering service which they offer to staff and patients, and the performance of their catering managers. We have not found any publication which is generally available, although some regions – notably Wessex – are producing a series of documents designed to fill this gap. We are, therefore, offering this report in the hope that it will help general managers and district health authorities to judge better their catering services.

SECTION 1

Nutrition, patient and staff feeding

NUTRITION

It is now generally accepted that a 'healthy' diet is important in the prevention of cardiovascular and intestinal disorders. As a consequence, people are much more conscious of the need to eat properly. There has been a great deal of literature published on the subject, suggesting the dietary changes which are needed to produce more sensible eating patterns. Because of this we do not intend to rehearse the arguments in detail once more in this report. We have included the recommendations of the NACNE and COMA reports in Appendix III to remind health authorities of the dietary requirements to which they should give thought.

We do think it important, however, to encourage authorities in considering their nutritional responsibilities towards patients and staff, to decide how far and in what way they should attempt to correct the eating habits of those they serve and those who work for them. Influencing staff and patients is the best way in which the NHS can fulfill its role as health educator in seeking to prevent ill-health. Diets for staff and patients should meet at least the minimum requirements for recommended daily allowance, while at the same time trying to include those ingredients which are regarded as most important for 'good health'. Clearly no single meal can encompass all these requirements, but a balance can be achieved over a period of days.

While this is practicable for staff, there may be problems with patients. With the shortening of hospital stays for most acute patients, the possibility of drastically altering eating patterns becomes more difficult. While it is important for all patients to have a nutritionally sound diet, it is as important, where patients are recovering from acute episodes of illness, for them to be encouraged to eat something, rather than to present them with food which is different from their normal eating pattern.

Long stay patients (for example, orthopaedic) and long term patients can be more easily encouraged and educated to change their dietary preference. But a careful watch must be maintained with these patients to see that nutritional goals are maintained, particularly for those groups where the current financial allocation is normally less than that for acute patients.

Consideration has also to be given to the maintenance of

nutrition in special diets. We include (in Appendix IV) the usual range of special diets which are required in the average health authority as an *aide-memoire* to those who are responsible for providing them.

Finally, although we have mentioned specifically three groups of patients authorities should always bear in mind that 'patients' are not a homogeneous group, whose dietary needs are – by and large – the same. One of the difficulties for hospital caterers is that their 'customers' are both captive and disparate. We have also included in Appendix IV a list of the typical groups of patients to be found in the average district – even in the average district general hospital. When authorities discuss the catering and nutritional needs of patients, they should seek to consider these questions by patient group rather than as a whole.

Dietary education

Although we have emphasised the difficulties in using hospital diets – particularly for patients – as a means of educating people to better eating habits, we believe that health authorities can begin to change eating habits while patients are in their care. Educating staff is an important element, since if staff understand the importance of healthy eating they are more likely to be able to help patients. Every opportunity should be taken to mount wall, counter or table displays (such as recipes) to educate staff. The opportunity to influence patients should be taken through the use of leaflets and menu cards – perhaps with recipes and 'tips' on the back, so that patients can take home those recipes which they find enjoyable.

We were surprised to learn from our questionnaire that one in 15 of our respondents had no formal dietary policies, nor plans to consider such a policy. We recommend that all districts should have a formal 'healthy eating policy' which they should publish, together with proposals for implementation.

PATIENT FEEDING

In the previous section we discussed the importance of food in a dietary sense, and the need to ensure that patients and staff are fed 'properly'.

But food is important for a number of reasons which have little to do with dietary content. Eating is regarded by most people as a pleasurable and, frequently, social activity. It can give comfort and reassurance, and consequently is therapeutic for all but few unfortunate anorexics. Food plays an important part in all our lives and must be seen as an essential part of the cure of patients. Meals are often the only break in the tedium of a patient's day. They should provide a welcome familiarity in an unfamiliar and often rather frightening world. The catering service in hospitals must be seen as an essential part of the patient's recovery and should be of concern not only to caterers, but also to doctors and nurses.

The recognition of the importance of food itself and the way in which it is served in the process of recovery should lead both authorities and catering officers to re-examine the whole way in which it is handled and served. We outline what we believe to be the important factors which authorities should pay attention to if they are to produce a satisfactory catering service for patients.

Timing of meals

We asked in our survey about the times at which main meals were served. Most respondents reported that they served breakfast between 7.30 and 8.00 am, and lunch between 12.00 noon and 12.30 pm. These times seem to us to be reasonable, but we are unhappy about the time at which most hospitals serve the last meal of the day. A number served at 5.00 pm and nobody served after 6.30 pm; 5.00 pm we thought was too early; 5.30 pm to 6.30 pm may be perfectly acceptable in parts of the country where the custom is for 'high tea'. On the other hand, many people are accustomed to eating between 6.30 and 8.00 pm and are quite unable to face the prospect of a meal before 6.00 pm (which is still early). Health authorities should be more flexible in the

timing of the evening meal and should take more account of local custom.

Many hospitals make no provision for patients who are receiving treatment during the day and only make food available at standard meal times. We have mentioned in our section on nutrition that patients are not homogeneous. Neither do they receive treatment or are ready for meals at precisely the moment when the meal is being served. A post-delivery mother, for example, is usually extremely hungry after birth – and babies do arrive at non-standard times. Post-operative patients may not be ready to eat for several hours after their return from theatre – and then will only want a light meal. We quote only these two examples, but a little thought readily produces a variety of situations which prevent a patient from taking a meal at the time when it is normally served. Some food ought to be readily available for these patients when they need it.

Menu choice

We were surprised to learn that only 30 per cent of the respondents gave patients a same day choice of menu. It is unlikely that most patients, particularly in the early stages of recovery, will know what they want to eat 24 hours before the meal is put before them. We understand, indeed, that some hospitals are still asking patients to choose their meals two or three days in advance. We think it important that patients should be able to choose their meals as near to the time of eating as possible, and, in any event, should at least be able to choose their meals on the day of consumption.

We regard four choices for each course of the two main meals of the day as a minimum requirement. Only 16 per cent of the hospitals in our survey provide this. We think that within a range of four choices on a standard menu most of the dietary requirements mentioned in the section on nutrition, and listed in Appendix III, can be accommodated. Patients should also be able to choose what they like from any part of the menu (subject to special dietary requirements). For example, a patient should be able to order two first courses and a pudding. (We acknowledge

that patients may not always choose sensibly, or may be confused about what they should choose; they should be helped. We return to this later in the section).

One of the major complaints of patients is the size of the portion; usually it is felt to be too much. Patients should be able to choose what size of portion they want. Nothing is more discouraging to the appetite than a large plate full of unwanted food.

We have been shown menus where 'healthy' food is starred, and the recipe given on the back. We commend this and would like to see the practice extended to all hospitals. But we have also heard of hospitals where the enthusiasm for 'new diets' has led to only wholemeal bread and pastry being offered and, in some extreme cases, to salt being virtually omitted from cooking. Such extreme measures must be regarded as counter-productive if the intention is to re-educate patients, since the most likely effect is to associate healthy eating with unpalatable food.

We also saw menus which provided a limited range of tastes, so that patients were unable to create a meal which was attractive and had complementary flavours. All too often the available choices led to a bland, unappetising meal. Menus should contain a mixture of the familiar and not so familiar to arouse a patient's interest, while providing elements of comforting familiarity.

Special needs

We regard the provision of frequent beverages as important. We were pleased to see that most of the hospitals who responded to our survey were serving some sort of hot drink on average seven times a day. We would like to see beverage-making facilities freely available on wards since hot drinks are often a comfort to a recovering patient. It would be beneficial for both patients and visitors if hot drinks could be available for visitors whom, we think, would be prepared to pay for them.

Food as therapy has a particular importance for mentally and physically handicapped people because catering is an important part of occupational therapy and rehabilitation. These patients should have their own kitchens in which to prepare their own food. Staff should be available to help these patients to shop if this is thought desirable.

Delivery and service of meals

We were particularly interested in the delivery and service of meals to patients. We observed that the best efforts of the catering staff to produce well-cooked meals were often spoiled by the way in which food was treated when it arrived on the wards. Sometimes the food was delivered well in advance of the mealtime, and often when it was delivered at the right time it was left to stand. The food inevitably deteriorated.

Most of the hospitals surveyed delivered food to the wards in bulk in heated trolleys. Only a few served plated meals. The only advantage we could see in the bulk delivery system was the ability of those serving the meals to apportion the food in line with patients' individual requests. However, this ceases to be an advantage if patients, as recommended, are able to pick their portion size at the time of ordering from the menu.

The problem with the delivery service, we believe, is that the kitchen staff and delivery staff are under different managements. This is discussed in more detail in the section on management, but we do think that it is impossible for the delivery and service of food to be done correctly while management is fragmented.

The serving of food in the majority of hospitals is carried out by nurses, a function which not only gives them some control over the diet and nutrition of patients but involves them in this aspect of patient care. However, a number of other groups (including ward orderlies and catering) may serve the food. Whichever group serves the meal, two things are important. Food should be given priority over other work when it appears on the ward (assuming that it arrives at the right time). This is demonstrably not the case at the moment. And whoever serves the food, the involvement of the nursing staff is essential.

The role of the nurse

Nurses have a crucial role in feeding patients. Currently, the nurse in most hospitals and institutions not only serves the food but helps those who cannot feed themselves and chooses meals for

those who are unable to do so. We mentioned earlier that patients should be able to choose what they want from the menu while acknowledging that they might need advice and help in selecting suitable food. The nurse should be the key figure in giving advice. In order to understand the importance of nutrition and food in the recovery of the patient, it is clear that more attention to this aspect of nursing care should be given to nurses in training. At present, insufficient time is devoted to it in the curriculum and we think that food should be the subject of a special teaching module reinforced by clinical tutors during ward training. Where the nursing process or individualised nursing care plan is used, feeding and nutrition should form part of the plan. We would draw authorities' attention to the recommendations of *Are They Being Served* (Vivian Coates, 1985), which we quote at Appendix V.

