This report has been prepared under Section 6 of the National Audit Act 1983 for presentation to the House of Commons in accordance with Section 9 of the Act.

John Bourn
Comptroller and Auditor General

National Audit Office
5 April 1994

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Preface

Food is an integral part of total hospital care, with well nourished people likely to make a quicker recovery. The provision of food to patients has many complex features which present a major challenge for caterers in the National Health Service. Primary responsibility for securing good quality catering at a reasonable cost lies with the catering units of individual hospitals.

The NHS Management Executive of the Department of Health set broad national policy on catering services which they seek to achieve through the effective working of the NHS internal market. To this end, they gather information on costs from hospital finance and catering departments and issue guidance and standards. The NHS spent some £491 million in 1991-92 on hospital catering in England, excluding water, energy and capital costs. There are approximately 19,000 NHS catering staff and managers, and 600 catering departments. The majority of catering services have been market tested, and at present most are managed in house.

This National Audit Office report examines the quality of the catering service provided to patients and how catering costs are controlled.

In reviewing how catering units provide a service to patients that is efficient, effective, economic and responsive to their needs, the National Audit Office focused on the roles of the Management Executive, district health authorities and catering units in hospitals in England.
Summary and conclusions

The quality of catering service provided to patients

Paragraph 2.3
1 The Citizen’s Charter calls for the setting and monitoring of explicit standards for the services that individual users can reasonably expect. At the time of the study around three quarters of hospital catering managers had quality standards against which they could judge their performance, although not all standards were explicit or complete. This still leaves a significant number who have neither standards nor targets to aim for.

Paragraphs 2.7 to 2.9
2 Regular and systematic consultation with customers is important if their views are to be understood and problems acted upon. The great majority of catering operations consult their customers by means of written questionnaires. At the hospitals visited by the National Audit Office, between 80 and 90 per cent of patients responding to such questionnaires said they were satisfied with the catering services they had received.

Paragraph 2.10
3 The National Audit Office survey of patients at 24 randomly selected hospitals found that out of those participating (1,500 out of a sample of 3,000) 85 per cent regarded the food they were given as good or excellent. The remaining 15 per cent thought that the food was either poor or very poor. There was, however, a significant difference in the responses from people in different age groups. Younger people taking part in the survey expressed considerably less satisfaction than older patients. Over a quarter of those questioned who were under 35 years of age thought that the food was either poor or very poor.

Paragraph 2.11
4 The patients survey also showed that levels of satisfaction varied substantially between individual hospitals. Twelve of the 24 hospitals in the sample had satisfaction levels of between 90 and 100 per cent. In a further five, however, less than 75 per cent were satisfied and over 25 per cent of patients thought that the food was either poor or very poor.

Paragraphs 2.14 to 2.21
5 The National Audit Office found a number of factors within the control of catering departments which might influence the extent to which patients are satisfied with the catering service they receive. Some will have cost implications, but many are areas where changes could be made with little or no increase in cost. Possible changes included the extent to which meals have to be ordered in advance, the appearance and presentation of food, the amounts served, the temperature of the food at the time it is served, and the way complaints are dealt with.
Paragraphs 2.22 and 2.26

6 Providing patients with information about healthy eating options on hospital menus can raise awareness of healthy eating issues and supports the aims of the Government's Health of the Nation White Paper. Sixty one per cent of hospitals provide some form of nutritional guidance on their menus.

Paragraph 2.27

7 In August 1992 the NHS Management Executive advised health authorities to include specific nutritional standards in their contracts to purchase services from hospitals. None of the authorities purchasing services from the hospitals visited had yet implemented this advice. Fifteen health authorities were asked whether they had set or planned to set nutritional standards. All confirmed that they had either set such standards, or would introduce them in the future. Seventy two per cent of hospitals had set specific nutritional standards and 52 per cent had specific nutritional targets.

Paragraph 2.33

8 If hygiene standards are to be maintained catering staff need to be properly trained. Most of the hospitals visited kept up-to-date staff training records which were easily accessible, although in a minority of hospitals these records were not up-to-date.

Paragraph 2.34

9 The absence of proper training can lead to poor and inherently dangerous hygiene practices. Such practices are not widespread, but in one of the twelve hospitals visited food was being regenerated in a way which could be perceived as breaching the Department's cook-chill guidelines.

How costs are controlled

Paragraphs 3.5 and 3.10

10 The Management Executive's information on the cost of NHS catering is not up-to-date and needs to be treated with some caution. Nevertheless, it shows a wide range of catering costs. The average reported cost of meals per patient day in NHS hospitals in 1991-92 was £5.45. Within this average some hospitals reported costs of less than £2 while some exceeded £10 and sometimes £15 per patient per day. There was no correlation between the amount spent on food and the satisfaction rating expressed by patients.

Paragraph 3.9

11 The information available shows that while size and type of hospital may have some influence on catering costs, many hospitals of similar size and nature can be found in both the upper and lower cost range. This suggests that within the wide range of reported costs there may be some scope for economy. If catering departments with higher costs could reduce them without loss of quality there could be significant savings for the NHS. However, in the absence of a detailed study of the relation between costs, quality of service, and other relevant factors, it is difficult to assess the degree to which savings could be achieved without reduction in standards. The Management Executive agree that there is undoubtedly scope for some saving.

Paragraphs 3.11 - 3.25

12 A number of measures contribute to good financial management including: improving the timeliness of financial information; increasing the accuracy of meal production forecasts; better monitoring of waste; the use of costed
recipes; considering alternative ways of delivering meals; tightening control over staff costs; enhancing security of assets and stocks; and improving the monitoring of contract expenditure.

Paragraphs 3.26 - 3.29

13 In 1983 the Department asked hospitals to test the cost-effectiveness of support services by putting them out to tender by September 1986. The survey of catering managers showed that 77 per cent of catering operations have now been market tested. Where market testing has taken place, four or five organisations have usually been invited to tender. In many cases, however, only one response was received. The great majority (82 per cent) of competitions have been won by in-house bidders.

Paragraph 3.31

14 There are, at present, no national targets or measures for catering operations. A number of hospitals told the National Audit Office that they would welcome the development of such indicators. Measures covering the cost of patient food, the level of patient satisfaction and compliance with hygiene standards would prove valuable to catering departments. The lack of effective competition during some market testing exercises makes the value of performance measures even greater.