Quality control

Controlling the quality of meals and monitoring the service at the point of presentation is clearly crucial if a satisfactory service to the customer is to be achieved and maintained.

Since the advent of the Griffiths management changes and the appointment by many authorities of a director of quality control, we envisage that the overall responsibility for the standard of catering for patients will be carried by the director. We think that reports on catering should be given at regular intervals to authorities.

The director will need to work closely with the manager in charge of catering, although we believe that an active part in monitoring should also be undertaken by the director of nursing at unit level.

We would suggest that the following points be taken into account when monitoring is carried out:

1. the meals which have been ordered are those which are received;
2. they are attractively presented;
3. they are at the right temperature;
4. they are nutritionally sound for ill patients;

5. they are served in suitable quantities, according to the wishes and needs of the patient;
6. the nursing staff are actively involved in supervising meals and meals are seen to be an important part of nursing care;
7. interruptions to the service or eating of meals are discouraged;
8. poor presentation and management of meals is rectified immediately;
9. all comments made by patients on food, complimentary or not, are reported to the catering staff.

Note on waste

Our terms of reference included the elimination of unnecessary waste. We have not devoted a separate section to this because we have come to the conclusion that the largest single cause of waste is the inability of patients to control the food, both in quantity and type, which they are being offered in most hospitals at the present time.

Some authorities reading this section of our report may be tempted to disregard much of what we recommend because it seems, at first sight, to be expensive. We believe, however, that any extra costs which may be incurred through offering wider choice and more elaborate menus will be largely offset by reduced waste. The catering industry generally has learned to appreciate that when people can choose freely what they eat, they eat more of it. There is no reason to suppose that people when ill will behave differently.

We can do no better than end this section with a quotation from Florence Nightingale's *Notes on Nursing*, published in 1895. As was so often the case, she was able to understand clearly the needs of patients.

> Remember that sick cookery should do half the work of your poor patient's weak digestion. But if you further impair it with your bad articles, I know not what is to become of him or it. If the nurse is an intelligent being and not a mere carrier of diets to and from the patients, let her exercise her intelligence in these things.

STAFF FEEDING

The importance we attached to meals as a relaxing and social activity for patients is, self-evidently, true for staff as well. Most organisations recognise this and pay a good deal of attention to the food which is provided for their employees and the surroundings in which it is eaten. The majority of firms still provide subsidised catering for their employees as Steele and Delaney noted in their Rayner scrutiny of NHS catering*: 'We recognise that subsidised staff catering is a very common feature, both in private and public enterprises. Its cost to an organisation is said to be more than outweighed by advantages, such as the fostering of good industrial relations, boosting staff morale and loyalty, and attracting and retaining staff'. The scrutiny also says 'it is often agreed that, because the nature of much hospital work is particularly demanding, and as staff working in close contact with sick people are placed in positions of special risk, hospitals have a special obligation to ensure that their staff are well nourished, the better to meet these demands and hazards.'

In strongly supporting the principle of subsidised catering for staff, we would go further than the arguments outlined above. We feel that the nature of hospital work and the long hours which staff frequently spend on hospital premises require that particular care should be taken by health authorities to make sure that staff food is well prepared and presented and that the physical surroundings are clean and attractive. For many hospital staff, meal breaks are their short period of badly-needed relaxation.

We recognise, however, that health authorities should be concerned about the costs of staff catering and the present level of subsidy at a time when they are seeking to save money.

The subsidy may seem large. The Rayner scrutiny report estimated it to be about £90 per annum per employee but this figure is no more than the average subsidy paid by firms in private industry, according to an Industrial Society survey†. Indeed in noting this the scrutiny report says: 'The evidence suggests that

* *Cost of Catering in the NHS* Steele and Delaney. A Rayner Scrutiny, October 1983

† Twenty-fourth survey, number 200. Catering prices, costs and subsidies and other information. The Industrial Society.

the subsidy enjoyed by NHS staff is by no means generous, but about average. We noted too, that subsidised canteens are not uncommon in the public sector.'

This committee would expect the public sector to behave in the same way towards its staff as the private sector. There is no reason why staff should be treated less favourably because they work in the public sector.

Despite their comments about the appropriateness of subsidy the authors of the Rayner scrutiny are concerned about all staff enjoying subsidised catering, believing that 'the present arrangement. ... cannot be justified in times of financial restraint.' They suggest that certain categories of staff should be designated as 'entitled' staff who would be issued with passes or tokens, allowing them to eat at a subsidised rate.

We share their belief that this system might prove difficult to operate. Indeed, we believe that the additional burden laid on treasurers' and catering departments together with the opportunities for grievances and disputes arising from the negotiations required to introduce such a scheme, would make the possible savings to be gained too small to be significant. The system also has the disadvantage that the recipients might be liable to pay income tax on the vouchers if their value exceeded 15p. Benefits like subsidised food are liable for taxation when they are not given to all staff. Very few of these schemes operate in the private sector and, so far as we know, none in the public sector. We therefore reject this suggestion and recommend that whatever level of subsidy is determined it should apply equally to all staff who use NHS facilities.

We support the suggestion of a single subsidy. We think that the NHS should follow the example of private industry and direct this subsidy to catering overheads, leaving the cost of food to be wholly recovered in the price charged for meals. This system should replace the pricing structure laid down in HM67/10.

We are concerned, however, about who is entitled to benefit from the subsidy. We asked catering managers which groups were allowed to use their dining areas in addition to staff: 86 per cent said patients' visitors; 65 per cent contract staff; 98 per cent visiting NHS employees; and 46 per cent ex-employees. The numbers of outside customers may be small, but the principle of

extending subsidised meals to people other than staff directly employed by the DHA should be carefully considered.

We think that a number of authorities could produce more revenue from catering. This would very much depend, however, on whether more staff would need to be employed if there were larger numbers of customers since this would raise the cost of the subsidy. But looking at the figures in our survey leads us to believe that many catering departments would find it possible to service more customers with present staff levels. According to the replies to our questionnaire, at present 55 per cent were attracting less than 50 per cent of the staff of their unit; 31 per cent said they served between 50 – 60 per cent and only 13 per cent were able to claim that they attracted up to 75 per cent of their potential customers. None of their customers spent over £1.50 on a main meal; the majority (72 per cent) spent between 50p and £1. These figures of 'take-up' of meals seem to have some relation to the private sector, where a decline in support is clearly marked. The overall average of staff taking a cooked meal each day in the Industrial Society survey* was 42 per cent. This survey records a swing towards light meals and snacks which we think is also happening in the NHS, although the evidence is less clear. We know that there is considerable growth in the use of social clubs and post-graduate centre facilities. This is probably because wine bar type food is served, and also because staff are able to buy alcohol with their meals. The service of alcohol in dining rooms is a subject which brings out great divisions of opinion, but we see a certain inconsistency in permitting alcohol to be served in some parts of the hospital complex while refusing it in others. DHAs should give serious thought to the whole question of the sale of alcohol on hospital premises. There seems to be some argument for providing a separate snack bar facility within the dining room area to provide the sort of wine bar food which is growing in popularity, together with limited sorts of alcohol – perhaps beer, cider and wine. We were surprised to learn that 68 per cent of our respondents had no separate snack bar facilities.

Apart from improving the provision of light meals, we think that more could be done to attract customers to the main dining

*Op cit.

rooms. There are a number of ways in which this can be achieved. Some catering managers have found that having 'special food' days or weeks brings in more customers (and gives interest and motivation to the kitchen staff). Only 52 per cent of those answering our survey laid on such special events. We would recommend that catering managers are encouraged to seek more diversity in such ways. Some hospitals, for example, are providing a take-away meals service. We recommend such ideas, but think that these services should be charged at full economic cost, without subsidy.

There should be more choice on the menu for staff. Choice is equally important for staff as for patients, since staff potentially use the dining rooms for most of the year. Managers should also take an active interest in staff comments about food. Most managers in our survey claimed that staff were encouraged to comment on food, but 37 per cent said that details of complaints were not registered. Most (88 per cent) of the complaints seem to have been made verbally.

In a twenty-four hour service industry, the provision of food for staff working unsocial hours is critical. Our observation is that the largest single category of complaints from staff is about the type of catering service provided at off-peak hours. No units who answered our questionnaire kept their evening catering service open after 9.00 pm. Indeed, 90 per cent closed at 8.00 pm. Arrangements for night staff seem to depend either on snack vending (85 per cent) or facilities for staff to cook their own meals (30 per cent). Eighty one per cent of the respondents provided automatic beverage vending machines. To provide full catering facilities at night is extremely expensive, and it is understandable that health authorities should seek cheaper ways to provide a service. But with the growth of technology in food production – such as cook-chill preparation and micro-wave ovens – full meals can be provided at night at considerably reduced costs. Health authorities should be prepared to provide a full meals service where the need and demand can be demonstrated. Vending machines can be used in certain places, but they should be capable of producing a reasonable range of food and drink and must be reliable.

We would underline too the necessity for ensuring that where

food is eaten is extremely important. Providing food in pleasant surroundings is important for all staff who have tiring and stressful jobs. It is particularly so for those working unsocial hours; working at night can be tiring and debilitating.

The opening section on nutrition said that it was important to educate staff in healthy eating. We would like to re-emphasise this. It is particularly important that staff should understand and enjoy healthy eating, since not only will they benefit but their efforts to educate patients will be better informed and more persuasive. We were pleased to see that 82 per cent of those surveyed said that they had improved their menus for staff.

Monitoring staff catering is probably the easiest of activities for health authority members. All that they and their senior managers need to do is to eat as regularly as possible in the staff dining rooms. We are sure that most authority members do this and hope that they will continue to do so. Where catering staff see that senior management is taking a positive interest in their service, commenting and praising where appropriate, they have the best incentive for maintaining good quality.

RECOMMENDATIONS

Nutrition

1. **Food provided for patients and staff should meet at least the minimum requirements for daily nutritional allowances as set out in the NACNE and COMA reports. Particular attention should be paid to the dietary needs of long-term patients.**
2. **These nutritional requirements should be maintained in highly specialised diets.**
3. **Particular attention should be paid to the education of staff in nutrition and diet.**
4. **All districts should have and implement a food and health policy, which should be made known to all staff.**

Patient feeding

5. **Authorities should recognise that food and feeding are crucial elements in the therapeutic regime.**
6. **There should be greater flexibility in the timing of meals.**
7. **Food should be available for patients who are unable to eat at standard meal times.**

8. Choice of meals should be daily, at least, and preferably shortly before each meal.
9. Each menu should contain a minimum of four choices for each main meal.
10. Menu choice should include portion size.
11. Beverages should be freely available on wards. Visitors should be able to obtain hot drinks on wards, and be asked to pay for them.
12. Special facilities should be provided for handicapped people to provide their own catering.
13. Nursing staff should guide patients in the choice of a broadly balanced diet.
14. Nutrition and dietetics should form a specific identifiable part of the nursing training curriculum.
15. Nutrition and diet should form a part of the nursing process or individual nursing care plan for each patient.
16. The overall responsibility for the standard of the catering service for patients should be the responsibility of the director of quality control, where there is such a post.
17 The director of nursing services at unit level should have an active role in supervising the participation of nursing staff in patient feeding.

Staff feeding

18. Health authorities should continue to subsidise staff catering.
19. All staff should continue to benefit from the subsidy.
20. The present pricing structure laid down in HM 67/10 should be replaced by a single rate of subsidy. This subsidy should be directed to catering overheads, leaving the cost of food to be recovered in the price charged for meals.
21. Health authorities should look carefully at those categories of people who are entitled to use hospital catering and consequently enjoy this subsidy.
22. More effort should be devoted to attracting staff customers to use the eating facilities.
23. Catering departments should respond to the trend towards lighter meals and snack bar facilities.
24. Health authorities should be prepared to consider the whole principle of the sale of alcohol on hospital sites.
25. There should be a wider choice of menu in staff dining rooms.
26. Customers should know to whom to comment on the catering service.
27. Health authorities should pay close attention to the physical surroundings in which food is served and eaten, particularly for night staff.

28. **Health authorities should examine closely the quality of catering for staff working unsocial hours. Where vending machines are used, the products should be of high quality and the machines reliable.**
29. **Healthy eating policies should be pursued with vigour, since their educational effects are likely to be particularly effective when directed at staff.**

SECTION 2

Management and cost control

MANAGEMENT OF THE SERVICE

Anyone who writes about management in the NHS today must have regard to the Griffiths report.* We support the Griffiths' principles and believe that they have paved the way not only for more effective overall management, but for the better management of service departments which have a vital part to play in patient care and staff welfare.

We sought to examine the strengths and weaknesses of the current catering management structure and to recommend ways in which the service could be better managed in the light of the Griffiths' comments and recommendations.

Catering has for too long been a neglected part of the NHS. Authorities have been reluctant to invest in new buildings and equipment, regarding catering as a peripheral part of the organisation. Salaries and wages paid to most people who work in the domestic, portering and catering departments are low compared with their equivalents in private industry. Too often the catering manager has no control over the catering budget. Neither does he/she have responsibility for the work of many of those who are concerned with the production – and more particularly the service – of food. This situation is changing, albeit slowly, because of the competitive tendering exercise, which has forced both authorities and managers to think more closely about the service they provide. Nevertheless, in many hospitals the situation remains unsatisfactory, with no overall control in one pair of hands. This has, in some cases, led to an unsatisfactory service, since where there is no responsibility there can be no true accountability. However, we are bound to say that we were impressed with the sense of dedication shown by many catering officers, who remain in the service for less than they would receive outside. But a satisfactory service demands more than a belief in the value of one's work.

In the first section of this report, we talked about the factors which we regarded as important in the provision of a satisfactory service for patients. We mentioned the necessity for food to arrive

* Department of Health and Social Security. NHS management inquiry (Leader Mr Roy Griffiths). London, DHSS, 1983

on time, to be as the patient had asked – both in content and in size – for it to be at the correct temperature, and served properly.

To produce such a service requires a series of operations over which, at present, the catering manager has no direct control. Neither does there seem to be any single identifiable individual, in many hospitals and institutions, with direct management responsibility for the coordination of patient services. Each section relies on another department to undertake its own role in order to supply, cook, deliver and serve the meals.

The result of this lack of coordination is that, all too often, food trolleys are kept waiting for the arrival of porters or domestic staff, neither of whom has any responsibility for the service.

During the committee's visits it was evident that the arrival of food at the bedside in good condition, even if it was well prepared, relied upon equal measures of goodwill and good luck. It was also clear, both from our visits and from our survey, that patients did not always receive the food that they had ordered and that nursing and domestic staff had no idea about the desired portion size, particularly when operating a bulk trolley service.

We know that the catering officer cannot always influence these factors. Where officers are successful, it is due to their personality and persuasive powers and the luck of having a senior manager (non-catering) who sees food as being important.

Good catering managers – of whom there are many in the service – are aware of the problems and their frustration is evident. But without a system which allows them full management accountability for the running of their department, they are unable to correct errors and cannot influence long-term change.

A good service depends on effective collaboration between various skills and groups of labour. Staff must be given clearly defined departmental and individual objectives, understanding clearly their role in the department's work and what their responsibilities are. This simple managerial truism cannot be carried through without a person being in overall charge at a sufficiently senior level to ensure that the needs of the department are considered.

The training of catering managers includes management as well as technical skills. We feel that authorities and senior managers do not always recognise this, and consequently prevent

caterers from assuming a wider role. We can do no better than to sum up our argument in the words of the Griffiths report:' ... at no level is the management role clearly being performed by an identifiable individual. Absence of the management support means that there is no driving force seeking and accepting direct and personal responsibility'.

Most of the managerial weaknesses which we have outlined affect the service to patients. In staff feeding, the system is clearer because the catering manager is seen to be in charge and there are fewer distribution problems.

Who should manage?

Unit level

We believe that this present situation of fragmented responsibility cannot be allowed to continue. We therefore recommend that a single individual should assume responsibility at unit level for patient and staff services, as a hotel services manager. The responsibility and grade of this post will clearly vary according to the size and complexity of the service and unit.

The hotel services manager must be a senior member of the unit general management team and should have overall responsibility for domestic, portering and catering services, for both staff and patients. He should also be the budget holder for these services and have management flexibility to operate the hotel section.

We see this person as being a manager. Consequently there would be no absolute necessity to appoint a qualified caterer, since managerial rather than a particular technical expertise would be the necessary qualification. The manager would have the help of the treasurer's department in framing budgets, paying bills and other financial matters. We discuss this in more detail in the following section on cost control.

The hotel services should be divided into three sections (according to the size of the unit). Each section should have a manager or supervisor directly responsible to the hotel services manager, who would act as the coordinator.

We see the three section heads as having the following responsibilities.

1. The domestic services manager/supervisor would be responsible for the coordination of all domestic services throughout the hospital, including ward domestics.
2. The portering manager/supervisor would be responsible for all portering services, although it might be possible to amalgamate domestic and portering services under one supervisor, depending on the size of the hospital.
3. The food services manager/supervisor would be responsible for the preparation of all food and for its service in staff dining rooms and associated areas, the hotel manager being responsible for patient food service. The experience and qualifications for this post would need to vary from unit to unit. In the smallest units, purchasing would be carried out by the hotel services manager and the food services supervisor would be a working member of the production team. The food services manager should work closely with the dietician. Indeed, given basic catering and management training we see no reason why the dietician should not be the manager.

In hospitals where the same kitchen produces food for staff and patients, we think it would be appropriate to appoint a catering supervisor (with OND/HND qualifications) as well as a food services manager, to supervise the dining room staff and operate the staff food services facilities.

In larger hospitals, where facilities allow, we see the staff food service operation as being entirely separate from patient facilities, with separate kitchens and dining rooms. In this case, the appointment of a catering manager (responsible to the hotel service manager) would be appropriate, thus enabling the hospital to develop catering more commercially, possibly extending the service to visitors' meals and outside organisations (this recommendation also appears in Steele and Delaney, page 24, 10.6).

While these recommendations have been arrived at quite independently, we were pleased to see that Steele and Delaney made much the same proposals: '9.10 If the NHS wants its catering managed as effectively as is found in a good hotel, *it must integrate it with its other hotel services*, and appoint professional managers with overall responsibility and accountability for the

authority's objectives.' We have noted that some authorities are already following this advice and appointing such a person.

We believe that the structure outlined above offers a means of implementing the principles set out by Steele and Delaney (a diagram showing the 'management tree' appears in Appendix VI).

District and regional level

We have no firm proposals to make about any appointments at district level. We have already suggested that where there is a director of quality assurance, one of his/her responsibilities should be to monitor the quality of catering services.

However, some districts may need to have a district hotel services manager. Where districts have not created a post of director of quality assurance, a district hotel services manager should be appointed to monitor the quality of the hotel services. Districts that are large and complex may find it useful to have a district post even where there is a director of quality assurance.

On the other hand, we believe that there is a clear role for a regional advisor. The major part of this regional role should be the coordination, monitoring and enforcement of performance standards through the region. We believe that the hotel services of each district should be included in the annual district-regional review. We welcome the initiative taken by the Wessex Region in establishing catering performance reviews and quality standards for cooked food and food services. We hope that Wessex will enforce these standards and that other regions will follow its example.

We see no reason why regional advisors, when appointed, should not work together to achieve similar standards to those set by Wessex. We do stress, however, that the mere act of producing a booklet will not, in itself, improve standards at patient level. Active enforcement and monitoring is essential if standards are to be raised and maintained.