Paragraph 1.8

15 In September 1993 the NHS Management Executive established a working group to examine the roles of district health authorities and hospitals in improving quality and value for money and in particular to develop performance indicators for their use.

General conclusions

16 Many hospitals have been successful in delivering high quality food within tight budgets to their patients. Nevertheless, there are significant variations in the extent to which patients are satisfied, both at individual hospitals, and between different patient age groups. There are also major differences in the cost of the meals delivered. This, together with the different approaches to financial management set out in this Report, suggests that many hospitals could go further towards achieving economies without prejudicing quality.

Action required by hospitals

17 Individual hospitals should review their catering service and consider, if they have not already done so:

- establishing and publishing specific quality standards and targets, and monitoring these by carrying out regular surveys of patients' views;
• improving patient satisfaction by allowing patients to order their meals as close to
the time of eating as is possible; varying meal sizes to match appetites; improving
the presentation of meals to make them attractive to sometimes jaded palates;
serving hot meals at an adequate temperature and promptly investigating patients' complaints;

• applying for the Health Education Authority's "Heartbeat" award and providing
informative menus which enable patients to choose healthy eating options;

• improving the provision of financial information for catering units so as to eliminate
undue delays and quickly detect excessive expenditure;

• improving the economy of catering by adopting meal ordering systems which
directly reflect patient requirements; monitoring and reducing waste; using costed
recipes; examining the security of assets; and reviewing staff costs; and

• reviewing their approach to market testing in the light of the Department's revised
guidance.

Action required by health authorities

18 Health authorities should:

• include specific nutritional standards in their contracts for healthcare services; and

• consider which other quality or delivery standards should be set for the provision
of food to patients, and how they should be monitored.

Action required by National Health Service
Management Executive

19 The NHS Management Executive should:

• review the progress of their working group and establish a timetable for
implementing agreed recommendations;

• monitor the overall impact of changes resulting from the recommendations of the
working group;

• identify their essential information needs and ensure such information collected
is accurate and timely;

• provide local managers with accurate and timely comparative information which
could form the basis for performance management;

• continue to monitor the progress made by hospitals towards testing the quality
and cost-effectiveness of catering services by putting them out to tender.
Introduction

"Food ..... breaks up the monotony of hospital life, giving us enjoyment, comfort and solace. Meal times should be a pleasurable experience, worthy of the wait. We don't want to be, and should not have to be, disappointed".

Albert Roux. Speech to Hospital Caterers Association. 1993

1.1 Food is an integral part of total hospital care, with well nourished patients likely to make a quicker recovery. For the majority of patients there are no alternative catering facilities - they are, in effect, captive customers. The quality, presentation, colour, aroma, taste and texture of food in hospitals are all important to ensure that meals are tempting to those with the poorest appetite. At the same time, hospital catering presents especially complex features compared with those met in most other large catering establishments. These features include the short time that some patients may spend in hospitals, special dietary requirements, the remoteness of kitchens from some wards, and the need for hospitals to stay within tight cost limits. All these aspects present a major challenge for caterers in the NHS.

1.2 The NHS spent some £491 million in 1991-92 on hospital catering in England, excluding water, energy and capital costs. In terms of expenditure, the NHS is the third largest purchaser of catering services in the United Kingdom and is exceeded only by business and industry (£1.5 billion a year) and local authority education catering (£1.1 billion a year). There are approximately 19,000 NHS catering staff and managers and 600 catering departments in England.

Departmental policy

1.3 Ministers have made clear, most recently in "Managing in the new NHS", that management responsibility should be exercised as close to the patient as possible, and that is in the hospitals providing the service. The Management Executive regard catering as a prime example of the kind of responsibility best left to local management who can more readily ascertain and respond to the needs of patients.
Responsibilities of Hospitals

1.4 The objective of hospitals is to provide a food service to patients that is economic, efficient and effective. They are responsible, within the discipline imposed by their financial targets, for day to day management and control of their own catering services, and setting and improving their own standards.

1.5 Hospitals have a wide variety of catering facilities serving between 14 and 1,400 beds. Food is prepared mainly through traditional cooking methods but in some hospitals meals are prepared in advance, chilled and then heated when required. At present nearly one third of NHS caterers use these cook chill techniques. Some cook chill meals are produced in kitchens on site but the majority are either prepared by central kitchens at other locations or are purchased from outside contractors. The vast majority of food used in preparing hospital meals is purchased through the NHS Supplies Authority. The Supplies Authority is contracted to provide a supply service to hospitals, although from 1 April 1993 trusts have been free to make their own supplies arrangements. Only a few (three or four) have done so.

District Health Authorities

1.6 District health authorities are responsible for maintaining an overview of the standards delivered through the contracts which they place with hospitals. The Management Executive now expect purchasers of healthcare services (mainly district health authorities) to ensure that contracts contain acceptable nutritional and other standards for catering services.

Rôle of the Management Executive

1.7 The objectives of the Management Executive are to set broad national policy for NHS catering which they seek to achieve through the effective working of the NHS internal market. The Management Executive aim to meet their objectives by providing guidance and advice and gathering information from memorandum trading accounts submitted annually by finance departments. The Department of Health retain responsibility for public health aspects of food safety and nutrition.

1.8 In September 1993 the Management Executive established a working group to undertake a review of a number of key aspects of NHS catering. This initiative will include: an examination of the rôles of purchasers and providers of catering services in improving quality and value for money; a review of how far it is feasible for the Executive to stimulate good practice in this area; consideration of the case for performance measures to help management decision making and improve the functioning of the internal market; and an examination of the availability of professional advice to catering departments.
together with provision of suitable training. Any recommendations for change made by its working group will be subject to the endorsement of the Management Executive.

Scope of the National Audit Office examination

1.9 Against this background, the National Audit Office examined the way the NHS seek to provide a food service to patients:

- the quality of the catering service provided to patients (Part 2); and
- how catering costs are controlled (Part 3).

1.10 The National Audit Office commissioned Thames Management Services to undertake a survey of:

- 3000 patients spread amongst 24 randomly selected hospitals (Appendices 1 and 2); and
- 420 National Health Service hospital catering managers in England (Appendix 2).

1.11 To assist their evaluation of hospital catering, the National Audit Office appointed Tricon Foodservice Consultants and Ron Anderson Consultancy as advisors to the study. The team took account of the views of the interested bodies listed at Appendix 3 and the experience of hospital caterers in France and the USA (Appendix 4).

1.12 In addition the National Audit Office visited with their catering consultants:

- a sample of 12 NHS hospitals, chosen as far as possible to be representative of hospitals in England (Appendix 1);
- a commercial supplier of cook-chill meals to the NHS (Appendix 3); and
- a private hospital (Appendix 3).
Quality of catering service provided to patients

"Hospital food isn't awful but I will admit that some hospital food is better than others".

Albert Roux. Speech to Hospital Caterers Association, 1993

2.1 Food served in hospitals should be enjoyed by patients, provide good nutritional value, meet environmental health requirements and be safe to eat. The National Audit Office considered these important aspects of quality by examining the approach adopted at 12 NHS hospitals, commissioning a patient satisfaction survey, and seeking information and views from NHS catering managers and interested bodies.

2.2 This part of the report examines the steps taken by the Management Executive, health authorities and hospitals to (i) set and monitor quality standards (ii) establish whether patients are satisfied with the food they are given (iii) encourage healthy eating and maintain nutritional standards, and (iv) ensure compliance with food safety and hygiene standards. The cost of catering is examined in Part 3 of the report.

Setting Quality Standards

2.3 The Citizen's Charter calls for the setting and monitoring of explicit standards for services that individual users can reasonably expect. Along with professional advice during the 1980s, the Department have, amongst other things, issued revised guidance on market testing, produced codes of practice for Environmental Health Officers and sent out a circular on the need for hygiene and nutritional standards. There are, however, no nationwide NHS catering quality standards or guidelines. The Department intend, however, to produce nutritional guidelines in 1994. At local level, the National Audit Office survey of catering managers found that the majority (79 per cent) set quality standards and about half (64 per cent) have quality targets against which performance can be monitored. This leaves a significant number who have neither standards nor targets to aim for.
2.4 All 12 hospitals visited have set quality standards for catering. These include standards for food purchases (such as cuts of meat) and codes of hygiene practice. At Princess Royal Hospital, Hull, performance payments to staff were influenced by their success in achieving quality standards. Some hospitals, however, lacked clearly defined targets for food quality, timing and delivery of meals. In August 1992 the Management Executive issued Circular HSG(92)34 which advised that contracts between health authorities purchasing catering services and individual hospitals should include comprehensive nutritional standards or targets for catering. At the time of the study none of the hospitals visited had included such standards or targets within contracts with their health authorities.

2.5 At the time of the study some health authorities had plans to establish not only standards for nutrition but also proposed to set and monitor other catering quality and delivery standards. Some, however, had made only limited progress towards achieving this objective.

Patients Association Guidelines

2.6 In May 1993 the Patients Association published guidelines for minimum standards of quality for food served to patients in hospitals. These stressed among other things, that:

- an attractive presentation is very important in making food appetising to the patient who may not feel like eating, but needs nourishment;

- patients should be able to order as near as possible to the time of the meal itself;

- patients should be able to select a meal from a choice of dishes and decide whether they want a large or small helping at the time of ordering; and

- hot dishes should, in fact, be hot, and smell appetising.

Patient Satisfaction

2.7 The Citizen's Charter requires regular and systematic consultation with those who use public services. The Patient's Charter encourages health authorities to continue and expand their use of questionnaires and surveys to find out what patients think of service provision and how things could be done better.
2.8 The great majority of catering operations seek feedback from patients on the catering services provided. Around 80 per cent do this by asking patients to complete questionnaires on the service provided. Patient surveys are carried out by catering departments at 11 of the 12 hospitals visited.

2.9 The responses to the patient satisfaction surveys carried out by hospitals suggest that patients are generally satisfied with the catering arrangements. Levels of satisfaction range between 80 and 90 per cent. This is in line with the findings of the Royal Commission on the NHS which in 1978 carried out a survey of patients and found that 82 per cent were satisfied with the food they were given in hospital.

2.10 The National Audit Office survey of patients at 24 randomly selected hospitals found that out of those participating (1,500 out of a sample of 3,000) 85 per cent regarded the food they were given as good or excellent. The remaining 15 per cent thought that the food was either poor or very poor. There was, however, a significant difference in the responses from people in different age groups. Younger people taking part in the survey expressed considerably less satisfaction than older patients. Over a quarter of those questioned who were under 35 years of age thought that the food was either poor or very poor (Figure 1).

Figure 1 Patient satisfaction with the catering service by age group

Source: National Audit Office

Figure 1 shows that patients in younger age groups express a higher level of dissatisfaction with the catering service than older patients.
2.11 The patients survey also showed that levels of satisfaction varied substantially between individual hospitals. Twelve of the 24 hospitals in the sample had satisfaction levels of between 90 and 100 per cent. In a further five, however, less than 75 per cent were satisfied and over 25 per cent of patients thought that the food was either poor or very poor (Figure 2).

Figure 2 shows that patient satisfaction levels vary considerably from hospital to hospital.

![Figure 2: Levels of satisfaction at hospitals surveyed](image)

Source: National Audit Office Patients Survey

2.12 Patients offered a wide range of comments on hospital catering when they replied to our questionnaire. The following examples illustrate the range of views offered.

**Patients Comments on Catering**

"I have only praise for the food I have enjoyed during my stay. It is well presented and served by clean helpful staff who always ask if I enjoyed the meal and had sufficient. I would give the catering team four stars. Well done!"

"The service provided is by and large good, but I feel that as always there is room for improvement."

"Food good and well presented."

"It is obviously difficult to cater for a large hospital with many varied diets. However, the menu supplied was varied and in theory appetising. However, the food was lukewarm, unappetising and, for example, egg florentine, was inedible - the egg was cooked so hard as to become rubber, the spinach was so runny it was revolting and it came with baked beans and reconstituted mashed potato - need I say more."