Again, we are pleased to see that Steele and Delaney also took the view that there should be regional advisors: 'We therefore recommend that regions which do not currently provide catering advisory services should be urged to establish them'. However, this committee urges that all the hotel services should be included.

Staffing

Training and appraisal

In any service industry the practical and social skills of craft, technical and operating staff are crucial to the success of the operation, whatever its size. To a considerable extent these skills are learnt on the job rather than at college or a training centre. Every manager and supervisor has a responsibility for first assessing and monitoring each person's training needs, and then ensuring that there is an effective and suitable programme to match them. We are pleased to see that 91 per cent of those who returned our survey indicated that they were running training programmes. We were less happy about how this training was devised for individuals, or how it was judged to be effective, since only 25 per cent had any staff appraisal systems in operation. And even with these we were uncertain how far down (or up) the appraisal system extended.

We believe that the key to a well run organisation lies with the staff as well as the management and in order to achieve maximum staff involvement and efficiency an effective, open system of appraisal and training is essential. We recommend most strongly that a system of appraisal for all grades of hotel services staff be devised and implemented as a matter of urgency. We also think that the system should be designed so that the employee sees the manager's comments and recommendations and discusses them with him/her. The scheme must indicate current and future promotion prospects, summarise the employee's strengths and weaknesses, and outline training programmes to help the employee to fulfil his/her potential.

Qualifications

We believe that there is no clear central, regional or district guidance on minimum qualifications to be expected for staff in various posts, or any criteria for promotion.

We would argue that unless guidelines are clear and widely known, staff will not be able to see any possible promotion prospects within the NHS. Morevoer absence of these guidelines probably leads to grading anomalies at all levels.

While the committee do not presume to lay down any specific

recommendation for the NHS, they noted that the following scheme based on five scales for cooks is being operated by an industrial company:

Scale I
City and Guilds 706/1/2 and two years experience or full-time college course.

Scale II
City and Guilds 706/1/2 with two to four years industrial experience plus ability of running a section with a Scale I assistant.

Scale III
As for Scale II with the ability to run any section, and a sound knowledge of menu planning and stocktaking.

Scale IV
As for Scale III plus the ability to place orders with suppliers, the potential to use a computer for costing purposes, organising staff and having a good understanding of staff and customer relations. Trainer Skills 1 and City and Guilds 706/3, or other appropriate City and Guilds courses or NEBBS supervisory course, could provide advanced craft courses.

Scale V
As for Scale IV with ability to supervise the kitchen on a day-to-day basis, organising and coordinating various sections.

Authorities may care to consider this scheme.

Salaries and benefits
There is a general belief that salaries and benefits are lower for all staff in the NHS than in comparable occupations in private industry.

The committee looked at figures to see whether this could be argued for catering managers and staff. Exact comparisons are difficult, because of the lack of matching data. This is particularly true of managerial posts. Only raw comparisons are possible. These are based on 1984 figures. The source for private industry is the annual survey carried out by the University of Surrey into rates in the catering industry. The figures for the NHS are those A and C rates agreed for 1984. The details are shown in Appendix VII.

Given the complexity of hospital catering there seems to be some validity in the argument that NHS managers are less well rewarded. On the other hand, some would argue that the level of formal responsibility of individual managers is higher in the private sector.

If our recommendation to appoint a hotel services manager is accepted, however, authorities will have to be prepared to move to match rates in the private sector.

In 1984 the median rate for hotel managers was £11,772 plus a number of fringe benefits. The rate has almost certainly risen significantly during the last two years, since the survey team found that management rates have been on an upward trend since 1982 – indeed have risen by 40–70 per cent in that period.

Direct comparisons betwen the NHS and the private sector are easier to make for non-managerial posts. These are also shown as part of Appendix VII. They are of course, only basic rates. Earnings will vary considerably according to shift allowances and overtime worked.

COST CONTROL OF CATERING IN THE NATIONAL HEALTH SERVICE

Pre-requisites for cost control

There are three pre-requisites for effective cost control in commercial businesses:

Clearly defined management responsibility for the activities to be controlled.
A realistic assessment of the costs to be allowed for the achievement of specific objectives in a defined period. The allowed costs are usually related to quantities that can be physically measured, for example, production output. The physical quantities and related costs are usually expressed as a budget.
Measurement of actual costs and comparison with the budget and the reporting of these results as soon as possible after the end of each control period, so that corrective action can be taken by management if necessary.

From the information which has been received by this committee so far, it would appear that each of these factors is rarely applied to health service catering and we are unaware of a hospital operation which satisfies all three. We must therefore conclude at this stage that there is little or no effective control of catering costs.

We make our recommendations for developing effective cost control under three main headings:

Catering policy
Management responsibility
Budgeting

We describe the recommendations and the reasoning behind them in more detail below.

Catering policy

The results of our questionnaire show that 50 per cent of districts responding have not agreed a formal catering policy. Sixty four

per cent were not aware of any catering advisor employed by their region. The results indicate a considerable lack of high-level management interest in the catering function.

Yet the issues are substantial:

Catering costs amounted to £397 million in 1983/4, representing 4.9 per cent of NHS hospital expenditure.

Clearly defined policies are needed for setting service-related budgets, rather than the traditional budgets based on previous year spend.

New technology offers major opportunities for both cost reduction of catering processes and cost control through computerised information systems.

The challenge of competitive tendering needs a sound basis for evaluating in-house catering against which outside tenders can be measured.

In particular, we recommend that senior managers should:

Examine options for providing catering services
Choose the best approach
Develop and implement a positive catering strategy

The catering strategy should address the whole range of service issues commented upon in the other sections of this review, such as location and frequency of meals, catering standards, menu choice, ingredients and nutritional content. Methods of production, distribution and serving also need to be reviewed.

The result of this strategy should produce explicit answers to financial questions such as:

What is the optimum level of capital investment in premises and equipment?

What (order of magnitude) cost reductions can be made from improved working methods or capital investment?

What range of service and quality levels are being considered and how much would each level cost?

What pricing policy should be adopted for function and staff catering?

In summary, the development of a catering policy will clarify what is to be achieved within an overall cost framework.

Management responsibility

It is apparent from the previous section of this review on the management of the service that there is no manager in most hospitals who is responsible for purchasing, preparing, transporting and serving food to both patients and hospital staff. Although hospital catering managers appear to fulfil this role, in reality their responsibility is frequently diluted, especially for purchasing, transportation and serving to patients. Our recommendation was that a hotel services manager should be responsible for aspects of service such as portering, ancillary staff and catering, and that the manager directly in charge of food services should only be held accountable for food preparation and direct serving of meals where this was carried out by his immediate staff.

The hotel services manager should be responsible for ensuring that the catering strategy is properly defined and agreed with the unit general manager and that the managers of the various services, including food preparation, put the strategy into effect.

However, to be properly responsible, even for the food preparation and restaurant serving activities, hotel services managers' roles should be developed so that they see themselves as responsible for their service to users, with the users being aware of the cost implications of the service they request (this theme is developed further under management budgeting). They must be responsible and accountable for:

The purchase, storage, usage and wastage of all materials.
The hiring, motivation, management and firing of staff, if necessary, under their control.
Making recommendations in the development of the catering strategy as to, for example, the balance of buying in semi-prepared food as against paying staff to prepare it, the balance of labour intensity and food preparation against capital equipment used and, in respect of staff catering, the pricing of one dish as against another in order to achieve an overall limit of subsidisation.

Once the overall strategy is agreed, the hotel services manager should have the authority to make decisions within the strategy

on the matters under his control, should be supplied with proper reports on his performance in service and financial terms, and be held accountable for the consequences. Some of these tasks can and should be appropriately devolved.

Budget preparation

Accountability for the catering budget rests with 62 per cent of the respondents to the questionnaire. However, only 34 per cent set their own budget – treasurers and administrators appear to take on that role – and 66 per cent did not. This seems to contradict the 83 per cent who said budgets were calculated making allowance for expected patient throughput and types of diet. We find it difficult to believe that in 66 per cent of the responding hospitals this system does not involve catering managers in setting their own budgets. Only a more detailed and extensive review could establish real practice.

We have discussed the preparation of hospital catering budgets with several catering managers and, while most have attempted at one time or another to build up a rational catering budget based on the predicted numbers of each category of patient and of staff, they appear to be discouraged from producing budgets by the overriding importance of cash limits. In order to overrule attempts to produce objective budgets, there appears to be a tendency to allow a notional catering budget calculated on the basis of the previous year, plus an inflation factor or minus a cost-saving percentage. The imposition of simple overall cash budgets must dilute any feelings of responsibility that the catering managers may have. Budgets prepared by them on a logical basis, and for which they would be held accountable, enhance feelings of responsibility.

In considering the preparation of detailed budgets related to predicted patient and staff populations, the committee noted that there was an absence of useful standard data to help catering managers estimate costs. The DHSS used to publish weekly ingredient costs for various categories of patient. We understand that this was discontinued some years ago but has been maintained, taking account of inflation, by a number of regional

health authorities. However, we understand that the basis of calculation of these figures was suspect in the first place.

There would appear to be scope for a properly conducted survey of the nutritional needs of different types of patient and a calculation of some type of standard catering costs which reflected seasonal variations in food prices and could form the basis of consistent budgeting by hotel service managers.

In our view, much stronger direction needs to be given from the centre of the NHS about the content of catering budgets and the necessity for these budgets to relate to both the predicted numbers of different categories of patients and to the properly established nutritional needs of these patients.

Within these guidelines, each UGM should give direction to the hotel services manager on the basis of a forecast of patient throughput by type and expected duration of stay based on the consolidated views of the consultants for each speciality.

Based on the expected throughput of patients by type and scaled to reflect meal consumption (for example, geriatric patients are likely to consume all main meals each day, but patients in acute hospitals usually forego several meals before and after surgical operations) a total forecast of meal demand for the year could be compiled.