Source: National Audit Office Patients Survey
2.13 Individual hospitals may choose to set different targets for patient satisfaction depending upon their local circumstances. The National Audit Office's consultants advise, however, that in the commercial and private hospitals sector satisfaction targets are often set at 95 per cent or more. While similar targets may not necessarily be appropriate in the NHS, in the National Audit Office's view any dissatisfaction needs to be taken seriously and the concerns of individuals should be addressed; levels of dissatisfaction at individual hospitals which exceed 25 per cent should be a major cause for concern.

2.14 Responses to the patients survey and the results of visits to hospitals indicate a number of factors within the control of catering departments which might influence patient satisfaction. Some will have cost implications, but many are areas where changes could be made with little or no increase in cost. Possible changes are described in the following paragraphs.

Ordering meals in advance

2.15 Nearly half the catering departments in our managers survey required patients to order their food three or more meals in advance of eating them. Seven per cent had to order seven or more days in advance. One patient in the survey reported that he had taken over a bed from someone who had ordered salads for every meal for four days in advance. Ordering far in advance is not only difficult for patients who may not know how they will feel the next day, but it can also increase levels of waste if patients have been discharged, moved, or have changed their minds. Ordering far in advance also appears to be unnecessary, as the purchasing and preparation of food does not depend on the orders of patients for specific meals; purchasing and preparation is, in practice, determined by the pattern of demand for food measured over a period of time.

2.16 The Management Executive branch responsible for catering services considered ordering two meals in advance to be a reasonable maximum. We found that some of the hospitals visited were taking positive steps to reduce the gap between ordering and eating. City General Hospital, Stoke, for example, intends to install a new computer based ordering system. This will enable patients to order their meals one or two hours in advance of consumption. Queen Elizabeth Hospital, Hackney have a same day ordering service while Heath Lane Hospital are moving towards such a system.

Attractive and appetising meals

2.17 Meals need to appeal to appetites which are sometimes jaded. Twenty per cent of the patients responding to the survey told us that their meals were not appetising. Standards of presentation varied at the hospitals visited. Hartlepool General Hospital came third in a recent national hospital catering excellence award scheme. At City General Hospital, Stoke, however, our consultants thought that the presentation of food could be improved.
Meal sizes

2.18 Twenty two per cent of patients told us that the meals served were too large or too small. These responses were linked to patients' ages. For example, 60 per cent of those who found their meals too large were aged 75 or over. The majority of hospitals deliver meals using a bulk trolley system. If properly used, this system allows patients a choice of portion size at the time that the meal is served. When such a system is not employed it should still be possible to offer patients a choice of portion size at the time of ordering. Five of the hospitals visited (Queen Elizabeth, Heath Lane, Northwick Park, Frimley Park and Princess Royal, Hull) allowed patients to specify the portion size desired when ordering their meals.

Temperature of meals

2.19 Sixteen per cent of patients thought that their hot meals were too cold. This may be due to insufficient cooking, faulty equipment, or slow delivery and service. Any of these factors could create hygiene and food safety risks. At Ealing Hospital, meals in excess of the capacity of the food trolleys were stored on top of the trolleys, resulting in heat loss and a breach of the Department's cook-chill guidelines. Ealing hospital have now addressed this problem.

Complaints about meals

2.20 The Citizens Charter notes that it is a principle of public service that there should be well publicised and easy to use complaints procedures. Without this patients may be frustrated and catering managers will find it harder to identify problems and respond positively. Ninety per cent of patients in the survey were not aware of local catering service complaints procedures, though we have no evidence that this deterred those who wished to lodge a complaint. Of the nine per cent who had reason to complain during their stay in hospital, 73 per cent were not satisfied with the response to their complaint.

2.21 Patients described the reasons for their complaints when they responded to the survey. The following examples illustrate the range of concerns expressed.

Causes for complaint: Examples of Patients’ Views

*Never received what I put on menu; food very poor*  
*the meal was not delivered to the new ward*

*Steak extremely hard, could not cut or chew it; so I ended up with nothing*  
*Poor quality of food. Poor choice - no vegetarian. Inadequate provision of ethnic dishes*

*Due to changing wards almost daily it became pointless ordering food the day before because*  
*Potatoes raw in centre. Cabbage and cauliflower etc overcooked. Food is cold when served*

Source: National Audit Office Patients Survey
Healthy Eating and Nutrition

2.22 The Health of the Nation White Paper encourages caterers to offer menus which enable and encourage people to choose healthy diets and follow Government nutritional advice. The Department of Health's Nutrition Task Force is preparing national nutrition guidelines for hospital catering for issue in 1994. It is also considering how nutrition training for all caterers could be improved. In 1988 the Department of Health published "The Recipe File", which provides over 200 healthy eating recipes. This is widely used within the hospital catering service.

2.23 Many hospitals now incorporate healthy eating options in their patient menus and a number have sought and received "Heartbeat" awards issued by the Health Education Authority. These awards aim to promote both healthy eating, so reducing the risk factors for coronary heart disease, and good standards of food hygiene. NHS hospitals have won ten per cent of the 693 certificates awarded since July 1992. Since that date the scheme has been administered locally and not all local authorities have chosen to participate. Some NHS hospitals are therefore unable to apply for the award.

2.24 Dietitians advise NHS caterers on special diets for patients and more generally on the type of food served. For example, 'Look After Your Heart' dishes feature on menus of hospitals with the "Heartbeat" award. The National Audit Office survey of catering managers and visits to hospitals showed that dietitians were usually involved in advising on menu content and that generally their advice was taken into account. Occasionally, there were delays in acting on such advice and at Ealing Hospital the catering department did not introduce an interim menu designed to meet their dietitian's most pressing criticisms until September 1993. This was over two years after the dietitian had pointed out that vegetarian meals did not contain sufficient protein.

2.25 Nutrition is an important factor in feeding long stay patients. It is especially important when patients arrive at hospitals malnourished or when they cannot eat or absorb nutrients from a normal diet because of their medical condition. Cases such as these are, however, addressed by doctors and dietitians rather than catering managers.

2.26 The food served to short-stay patients is less likely to have a major impact on their health. Catering managers aim to strike a balance between what is good for the patient and what the patient chooses to eat. Letting patients have information about the nutritional aspects of the food they are served can, however, raise awareness of healthy eating issues. An example of good practice is provided by the menu from Hartlepool General Hospital at Appendix 5. This hospital is a holder of a Heartbeat award. The catering managers survey found that 61 per cent of hospitals provided some form of nutritional guidance on their menus.
2.27 In August 1992 the NHS Management Executive advised health authorities to include specific nutritional standards in their contracts to purchase services from hospitals (paragraph 2.4). The onus lies on health authorities who are purchasers of catering services to seek such standards. None of the authorities purchasing services from the hospitals visited had yet implemented this advice. Fifteen health authorities were asked whether they had set or planned to set nutritional standards. All confirmed that they had either set such standards, or would introduce them in the future. The survey of catering managers found that 72 per cent of hospitals had set some specific nutritional standards for the food they served and 52 per cent had specific nutritional targets. This leaves over a quarter who have no nutritional standards or targets.

2.28 A substantial proportion of comments received in the patients survey concerned nutrition and healthy eating issues. The following comments illustrate the concerns of patients:

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<td>&quot;I am a person with a severe condition of disease of my bowel which the doctors have told me I should not have food with fibre or fruit or vegetables, yet even after speaking to the dietitian, I am still constantly given dinners with vegetables, desserts with fruits and breakfasts with brown bread and things like Weetabix and Ready Brek.&quot;</td>
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<td>&quot;Although I was an inpatient with heart problems and have always been advised to eat only 2 eggs per week, the only meal left was often omelette.&quot;</td>
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<td>&quot;Order white sandwiches and get brown every time.&quot;</td>
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<tr>
<td>&quot;Uncutable items on low fat menu, such as greasy lamb chops marked as low fat and chips classed as 'low fat.'&quot;</td>
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*Note: Not all patients sought healthy eating options

Source: National Audit Office Patients Survey

Safety and Hygiene

2.29 Food safety and hygiene is particularly important in hospitals given the vulnerability of sick and elderly patients. Under the 1990 Food Safety Act, Environmental Health Officers are required to monitor and report on hygiene standards in hospitals. Environmental Health Officers select hospitals for inspection on the basis of a risk assessment. Reports are issued to each hospital inspected but are not available to the public. Where hospitals do not conform to the Food Safety Act, Environmental Health Officers can take appropriate legal action.
2.30 The Department have issued a consultation document on how they will implement the 1993 European Union Food Hygiene Directive. This will place additional responsibility on hospital caterers to ensure they are providing safe food.

2.31 The Institution of Environmental Health Officers said that they believed standards have generally improved since the removal of Crown immunity in 1987. The Management Executive do not, however, receive separate statistics on the performance of hospitals. Available statistics group hospitals together with other catering establishments, such as restaurants and hotels.

2.32 The Management Executive do not need to maintain separate statistical returns on the NHS’s ability to conform to food legislation as it is the legal responsibility of local authorities to monitor the observance of United Kingdom food hygiene law. One of the performance indicators under consideration by the Management Executive’s working group (paragraph 1.8) will, however, address the issue of compliance with hygiene requirements.

2.33 If hygiene standards are to be maintained catering staff need to be trained. Most of the hospitals visited kept up-to-date staff training records, which were easily accessible, although in a minority of hospitals these records were not up-to-date.

2.34 The absence of proper training can lead to poor and inherently dangerous hygiene practices. Such practices are not widespread. For example, Ealing Hospital was serving regenerated food in a way which could be perceived as breaching the Department’s cook-chill guidelines. The hospital has asked a consultant to look at this as part of a wider review of catering practices.
How Catering Costs are Controlled

"I am well aware of the restraints a budget can inflict but I also know that a quality product can be achieved despite it, by having the right approach and by the application and implementation of the basic rules".

Albert Roux. Speech to Hospital Caterers Association 1993

3.1 There are considerable pressures in the NHS to keep catering costs low, given the constraints which operate on all areas of expenditure. These pressures impinge particularly on non-medical functions, such as catering. Against this background, the National Audit Office examined the way in which the NHS seeks to control the costs of hospital catering.

3.2 This part of the report examines (i) the information on catering costs collected by the Management Executive (ii) the extent to which catering costs vary and the factors influencing costs, and (iii) the progress made by the NHS in testing the effectiveness of catering services by putting them out to commercial tender.

Information collected from hospitals

3.3 Each year the Management Executive obtain catering memorandum trading accounts from the finance departments of NHS hospitals. These showed the cost of food and until 1991-92 patients and staff costs were shown separately. From 1992-93 the Management Executive introduced a new form as part of the move towards a more devolved style of management. The Management Executive have reviewed their information requirements and now intend to collect only the information needed as a basis for comparative performance indicators. From 1993-94 only total meal costs need be provided by trusts and directly managed units. Within the total meal cost figure direct costs such as labour are included but not all overheads. For example energy costs are excluded. The costs provided by hospitals do not therefore represent the full cost of meals.

3.4 There are gaps in the information currently collected by the Management Executive. The latest information available at the time of the study related to 1991-92. Some 300 of the 1,200 accounts submitted had missing or ineligible identification data and could not be entered onto the Management Executive's database. Some of the remaining data also appears to be unreliable. For
example, in one case total meal costs were shown as less than food costs. The
Management Executive explained that following the introduction of the NHS
reforms, health bodies (including the Management Executive itself) gave priority
to producing the new-style statutory accounts. The catering returns were
judged to be of lower priority in a year of exceptional pressure on finance
departments.

3.5 The cost figures therefore need to be treated with some caution. Nevertheless,
they illustrate the very wide range of reported meal costs. Some hospitals
reported a total cost per meal per patient day of less than £2. Others reported
costs which exceeded £10 and sometimes £15 per patient per day (Figure 3).
The average reported cost per patient day in 1991-92 was £5.45.

![Figure 3: Total cost of meals per patient day for 1991-92](image)

Source: Department of Health, Memorandum Trading Accounts for 1991-92

3.6 The Management Executive look principally to local management to consider
how far variation in catering costs could be explained by local circumstances
and, if not, what further investigations to carry out. They believe that the
development of performance indicators could assist greatly in this process. The
Management Executive have not themselves, therefore, investigated the reason
for these cost variations nor have they asked high cost units to justify their
expenditure.