Staff provisions and capital expenditure budgets should then be based on the estimated demand for meals and presented in a form against which progress would be reported during the year. Cost Form 20 could form the basis of a suitable financial summary for this purpose, but the range of costs shown needs to be reviewed and to be supported by schedules showing the statistics on which budget and actual meal demand, and the consequent costs, are calculated and calendarised across the accounting periods in the year.

Notes on the assumptions made about capital expenditure vs. labour and food preparation methods should be included in the plan.

In considering the basis of estimating costs for meals, we noted that some institutions use a points system in which the costs of each meal are weighted, for example:

Breakfast	2
Lunch	3
Dinner	4
Snack	1

This could be useful not only for budgeting, but for day-to-day costing of meal requirements. A more sophisticated version could be developed with weightings for different types of patients.

The fundamental reasons for setting down the detailed assumptions on which the budget is based are:

to ensure that the budget is soundly based; to enable rational explanations of variations to be given.

Monitoring of actual costs against budget

Fifty three per cent of the respondents said that they received information on catering costs within a month of the month end, but of these only five per cent received the information within a week, which is probably the time scale required for any effective management action.

During our visits we also asked a number of catering managers whether they received a regular and detailed breakdown of the costs incurred by them from the finance functions of their hospitals. In general the answers were negative. If any information was received it was usually months after the event and lacked sufficient detail for any management action. This problem is not peculiar to catering costs, since hospital finance functions appear to be staffed and provided with systems that are geared to carrying out the normal day-to-day transactions and accumulating information primarily for the purpose of annual returns to the DHSS. The fact that very few staff or other resources were being devoted to management accounting, and that there was a general need to improve this, was emphasised by Griffiths in 1983.

If budgets have been prepared as suggested earlier it will be important to respond to changes in service levels. This will involve noting stock levels, amending purchase orders and reviewing staffing levels, and then flexing budgets down if demand is reduced and up if it is increased, both throughout the year and from year-to-year.

It appears unlikely that hospital finance functions can produce, in the short term, information of adequate detail, frequency and timeliness to enable proper control to be kept of catering costs.

Catering management should, therefore, maintain its own records, as do caterers in many other types of establishment. We noted that this was done in some hospitals under the 'functional management' organisation by assigning staff from finance to the catering department. Where this has been retained it can work well. The records should be in such a form that they are useful for day-to-day control and can be reconciled overall to treasurers' records.

In small hospitals, these records can be kept manually, but in larger ones a system based on a micro-computer could be justified. These systems can keep records of food purchases and wages and also recipes and cost rates. From such programmes the costs of various menus can be calculated in advance, enabling forward planning to meet budgetary constraints or seasonal effects. The records should enable useful comparisons with budget and provide explanations of variances.

We understand that a number of hospitals are already using a micro-computer with appropriate catering software. The cost of running such a system is approximatey £3,000 per annum, so that a very small improvement in wastage or labour utilisation in a large hospital with a £500,000 to £1 million catering budget, could cover the cost of the system.

As with budgeting methods, the NHS could provide in our view much stronger central direction by testing and recommending micro-computer systems for use in hospitals.

Management budgeting

The potentially beneficial effects on the cost effectiveness of the health service of fully developed cost control systems related to physical activities were recognised by the Griffiths enquiry team. Among their recommendations they set out the objectives of a management budgeting system whose aim was to strengthen unit level management by involving clinicians and others in setting and managing work-load related budgets for finance, manpower and full overhead costs against which performance and progress can be monitored. Experiments have taken place to introduce management budgets and the approach adopted and their outcome

is of interest to this review because they offer a way of producing a logical basis of predicting catering demand on which budgets can be based.

Under the management budgeting system, budgets are based on an examination by clinicians of trends in work loads for the various specialists and the development of hospital services. The nursing staff and heads of departments, such as catering, review the impact of the predicted work load and service developments on their own work. After reviewing the options and establishing priorities with the UGM, appropriate budgets are drawn up based on the agreed estimated patient throughput.

In the experiments, it was found that existing statistical and cost recording was often inaccurate, and seldom sufficiently detailed or delivered promptly enough for realistic control of management budgets.

Various units have implemented systems to produce the type of information outlined above; in some cases it is based on manual processing, in others on the use of micro-computers. While these partial systems have been adequate for experiments in management budgeting, accounting systems matching the best in commercial organisations are needed to give effective control over all aspects of cost in the NHS, including our recommendations on the control of catering cost. The development of such systems is envisaged, but not until about 1990.

RECOMMENDATIONS

Management of the service

1 **Authorities should end the present fragmented system of managerial responsibility by appointing a hotel services manager.**
2 **This manager should have overall responsibility for domestic, portering and food services.**
3 **These services should be divided into three sections, where size allows, and a manager/supervisor for each appointed, directly responsible to the hotel services manager.**
4 **In hospitals where the same kitchen produces food for staff and patients, a catering supervisor (with OND/HND qualifications) should be appointed to supervise the staff dining rooms.**

5 Where hospitals are large enough to allow for separate staff feeding operations, a catering manager should be appointed to develop catering more commercially.
6 Where there is no director of quality assurance, districts should appoint a district hotel services manager to monitor the quality of the hotel services (see recommendation 16, section 1).
7 Regions should appoint hotel services advisors.
8 These advisors should be responsible for the coordination, monitoring and enforcement of performance standards throughout the region.
9 Hotel services should form a part of the annual region/district review.
10 The hotel and section managers should institute an appraisal scheme for all hotel service workers.
11 This scheme should include individual training programmes, for which managers should be responsible.
12 Authorities should urge the Department of Health to issue clear guidance about minimum qualifications for trained staff in districts.

Cost control

13 Formal catering policies should be established by each district and devolved for implementation to unit level. These should include:
- levels of capital expenditure
- working methods
- service levels and quality standards
- pricing policy for function and staff catering

14 Financial responsibility for all aspects of catering should be carried by a hotel services manager and delegated to appropriate managers in his group for food preparation, distribution and serving.
15 This manager should be responsible for setting his own budgets based upon agreed statistics of patient throughput and catering policy as defined in the final paragraph of the management budgeting paragraph above (page 46).
16 Catering statistics and financial performance reconciled to the finance department records should be reported quickly at the end of each week/month. Consideration should be given to the larger catering departments having their own micro-computer systems for this information and for diet-based planning.
17 The DHSS should provide guidelines for dietary content, catering costs and micro-computer systems.
18 The use of points systems for meal costing should be considered.

19 The introduction of management budgeting and the consequent development of management accounting should provide catering management with an opportunity to develop their budgeting on a much better basis; they should take this opportunity.

Appendix I

MEMBERSHIP OF REVIEW BODY

LADY MARGARET MCCARTHY	CHAIRMAN (Fellow, King's Fund College)
MISS JACKIE FLINDALL	Formerly Regional Nursing Officer Wessex Regional Health Authority
MRS RACHEL KELLY	National Association of Health Authorities
MR ALAN MCNABB	Associate Director Coopers and Lybrand Associates
DR COLIN SMITH	Senior Lecturer in Medicine Southampton General Hospital
MR BRIAN WATTS	Managing Director B E Services Ltd Bank of England

Co-opted advisors

Hospital Caterers Association

MR RICHARD DYSON	Formerly District Catering Manager Nottingham Health Authority
MR MICHAEL HAWKES	District Catering Manager S Glamorgan Health Authority
MRS ALISON DOBSON	Department of Dietetics University College Hospital (formerly Dietetic Advisor, DHSS)
MR ALAN HORTON	Formerly Chief Officer Department of Catering and Dietetics DHSS

Secretary to the committee

MISS AMANDA MILLARD	Catering Manager Royal Marsden Hospital

Appendix II

HOSPITAL CATERING QUESTIONNAIRE

PART A: PERSONAL PLEASE CIRCLE ANSWER

1. What position do you hold?*

   (a) District Catering Manager

   (b) Unit Catering Manager

   (c) Assistant Unit Catering Manager

   (d) District Catering Advisor

   * (Please answer this questionnaire according to your principal managerial function.)

2. To whom are you accountable?

   (a) District General Manager

   (b) District General Administrator

   (c) Distict Catering Manager

   (d) Unit Administrator

   (e) Support Services Manager

   (f) Other (please specify)

3. What size is your unit (in beds)?

   (a) 20 – 40

   (b) 41 – 60

   (c) 61 – 80

   (d) 81 – 100

   (e) 101 – 200

   (f) 201 – 300

   (g) 301 – 400

   (h) 401 – 500

   (i) 501+

4. What kind of hospitals are in the unit that you manage?
   (a) Acute
   (b) Psychiatric
   (c) Geriatric
   (d) Mental Handicap
   (e) Maternity
   (f) Orthopaedic
   (g) Community Hospitals
   (h) Other (please specify)
5. What is your total budget?
6. What grade are you on?
   (a) Assistant Catering Manager 1
   (b) Assistant Catering Manager 2
   (c) Assistant Catering Manager 3
   (d) Catering Manager 1
   (e) Catering Manager 2
   (f) Catering Manager 3
   (g) Scale 9
   (h) Scale 14
   (i) Scale 18

PART B: GENERAL PLEASE CIRCLE ANSWERS

1. How many kitchen staff do you employ?
   (a) below 5
   (b) 5 – 10
   (c) 11 – 20
   (d) 21 – 30
   (e) 31 – 40
   (f) 41 – 50
   (g) 51 – 60
   (h) 61 – 70
   (i) 71 and above

Of these what percentage are qualified cooks?

(j) 5%

(k) 6 – 10%

(l) 11 – 20%

(m) 21% and above

What percentage are unqualified cooks?

(n) 5%

(o) 6 – 10%

(p) 11 – 20%

(q) 21% and above

In supervisory grades?

(r) 5%

(s) 6 – 10%

(t) 11 – 20%

(u) +21%

2. How many dining room staff are employed?

(a) 5 – 10

(b) 11 – 20

(c) 21 – 30

(d) 31 – 40

(e) 41 – 50

(f) 51 – 60

(g) 61 – 70

(h) 71 and above

How many supervisors?