3.7 Costs varied between the hospitals visited during the study, but only to a limited
extent. Their average cost in 1991-92 was £5.25 per patient day.

3.8 Meal costs will naturally vary according to such factors as:

- size of hospital. Larger catering operations allow scope for overheads to be
  spread across a greater number of meals;

- type of meal service;

- the needs of different groups of patients.
3.9 The information available shows that while size and type of hospital may have some influence on catering costs, many hospitals of similar size and nature can be found in both the upper and lower cost range. This suggests that within the wide range of reported costs there may be some scope for economy. If catering departments with higher costs could reduce them without loss of quality there could be significant savings for the NHS. However, in the absence of a detailed study of the relation between costs, quality of service, and other relevant factors, it is difficult to assess the degree to which savings could be achieved without reduction in standards. The Management Executive agree that there is undoubtedly scope for some saving.

3.10 A comparison of the results of the patient satisfaction survey with the meal costs of the hospitals concerned showed that high satisfaction ratings did not necessarily involve high costs and there was no correlation between the two factors. In 1990 Wessex Regional Health Authority commissioned a survey of all hospitals in the region which concluded that Poole District General Hospital was producing the highest quality food at the lowest cost of all hospitals of its type in the region.

3.11 In view of the extent of potential savings, the National Audit Office examined the approach adopted at each of the hospitals visited to see what factors influenced the cost variations. The examination identified a number of possible contributors to financial economy and efficiency. The approaches adopted by some hospitals may therefore be of value and application on a wider basis. The factors are reviewed in the following paragraphs.

Keeping track of expenditure

3.12 Day to day monitoring of catering costs is the responsibility of the hospital catering manager; the financial systems which enable monitoring to be undertaken are normally operated by the finance department.

3.13 The study's catering consultants advised that in the commercial sector, catering managers are expected to monitor costs on a regular basis, and trading accounts are generally produced within one to two days of the end of each week's business. This would not necessarily be justifiable in the NHS, but NHS managers need to consider carefully the frequency and timeliness of their cost information. In each of the hospitals visited, the aim is to prepare accounts as soon as possible after the month to which they relate but in practice there was considerable variation in the time taken to produce them. For example, at St Clement's Ipswich, accounts took up to eight weeks to be delivered. Following our visit the hospital reduced the delay in providing data and started producing accounts covering periods of two weeks.

Estimating meal requirements

3.14 The majority of hospitals estimate the number of meals they need to prepare on the basis of a midnight count of patients. The proportion of different dishes produced is based upon past experience of demand. This is not always an accurate system and takes no account of fluctuations in the number of patients
attending only during the day and meals to be provided to staff. Northwick Park hospital have switched to a same day meal ordering system for patients. This enabled them to reduce wastage and save between eight and 12 per cent of costs previously incurred. Central Middlesex, Hull and Frimley Park have menu card readers which allow patients to order their meals close to the time of eating them. A number of computer systems are widely available which link patient ordering, production planning, stock replenishment and control and the production of financial information.

Monitoring waste

3.15 In the commercial sector food wastage is normally expected to be no more than five per cent of food costs. Five of the hospitals visited (Queen Elizabeth, Ealing, Frimley Park, Heath Lane and City General, Stoke) monitored the number of uneaten meals returned so as to keep wastage at ward level to a minimum. Wastage at other stages of production and supply were not identified or costed at any of the hospitals visited. None of the hospitals set targets or regularly monitor actual wastage.

Use of costed recipes

3.16 Costed recipes are widely used in the commercial sector. These are standard recipes which specify the ingredients and methods of preparation together with the costs. Prices are updated regularly to ensure effective cost control. Such recipes are used with standard quantities of ingredients and production forecasts to control production and minimise waste. Four of the hospitals visited (Queen Elizabeth, Ealing, Hartlepool General, City General, Stoke) used costed recipes and a fifth, Heath Lane, are currently considering their introduction.

Delivery of meals

3.17 Following preparation, meals are despatched to patients in a variety of ways:

- meals may be put onto the plate in the kitchen (trayed meal system) or at the ward (bulk trolley system);

- distribution of trolleys and serving of food may be carried out by catering, nursing or domestic staff. Our catering managers survey found that 30 per cent of units employ catering staff to deliver food to wards.

3.18 The use of non-catering staff to deliver and serve food reduces the apparent cost of catering operations because their costs are not recorded on catering memorandum trading accounts. This may be misleading and hospitals should evaluate full costs. Mayday Hospital, Croydon have switched from the use of porters to catering staff in order to keep better control of quality.

Control of staff costs

3.19 The major cost (47 per cent) in catering is staff cost. A number of hospitals visited had developed initiatives to address what they perceived as high levels of staff absenteeism. For example, Frimley Park have converted part of their
bonus scheme into an attendance allowance which is only payable when staff were not sick, absent or late. As a result, sickness and absenteeism have been reduced from up to seven per cent to one and a half per cent.

3.20 Three other hospitals (Queen Elizabeth, Hartlepool General and City General, Stoke) monitored absences and overtime on a weekly basis and have put in place procedures for taking remedial action where necessary. Sickness levels at Stoke have fallen from six per cent in the period April to June 1992, to less than three per cent in the same period in 1993. Hunters Moor, Newcastle more than halved the number of absences attributed to sickness from five to two per cent by requiring those returning to work after a period of absence to report to management.

Security of assets and stocks

3.21 Catering is a high risk area for fraud and petty theft. Among the hospitals visited there was a mixed awareness of the risk of fraud. Management controls which would help to ensure a vigorous control were not always present. Particular weaknesses included:

- the absence of firm control over food wastage;
- lack of timely financial and management information;
- deficiencies in stock controls which meant that some hospitals carried out infrequent stock checks (sometimes, as little as once a year). Commercial caterers usually carry out weekly stock takes to calculate stock values and the cost of consumption.

3.22 These factors, together with major variations in the cost of meals and the absence of evidence of effective management scrutiny of costs, meant that it was not possible to be confident that catering assets are always well controlled. The Department take very seriously the problem of hospital security, though the need to allow open access to patients and their relatives for long periods of each day causes particular problems. Ministers have written to the Chairs of Health Authorities and Trusts calling upon them to appoint a board member to take personal responsibility for reviewing procedures for the security of NHS assets which would include catering.