(i) below 5

(j) 5 – 10

(k) 11 – 20

(l) 21 and above

Have you a minimum qualification policy for staff?

YES NO

3. Has your District agreed a formal catering policy?

YES NO

4. Is a catering advisor employed by your Region?

YES NO

5. (a) Have you read the Rayner Scrutiny on: 'The Cost of Catering in the Health Service'?

YES NO

If yes:

(b) Have you been asked to comment on it?

YES NO

(c) Have you had a response to your comments?

YES NO

Is your authority implementing the Report?

(d) Yes

(e) No

(f) Don't Know

(g) In Part

6. (a) Do you have training programmes for your staff?

YES NO

If yes: how far does this training extend?

(b) Cooks only

(c) Kitchen Supervisors

(d) Dining-room Supervisors

(e) Other Kitchen Staff

(f) Other Dining-room Staff

(g) Stores Staff

7. Is the training undertaken:

   (a) In-house

   (b) Externally

   (c) Mixed

8. What type of training is undertaken:

   (a) Supervisory

   (b) Craft

   (c) Hygiene

   (d) Fire

   (e) Health and Safety

   (f) Dietetic

   (g) First-aid

   (h) Other (please specify)

9. Is any staff appraisal system in operation?

   YES NO

10. (a) Do you have performance indicators?

   YES NO

   If yes: who sets them?

   (b) Catering Manager

   (c) District Catering Manager

   (d) Unit Administrator

   (e) Other (please specify)

11. Do Environmental Health Officers have open access to your Catering Department?

   YES NO

PART C: COSTINGS AND BUDGET CONTROL

1. (a) Do you hold your own budget?

   YES NO

   If no: who does?

   (b) Unit Administrator

   (c) District Catering Manager

   (d) District Treasurer

   (e) Other (please specify)

2. (a) Do you set your your own budget?

   YES NO

   If no: who does?

   (b) Unit Administrator

   (c) District Catering Manager

   (d) District Treasurer

   (e) Other (please specify)

3. Which items form part of the Catering Budget?

   PLEASE CIRCLE ALL APPLICABLE ANSWERS

   (a) Provisions

   (b) Baby Food

   (c) Dietary Supplements

   (d) Special Diets

   (e) Catering Wages

   (f) Catering Salaries

   (g) Administrative charges from other Departments

   (h) Cleaning Materials (Detergents etc)

   (i) Disposables

   (j) Crockery, cutlery and glasses

   (k) Other light equipment

(l) Travel, Subsistence etc

(m) Capital Equipment

(n) Maintenance

(o) Heat, Light and Power

(p) Floor Space

(q) Other (please specify)

4. (a) Is the budget calculated from a zero base, making allowance for expected patient throughput, types of diet etc.?

YES NO

If not: how is the budget decided?

(b)

5. (a) Is the budget divided into 13 × 4 week periods?

YES NO

If not: is it monthly?

YES NO

6. (a) Do you make comparisons between actual spend and budget:

YES NO

(b) If so are comparisons made each accounting/budgeting period (as in Question 4 – 4 weekly or monthly)?

YES NO

(c) Are the comparisons available to you:

(i) within a week of the period end

(ii) within a month of the period end

(iii) longer than a month (please specify)

7. (a) Do you use any form of micro-computer?

YES NO

For what purpose?

(b) Expenditure

(c) Accounting

(d) Budgeting

(e) Costing

8. (a) Do you know the cash value of stock held by you or by suppliers on your behalf who have been *paid* for it? (i.e. the value of all stock held that has been paid for by the unit or charged to it by district etc.)

   YES NO

   If yes: Is that value available to you

   (b) daily

   (c) weekly

   (d) monthly

   (e) longer (please specify)

   Does the stock value represent up to

   (f) 1 week's consumption

   (g) 2 week's consumption

   (h) 3 week's consumption

   (i) more than 3 week's (please specify)

9. If you underspend against your budget for a year is the cash value:

   (a) Carried forward on your catering account or permitted to be spent on extra equipment etc. in catering?

   (b) Transferred to someone else's budget in the unit or district?

   (c) Deducted from your budget allocation for the following year?

10. If you overspend your budget for a year is the cash value:

    (a) Carried forward on your catering account?

    (b) Absorbed into the unit budget?

    (c) Set against your allocation for the following year?

11. (a) Has your budget been increased by the NHS recommended allowance for inflation (five and a half percent for 1985/86)

    YES NO

If not: what allowance has been made?

(b) None

(c) Less than NHS recommendation

(d) More than NHS recommendation

PART D: PATIENTS PLEASE CIRCLE ANSWERS

1. How far in advance are patients asked to choose their meals?
   (a) Less than one day
   (b) One day
   (c) Two days
   (d) Three days
   (e) Four or more days
2. How many items of main course choice are there for each week?
   (a) One
   (b) Two
   (c) Three
   (d) Four or more
3. Do you know how often patients are unable to get their chosen meal?

   YES NO
4. Who decides on the dietary content of the meal?
   (a) Catering Manager
   (b) Dietitian
   (c) Joint Catering Manager/Dietitian
   (d) Other (please specify)
5. Do you provide *separate* menus for different diets?
   (a) Ordinary YES/NO
   (b) Therapeutic YES/NO
   (c) Vegetarian YES/NO
   (d) Ethnic YES/NO

(e) Children YES/NO

(f) Very Light YES/NO

(g) Others (please specify)

6. What times are meals served?

(a) Breakfast
- (i) Before 7.00 am
- (ii) 7.00 am – 7.30 am
- (iii) 7.30 am – 8.00 am
- (iv) 8.00 am – 8.30 am

(b) Lunch
- (i) Before 11.30 am
- (ii) 11.30 am – 12 noon
- (iii) 12 noon – 12.30 pm
- (iv) 12.30 pm – 1.00 pm
- (v) After 1.00 pm

(c) Supper
- (i) Before 5.00 pm
- (ii) 5.00 pm – 5.30 pm
- (iii) 5.30 pm – 6.00 pm
- (iv) 6.00 pm – 6.30 pm
- (v) After 6.30 pm

7. How often are beverages served per day?

(a) 3 times

(b) 4 times

(c) 5 times

(d) 6 times

(e) 7 or more times

8. Who is responsible for serving meals to patients?

(a) Catering Staff

(b) Nursing Staff

(c) Domestic Staff

(d) Other (please specify)

9. How are meals served?

(a) Plated

(b) Trayed

(c) Bulk Service

(d) Family Service

10. How far in advance of meal service times does food leave the kitchen?

(a) 5 – 15 minutes

(b) 15 – 20 minutes

(c) 20 – 30 minutes

(d) More (please specify)

(e) Less (please specify)

11. Do catering managers and staff visit wards at meal times?

(a) Regularly

(b) Frequently

(c) Rarely

12. What crockery is used for:

(a) MEALS	(i) China (ii) Melamine (iii) Disposable
(b) BEVERAGES	(i) China (ii) Melamine (iii) Disposable

13. (a) Are patients encouraged to comment on food?

YES NO

If yes: How?

(b) Verbally

(c) Questionnaire

(d) Patient Information Booklet

To whom?

(e) Nursing Staff

(f) Catering Manager

(g) Administrator

(h) Other (please specify)

14. Who deals with patients' complaints about food?
    (a) Nursing Staff
    (b) Catering Manager
    (c) Administrator
    (d) Other (please specify)

15. Are details and number of complaints registered?
    YES NO

PART E: STAFF PLEASE CIRCLE ANSWERS

1. What number of main staff meals do you serve?
    (a) up to 50
    (b) 51 – 100
    (c) 101 – 200
    (d) 201 – 300
    (e) 301 – 400
    (f) 401 – 500
    (g) 501 – 600
    (h) 601 – 700
    (i) 701 – 800
    (j) Over 800 (please specify)

    What percentage of total staff is this?
    (k) 50%
    (l) 51 – 60%
    (m) 61 – 70%
    (n) 71 – 80%
    (o) 81% and over

2. What is average spend per main meal per customer?
    (a) 50p – £1
    (b) £1 – £1.50

(c) £1.50 – £2

(d) Over £2

3. (a) Do you provide a night service?

YES NO

If yes: Is it

(a) Full meals service

(b) Hot snack service

(c) Cold snack service

(d) Beverages only

If no: when does the catering service close?

(e) 5.00 pm

(f) 6.00 pm

(g) 7.00 pm

(h) 8.00pm

(i) 9.00 pm

(j) Between 9.00 pm and 12 midnight

What arrangements are made for staff working 'unsocial hours'?

(k) Snack Vending

(l) Beverage Vending

(m) Own cooking facilities

(n) Nothing

4. How many dining rooms do you have?

(a) 1

(b) 2

(c) 3

(d) 4

(e) 5 or more

If the answer is more than 5, how are they categorised?

(f) By price

(g) By status

(h) By nature of service e.g. waitress, private function, other

(i) Post-graduate Centre

(j) Other (please specify)

5. Do you have a separate coffee lounge?

   YES NO

6. Do you have a separate snack bar?

   YES NO

7. Do you offer a call order service?

   YES NO

8. Are your menus the same for patients and staff?

   YES NO

9. How many many meal choices are there for staff?

   (a) None

   (b) 1

   (c) 2

   (d) 3

   (e) 4

   (f) 5

   (g) 6 or more

10. Do you make provision for:

    (a) Vegetarian Diets YES/NO

    (b) Ethnic Diets YES/NO

11. Do you supply a request service for

    (a) Theatres

    (b) Out-patients

    (c) Occupational Therapy

    (d) Creche

    (e) Other (please specify)

12. Who is allowed to use your dining areas?

(a) Staff YES/NO

(b) Patients YES/NO

(c) Patients' visitors YES/NO

(d) Contract Staff YES/NO

(e) Visiting NHS Employers YES/NO

(f) Ex-employees YES/NO

(g) Others (please specify)

13. Are there other catering outlets on your site?

(a) Social Club YES/NO

(b) League of Friends YES/NO

(c) Medical Schools Clubs YES/NO

(d) Other (please specify)

14. Do you know the perecentage of staff who use these outlets?

YES NO

15. Do you have 'special food' days or weeks?

YES NO

16. (a) Are staff encouraged to comment on food?

YES NO

If yes: how?

(b) Verbally

(c) Questionnaire

To whom?

(d) Catering Manager

(e) Administrator

(f) Other (please specify)

17. Who deals with staff complaints about food?

(a) Catering Manager

(b) Administrator

(c) Other (please specify)

18. Are details and numbers of complaints registered?

YES NO

PART F: FOOD AND HEALTH POLICY PLEASE CIRCLE ANSWERS

State of Development of Food and Health Policy in your District

1. Is any work being done in your District in developing or implementing a Food and Health Policy?

YES NO
If YES – please see Question 2
If NO – please see Question 3

2. If you answered 'Yes' to Question 1 –
How far have you progressed?

PLEASE CIRCLE STAGES REACHED SO FAR

(a) Informal discussions prior to setting up working groups(s)

(b) Formal discussions e.g. with DMT, DHA

(c) Working groups/Food and Health Policy teams set up

(d) Draft Policy Document produced

(e) Official Policy Document produced

(f) Strategy/plans for implementation agreed

(g) Other (please specify)

3. If you answered 'NO' to Question 1 –

Are there plans to develop a District Food and Health Policy in the future?

YES NO

Plans for Implementation

4. The following is a list of areas included by some Districts in their Food and Health Implementation Plans. Please circle those which apply to your District in the plans drawn up so far.

Hospitals –

(a) Improved Menus for patients

(b) Improved menus for staff

(c) Training of catering staff

(d) Training of hospital nursing staff

(e) Training of other staff

(f) Supplies involvement – improved purchasing procedures

(g) Nutritional specifications

Patient Feeding

Advice on Healthier Eating

5. (a) Is there guidance on selecting foods to promote healthier eating

YES NO

If yes: Is it given

(b) Verbally

(c) On the back of individual menus

(d) Provided in a handbook issued to patients on their admittance to hospital

(e) If other arrangements exist please specify

Recipes

6. Please indicate by how much the following ingredients have been reduced in dishes prepared for the patients.

(a) Salt	(i) 5 – 10%
	(ii) 11 – 20%
	(iii) 21 – 30%
	(iv) +31%
(b) Fat	(i) 5 – 10%
	(ii) 11 – 20%
	(iii) 21 – 30%
	(iv) +31%
(c) Sugar	(i) 5 – 10%
	(ii) 11 – 20%
	(iii) 21 – 30%
	(iv) +31%

7. Do you provide pastry and bread made with wholemeal flour?

   YES NO

8. What proportion of bread used is made of wholemeal flour?

   (a) 5 – 10%

   (b) 11 – 20%

   (c) 21 – 30%

   (d) 31 – 40%

   (e) 41 – 50%

   (f) +51%

9. What proportion of pastry dishes are made of wholemeal flour?

   (a) 5 – 10%

   (b) 11 – 20%

   (c) 21 – 30%

   (d) 31 – 40%

   (e) 41 – 50%

   (f) +51%

Use of Salt

10. Please state whether the patients receive individual condiment sets at meal times?

    YES NO

11. What amount (in Grams) of salt is used per patient per week?

Staff Feeding

12. Please describe briefly the arrangements to promote healthier eating in Staff Restaurant(s).

13. Do you collarborate/enlist the help of a dietitian in compiling the menu?

YES NO

14. Please indicate by how much the following ingredients have been reduced in dishes prepared for sale in the Restaurant(s).

(a) Salt	(i) 5 – 10% (ii) 11 – 20% (iii) 21 – 30% (iv) +31%
(b) Fat	(i) 5 – 10% (ii) 11 – 20% (iii) 21 – 30% (iv) +31%
(c) Sugar	(i) 5 – 10% (ii) 11 – 20% (iii) 21 – 30% (iv) +31%

15. Do you provide pastry and bread made with wholemeal flour?

YES NO

16. What proportion of bread is made of wholemeal flour?

(a) 5 – 10%

(b) 11 – 20%

(c) 21 – 30%

(d) 31 – 40%

(e) 41 – 50%

(f) +51%

17. What proportion of pastry dishes are made of wholemeal flour?

(a) 5 – 10%

(b) 11 – 20%

(c) 21 – 30%

(d) 31 – 40%

(e) 41 – 50%

(f) +51%

18. What are the principal problems you have encountered so far?

19. Any other comments?

20. Could you please enclose with this completed questionnaire a copy of your Food and Health Policy and/or dietary guidelines if available?

PART G:FUNCTIONS PLEASE CIRCLE ANSWERS

1. How many functions, other than routine refreshments and working lunches, does your department cater for in a year?

   (a) 10 – 20

   (b) 21 – 30

   (c) 31 – 40

   (d) 41 – 50

   (e) 51 – 60

   (f) 61 – 70

   (g) 71 – 80

   (h) 91 – 100

   (i) 101+ (please specify)

2. Of these how many are:(a) For individuals employed by the authority e.g. retirement parties, birthdays, weddings.

   (i) 10 – 20%

   (ii) 21 – 30%

   (iii) 31 – 40%

   (iv) 41 – 50%

   (v) 51 – 60%

   (vii) 71 – 80%

   (viii) 81 – 90%

   (ix) 91%+

(b) Special Authority Events

(i) 10 – 20%

(ii) 21 – 30%

(iii) 31 – 40%

(iv) 41 – 50%

(v) 51 – 60%

(vi) 61 – 70%

(vii) 71 – 80%

(viii) 81 – 90%

(ix) 91%+

(c) Special Occasions (e.g. Christmas)

(i) 10 – 20%

(ii) 21 – 30%

(iii) 31 – 40%

(iv) 41 – 50%

(v) 51 – 60%

(vi) 61 – 70%

(vii) 71 – 80%

(viii) 81 – 90%

(ix) 91%+

(d) Promotion Events (e.g. Drug Companies etc)

(i) 10 – 20%

(ii) 21 – 30%

(iii) 31 – 40%

(iv) 41 – 50%

(v) 51 – 60%

(vi) 61 – 70%

(vii) 71 – 80%

(viii) 81 – 90%

(ix) 91%+

(e) Other – please specify

3. For individuals employed by the authority e.g. retirement parties etc are these events costed:
   (a) 60/40 + vat
   (b) 75/25 + vat
   (c) 60/40 + labour + vat
   (d) Labour + provisions only
   (e) Trust funds
   (f) Endowment funds
   (g) Staff amenities
   (h) Individual
   (i) Other (please specify)

4. For special authority events, are these events costed:
   (a) 60/40 + vat
   (b) 75/25 + vat
   (c) 60/40 + labour + vat
   (d) Labour + provisions only
   (e) Trust funds
   (f) Endowment funds
   (g) Staff amenities
   (h) Individual
   (i) Other (please specify)

5. For special occasions, are these events costed:
   (a) 60/40 + vat
   (b) 75/25 + vat
   (c) 60/40 + labour + vat
   (d) Labour + provisions only
   (e) Trust funds
   (f) Endowment funds
   (g) Staff amenities

(h) Individual

(i) Other (please specify)

6. For promotion events e.g. Drug Companies are these events costed:

   (a) 60/40 + vat

   (b) 75/25 + vat

   (c) 60/40 + labour + vat

   (d) Labour + provisions only

   (e) Trust funds

   (f) Endowment funds

   (g) Staff amenities

   (h) Individual

   (i) Other (please specify)

7. (a) Are all events re-charged to another budget?

   YES NO

   If no: Who pays (absorbs) the account?

   (b) Catering budget

   (c) Admin budget

   (d) Finance budget

   (e) Other (please specify)

8. (a) Do any categories of events under question 2 make a profit?

   YES NO

   If yes: to whom is the profit credited?

   (b) Catering

   (c) Trust/Endowment Funds

   (d) Admin

   (e) Other (please specify)

9. Does the catering department aim to make a profit on functioning catering?

   YES NO

Appendix III

THE NACNE REPORT

	In the 1980s (five years)	By year 2000 (fifteen years)
FATS	Reduce intake from 38% now, to 34% of total energy. (128g to 115g daily)	Reduce to 30% of total energy (101g daily)
	Saturated fat should be reduced soon to 15% of total energy (56g daily); in the long term to 10% (37g daily). An increase in polyunsaturated fat at first is recommended, to make the eventual reduction easier.	
SUGAR	Reduce from 14% to 12% of total energy 104g to 89g daily)	Reduce to 7% of total energy (52g daily)
CARBOHYDRATE (other than sugar)	Increase, to make up individuals' calculated energy needs	
	The Report recommends an increase in exercising, which would mean an increased energy demand for most individuals. The weights of foodstuffs shown above are averages for the population, and not as important as the percentages of total energy.	
SALT	Reduce by 10%, from average 10g to 9g daily	Reduce to 7g, average, daily
PROTEIN	Daily intake should stay the same (about 11%) but more should come from vegetable sources).	
FIBRE	Increase from present 20g to 25g per day	Increase to 30g per day
ALCOHOL	Reduce to 4% of total energy intake per day	

A discussion paper on proposals for nutritional guidelines for health education in Britain prepared for the National Advisory Committee on Nutrition Education by an ad hoc working party under the Chairmanship of Professor W P T James. Published by the Health Education Council, September 1983.

Recommendations

The report outlined goals for dietary change during the 1980s and, in the longer term, by the end of the century.

THE COMA REPORT

Committee on Medical Aspects of Food Policy Report of the Panel on Diet in relation to Cardiovascular Disease, DHSS, July 1984

The report of a Government committee convened to examine the relationship between diet and heart disease.