Purchase of Food

3.23 From 1 April 1993 trusts are no longer bound to purchase food from the NHS Supplies Authority and are free to select their own sources of supply. Three of the twelve hospitals visited had, as part of their market testing process, reviewed their source of procurement. Two had concluded that the NHS Supplies Authority represented best value for money while the third now obtains its supplies largely from commercial sources but continues to use the NHS Supplies Authority for selected food items.
Contracts

3.24 Catering contracts at some hospitals visited do not always define essential elements of meal delivery. For example, at the time of our visit to Ealing hospital the original contract had no controls over meal portion sizes. It was not, therefore, possible to be sure that value for money was achieved. Ealing have subsequently included an agreement about portion sizes in their revised tender document.

3.25 At City General Hospital, Stoke, the in-house team exceeded the tender price within a year of agreeing the catering contract. This was due to unrealistic estimates in the tender including relief for sickness, holidays and absence, and an unanticipated rise in the cost of dry goods. The contract has since been amended.

Market testing

3.26 In September 1983 health authorities were asked by the Department of Health to test the cost effectiveness of support services by putting them out to commercial tender. The target was that, save in exceptional circumstances, all competitive tender proposals were to be completed by September 1986.

3.27 The survey of catering managers showed that 77 per cent of catering operations have now been market tested (Figure 4). Where market testing has taken place, four or five organisations have usually been invited to tender. In many cases, however, only one response was received. The great majority (82 per cent) of competitions have been won by in-house bidders. At present external contractors have only ten per cent of the total NHS catering market (Figure 5).

3.28 Some hospitals surveyed said that there had been a lack of interest on the part of catering contractors. Others had agreed with staff not to market test services in return for efficiency savings and more recently uncertainty on the interpretation of the Transfer of Undertakings (Protection of Employment) Regulations 1981 had caused delay.

3.29 The Management Executive told the National Audit Office that the limited inroads made by external contractors should be seen against the perspective of the complex problems and challenges faced by NHS caterers. In June 1993 they issued revised market testing guidance with the aim of making catering more attractive to external contractors by creating a level playing field for both in-house and private caterers. For example, the new guidance permits contract length to be increased from three to a maximum of seven years. This is an important development; given the range of catering skills available in both the public and private sectors in this country, market testing has potentially a most valuable contribution to make.
Performance Measures

3.30 A number of regional initiatives have been taken to develop financial and quality performance measures which enabled catering units to monitor their progress over time and to compare their performance against others. South West Thames and Wessex Regional Health Authorities had both established regular performance monitoring and South West Thames will shortly delegate this function to hospitals in the region. The Management Executive have highlighted the Wessex approach in the recent publication "Quality: an A-Z of good practice".

3.31 There are, at present, no national targets or measures for catering operations though these are under consideration by the Management Executive working group. A number of hospitals told the National Audit Office that they would welcome the development of such indicators. Measures covering the cost of patient food, the level of patient satisfaction and compliance with hygiene standards would prove valuable to catering departments. The lack of effective competition during some market testing exercises makes the value of performance measures even greater.
Hospitals surveyed and hospitals visited

Hospitals surveyed by patient questionnaires:

**North East Thames:**
Whittington Hospital, Highgate Hill

**North West Thames:**
Heath Lane, Birmingham
Queen Elizabeth II Hospital, Herts
West Middlesex University Hospital, Isleworth
Ealing Hospital

**South East Thames:**
The Maidstone Hospital, General Wing
Dulwich Hospital, London

**South West Thames:**
St George's Hospital, Tooting

**East Anglia:**
West Suffolk Hospital, Bury St Edmunds
West Norwich Hospital

**North Western:**
Ormskirk and District General Hospital
Bury General Hospital
Birch Hill Hospital, Rochdale
University Hospital of South Manchester

**Trent:**
County Hospital, Lincoln
Leicester Royal Infirmary
Louth County Hospital, Lincs
Derbyshire Royal Infirmary

**Northern:**
The Royal Infirmary, Sunderland
Cumberland Infirmary, Carlisle
North Tees General Hospital, Stockton-on-Tees

**West Midlands:**
Worcester Royal Infirmary, Ronkswood Branch

**Mersey:**
County of Chester Hospital, General Wing
Arrowe Park Hospital, Wirral

**Wessex:**
St Mary's Hospital, Isle of Wight

Hospitals visited by the National Audit Office

**West Midlands:**
Heath Lane, Birmingham
City General Hospital, Stoke on Trent

**North East Thames:**
Queen Elizabeth, Hackney
North West Thames:
Northwick Park Hospital, Harrow
Central Middlesex Hospital
Ealing Hospital

South West Thames:
Frimley Park Hospital, Camberley

East Anglia:
St Clements, Ipswich

Oxford:
Heatherwood Hospital, Ascot, Berks

Yorkshire:
Princess Royal, Hull

Northern:
Hunter's Moor Rehabilitation Centre, Newcastle
General Hospital, Hartlepool
Appendix 2

Sampling Methodologies

Surveys of Catering Managers and Patients in England

Background
1 The National Audit Office commissioned Thames Management Services to undertake surveys of catering managers and patients. The purpose of the catering managers survey was to obtain information on the NHS hospital catering service which was not held centrally by the NHS Management Executive. Their views were also sought on the operation of the service. The purpose of the patients survey was to seek the opinions of hospital in-patients about the food and catering service they received.

2 The two questionnaires were designed with the aid of Thames Management Services, the Patients Association and the catering consultants, and agreed with the Department of Health.

Methodology - Catering Managers Survey
3 Copies of the catering managers questionnaire were sent to every Directly Managed Unit and Trust in England with a hospital catering facility. A total of 420 catering managers responded.

Methodology - Patients Survey
4 The National Audit Office sought the views of 3,000 patients on hospital catering services at 24 randomly selected hospitals in England. Each of the hospitals surveyed had a minimum of 125 patients (excluding paediatric, mental health and intensive care patients who might not be able to answer questions and day patients who may not use the catering facilities).

5 Thames Management Services randomly selected a sample of 125 patients from each hospital’s Patient Administration System, where such a system existed, or from a suitable alternative. Self completion questionnaires were distributed to respondents on their wards.

6 The respondents posted their replies to the National Audit Office in freepost envelopes. The response rate from patients was 50 per cent (1,486 out of 3,000) which the consultants described as good.

7 Results were weighted to reflect the number of beds at the hospitals selected.
Organisations consulted and bibliography

Organisations consulted by the National Audit Office

Institution of Environmental Health Officers
British Dietetic Association
Hospital Caterers Association
Association of Community Health Councils
Patients Association
British Hospitality Association
Royal College of Nursing
Health Education Authority
South West Thames Regional Health Authority
West Midlands Regional Health Authority
Wessex Regional Health Authority
Yorkshire Regional Health Authority
Community Hospitals Ltd (Pinehill Hospital)
Tillery Valley Foods Ltd
Brake Bros Foodservice Ltd
Health Policy Advisory Unit
Independent Healthcare Association

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The Patient's Charter, Department of Health, 1991
The Citizen's Charter, HMSO 1991
Department of Health: The Health of the Nation, A Strategy for Health in England Cm 1986, July 1992
Management of Food Services and Food Hygiene in the NHS, Department of Health Circular HSG(92)34, August 1992
Hospital Food Guidelines: Catering for Patients in Hospital, The Patients Association, May 1993
Market Testing in the NHS, Revised Guidance, Department of Health, HMSO June 1993
Managing the New NHS, Department of Health, November 1993
Appendix 4

Hospital Catering in France and the USA

France

1 The United Kingdom's policy is to provide food free to patients. In France, until recently, food was also free to patients in hospitals, but new legislation has resulted in patients being charged 55 Francs (approximately £6) per day to cover food and other ancillary costs incurred during a hospital stay.

2 Contractors have been able to establish a greater level of penetration in hospital catering in France than in the UK. The largest contractor is Sodexho with 334 restaurants and 24 million meals distributed in 1991. Their total sales figure was 85 million Francs (approximately £9.3 million) in that year. This company has developed a new innovation in information technology called Convivia which allows meal orders to be taken by a hostess who directs the information immediately to the kitchen. The concept is one long established in the USA and ensures a high degree of communication and improved relationships between the patients, medical staff and the food production department.

USA

3 The American system of allocating costs to the various hospital departments makes it extremely difficult for foodservice costs to be identified. These costs are included as part of patient room rates which prevents food cost accounting being carried out.

4 Pressure is mounting on hospitals to gain a more detailed understanding of their costs and methods, by which patient and non-patient foodservice costs can be discerned. Currently little statistical information is available and food trends have not been identified.

5 Catering contractors penetration of the US healthcare feeding market is low although the ratio of in-house to contract caterers has not been determined.

6 Computerised meal order systems are being developed that are able to handle constantly changing dietary requirements. It is not uncommon for over 20 diet variations on a core menu of five main dishes to be prepared each day. Approximately 70 per cent of patients are on some form of diet whether for medical, allergic or other reasons. Modern systems incorporate a card file system on which each patient's dietary requirements or sensitivities such as diabetes or high blood pressure are recorded. If the patient orders a meal that is not compatible with the recorded information, the system will identify that an error may have occurred and the meal order will be verified and changed as appropriate.

7 Research is currently underway towards developing a system which will allow a patient to touch a permanent screen at ward level which instantly relays information to the catering office.
Example of a Hospital Menu:

Hartlepool General Hospital (Holder of Heartbeat award)

### Breakfast

<table>
<thead>
<tr>
<th>Item</th>
<th>D</th>
<th>R</th>
<th>L</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Porridge or</td>
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<tr>
<td>Grapenut segments or</td>
<td>D</td>
<td>R</td>
<td>L</td>
<td>F</td>
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<tr>
<td>Cornflakes or</td>
<td>R</td>
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<tr>
<td>Bran Cereal</td>
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<tr>
<td>Grilled Bacon or</td>
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<td></td>
</tr>
<tr>
<td>Grilled pork and beef sausages</td>
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<tr>
<td>Boiled egg</td>
<td></td>
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<tr>
<td>Baked beans or</td>
<td>D</td>
<td></td>
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<tr>
<td>Canned Tomatoes</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Wholemeal bread or</td>
<td>D</td>
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<td></td>
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<tr>
<td>Marmalade or</td>
<td></td>
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<td>F</td>
</tr>
<tr>
<td>Jam</td>
<td></td>
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<tr>
<td>Low fat spread</td>
<td>D</td>
<td>R</td>
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### Lunch

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<td>Celery soup</td>
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</tr>
<tr>
<td>Ham and Tomato Sandwich or</td>
<td>D</td>
<td>R</td>
<td>LF</td>
<td>LR</td>
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<tr>
<td>Beef Casserole or</td>
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<td>LF</td>
<td></td>
</tr>
<tr>
<td>Poached Cod</td>
<td>D</td>
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<td>LF</td>
<td>LR</td>
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<tr>
<td>Cheese sauce</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Cauliflower</td>
<td>D</td>
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<td>LF</td>
<td>LR</td>
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<tr>
<td>Brussels sprouts</td>
<td>D</td>
<td>R</td>
<td>LF</td>
<td>LR</td>
</tr>
<tr>
<td>Creamed potato</td>
<td>D</td>
<td>R</td>
<td>LF</td>
<td>LR</td>
</tr>
<tr>
<td>Roast potato</td>
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</tr>
<tr>
<td>Stewed Rhubarb</td>
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<td>Custard or</td>
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<td>Creamed Rice pudding</td>
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### Supper

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<td>Vegetable Lasagne or</td>
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<td>Corned beef</td>
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<td>LR</td>
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<td>Green salad</td>
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<td>LF</td>
<td>LR</td>
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<td>LF</td>
<td>LR</td>
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<td>Jacket Potato</td>
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<td>Strawberry ice cream or</td>
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<tr>
<td>Apricot tart or</td>
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<tr>
<td>Fresh fruit or</td>
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<td>LF</td>
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<tr>
<td>Cottage cheese and crackers</td>
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**Diet Coding:**

- **D** = Diabetic
- **R** = Reducing
- **LF** = Low Fat
- **LR** = Low Residue