Recommendations

FATS

Recommended average daily intakes of total fat, and of saturated and polyunsaturated fatty acids

Category	1981	Recommended average
Total fat:–		
g per day	104	77–87*
per cent energy	42	31–35*
Saturated fatty acids**:–		
g per day	49	37
per cent energy	20	15
Polyunsaturated fatty acids:–		
g per day	11.4	8.6–16.7*
per cent energy	4.7	3.5–6.8*
P/S ratio	0.23	0.23–0.45

** Inclusive of trans fatty acids

* Depends upon the P/S ratio; the upper limit corresponds to the recommendation ratio of approximately 0.45

SUGAR

Intake of simple sugars (sucrose, glucose and fructose) should not be increased further. Restriction of intake of these sugars has been recommended on other health grounds (for example, dental caries).

CARBOHYDRATE	There are advantages in compensating for a reduced fat intake with increased fibre-rich carbohydrates (for example bread, cereals, fruit, vegetables), provided this can be achieved without increasing total intake of common salt or simple sugars.
SALT	The UK average daily intake of salt is needlessly high (currently 7g–10g per day). C.70% of salt is taken in from processed foods, with c. 30% added during cooking and eating. This could be cut down immediately.
ALCOHOL	An excessive intake of alcohol is to be avoided on general health grounds. No specific recommendations are made in respect of low or moderate intake of alcohol in relation to cardiovascular disease.

Appendix IV

RANGE OF DIETARY NEEDS WITHIN THE NHS

Very ill patient (may require intravenous or enteral feeding)

Liquid/fluid diet

Liquid supplements (to accompany enteral feeding)

Soft/semi-solid

'Light'

'Normal'

Balanced study diets

Vegetarian (lacto-vegetarian/vegan)

Kosher

Chinese/Asian/West Indian

Prescribed diet, for example: low protein
diabetic
reducing
low fat
milk-free
low cholesterol

Sterile diets

Types of patient

Paediatric
Maternity
Geriatric
Mentally ill
Mentally and physically handicapped

Medical
Surgical
Psychogeriatric
Gynaecological
Orthopaedic

ENT
Ophthalmological
Neurological

Specialities

Oncology
Renal
Liver
Bone marrow transplant
Heart transplant
Metabolic unit

Appendix V

Recommendations from *Are They Being Served?* by V Coates, Royal College of Nursing, 1985

As a result of this study and other work it is advocated that nurses must accept greater responsibility for the nutritional care of patients on the ward for which they should be held accountable.

The intake of patients with anorexia, or special dietary requirements was not observed to be checked, relevant information was not always communicated, and patients were not necessarily weighed, even if prescribed a reducing diet. Nursing responsibility for the nutrition of patients on the ward must encompass such aspects of care.

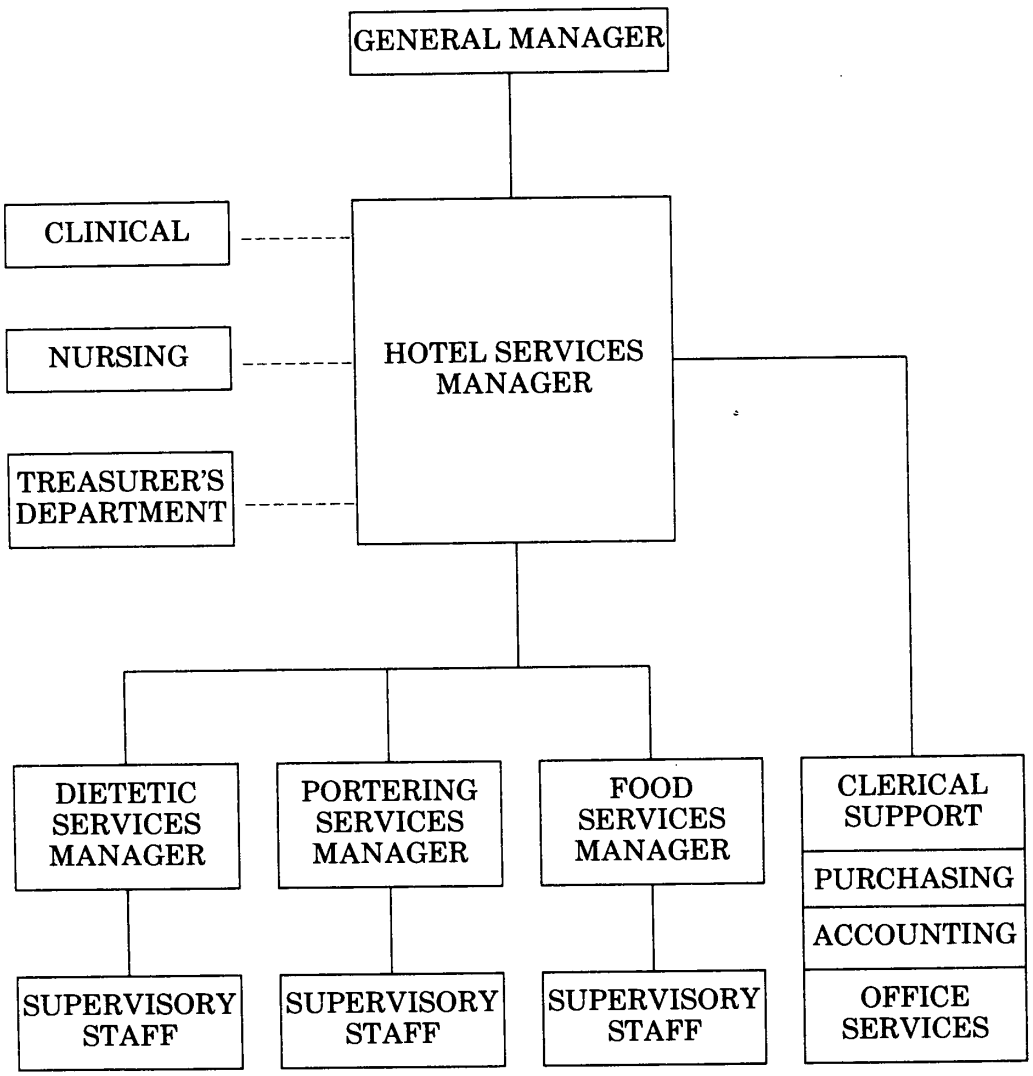
Before nurses are able to undertake this responsibility they require a greater understanding of the nutritional needs of patients. More emphasis needs to be placed on this aspect of the curriculum during training. Such a change would obviously require considerable planning by the nurse tutors.

During the course of the study it was found that many patients has a very low nutritional intake. If there are indications that a patient has a problem with his eating or nutritional status his nutritional intake should be observed and its adequacy estimated in relation to his recommended needs.

The intake of patients prescribed a special diet should be assessed, and (if necessary) charted. Nurses should be aware of, or have access to, the recommended or prescribed intake of the patients for which they are caring.

Appendix VI

MANAGEMENT TREE



Appendix VII

SALARIES AND BENEFITS

Managerial posts

The Surrey survey shows the median rate of pay for each group surveyed: that is the mid-point in each range of grades. We have used the rates of pay shown for *direct* industrial catering staff rather than those for *contract* catering because the direct rates are nearer in work comparison terms to NHS caterers. One of the chief difficulties in using these figures is that they are given for 'unit' managers, with no indication of the size of unit.

Direct industrial catering

Inside London £10,764 per annum

Outside London £8,800 per annum*

We have much more information for NHS catering managers. A large number of grades can be used for managerial posts and in principle the scale runs from HCO at £4,897 to £,925 (plus a £366 allowance) to a Scale 23 at £12,370 to £15,611. Scale 23 is, however, only used for regional catering advisors and one district catering advisor. Normally, district catering advisors – who are also responsible for managing a catering unit – are on a salary range from £9,827–£13,183. These rates are at the top of the normal range for NHS catering managers and 115 people are on them.

By far the largest number of managers are at much lower levels. Five hundred and seventy seven managing larger units are on scales ranging from £6,190 to £9,431. Assistant catering managers and catering supervisors who run smaller establishments number 578. Their rates are from £5,000 to £7,737.*

*1984 figures

Non-managerial posts

Direct comparisons between the NHS and the private sector are easier to make for non-managerial posts. The following NHS figures are for January 1985 and are for *basic* weekly rates.

Direct industrial catering*		NHS	
Head chef	£146.60	Head cook	£86.16
Cook	£110.00	Senior cook	£81.62
Trainee cook	£ 92.80	Cook	£79.40
Catering assistant	£ 91.60	Catering assistant	£68.98
Waitress	£ 93.60		
Kitchen porter	£104.00	Porter (Grade 3)	£71.73

If rates are difficult to compare, benefits are doubly difficult. It is probable that the hours worked in the NHS are longer than those in private industry, which of course sends the level of ancillary earnings up considerably, particularly for men. It is more difficult to make such a statement about managers. Managers in the NHS attract no enhancements for the number of hours worked over the standard week, nor do they attract unsocial hours payments. Holiday entitlement and pensions are better for most NHS staff, although direct industrial catering staff benefit from any collective agreements secured at the place of work. When Clegg wrote about comparability between NHS staff and private sector workers in 1980, he made the point that job security, although unquantifiable, clearly improved the benefit part of the reward package for NHS staff. Now that NHS staff, particularly in catering and cleaning, can no longer enjoy a feeling of security, that benefit must be deleted from the package.

*1984 figures

This is the report of an independent committee, chaired by Lady Margaret McCarthy, which undertook the review at the invitation of the Hospital Caterers' Association and with the support of a grant from the King's Fund. The committee was asked to investigate and report on the perceived needs of patients and staff in hospitals with special reference to nutrition and dietary education, elimination of unnecessary waste, varied and attractive menus, and a pleasing and healthy environment — all within the framework of an economic and cost-effective catering service.

The two sections of the report deal with catering services provided for patients and staff, and with the finance and management systems required to support these services, and makes recommendations for both.

£2.50