Implementation of the FSA Listeriosis Guidance: Chapter 1: Executive summary

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Following the 2019 listeriosis outbreak in hospitals in England, the Food Standards Agency (FSA) committed to reviewing its guidance 'Reducing the risk of vulnerable groups contracting listeriosis' (2016). The FSA commissioned research to measure awareness, implementation and perceived effectiveness of the guidance, including barriers to implementing the guidance in full.

This report covers findings from 39 respondents within NHS Trusts and 445 from Health and Social Care (HSC) (non- NHS Trust) settings, such as nursing homes, home care service providers and hospices, in England, Wales and Northern Ireland. Findings from the NHS Trust survey are reported in their own chapter and their own section of this executive summary.

HSC (Non-NHS Trust) Settings

Awareness and usage of the guidance

Most settings - 63% - had some knowledge of the guidance. However, 36% did not know anything about the guidance or were not aware of it.

Most settings stated that they trained kitchen staff (57%), nurses, midwives or carers (55%) and management personnel (52%) in controlling the risk of Listeria monocytogenes (referred to as Listeria or L. monocytogenes in the reminder of this report). Fewer stated that they trained staff who sell or serve food as their main role (35%) or non-catering staff, such as maintenance or reception staff (19%).

Implementing good practice and the barriers to this

Generally, settings found the good practice outlined in the control of contamination section of the guidance (around personal hygiene, washing fruit, cleaning of food preparation areas and access to kitchens) to be easy to implement. 71%-81% reported that they found each area of recommended good practice 'very easy' to implement. Good practice in 'controlling access to kitchens/pantries' was considered most difficult to implement, with 6% of settings finding it difficult, rising to 11% in community care settings.

Among settings that found any good practice difficult to implement, a lack of control over the kitchen area was the most frequently mentioned difficulty (44%), followed by 30% of settings who found it challenging to implement good practice in clients' homes or residents' rooms.

In terms of controlling the growth of Listeria, only half of settings felt that 'ensuring packed lunches for patients going home or off-site, including advice on how quickly any ready-to-eat food should be eaten' was very easy, while 5% thought it was very or fairly difficult. There were similar

levels of perceived difficulty (3-5%) for ensuring chilled ready-to-eat food was kept at 5°C or below from delivery to service, time and temperature control during food service and temperature monitoring of fridges in residents' rooms.

When asked why implementing good practice around control of growth was difficult, lack of control over when food was consumed was the most common barrier faced by settings, with almost two in five (39%) reporting this.

Settings generally found good practice relating to management controls less easy to implement, compared to practice in the 'control of contamination' and 'control of growth' sections of the guidance. For example, 41% found it very easy to include food safety requirements in contracts for on-site retailers or contracted caterers.

Areas which settings found more difficult were the labelling and refrigeration of food brought in by visitors / patients / residents / customers (8% found this very or fairly difficult), as well as the collecting of feedback from patients / residents / customers (12%). The most difficult area of Listeria control was the carrying out of unannounced visits to suppliers every 6-12 months to check food safety - while 35% of respondents found this very easy, 23% found it very or fairly difficult.

When asked about the reasons why good practice in management controls were difficult, 38% of settings reported residents' lack of comprehension of the risks. This includes the challenge of collecting feedback from, and communicating risks to, patients with dementia or learning difficulties.

Controlling the risk of Listeria

Almost all settings (98%) agreed that 'food safety controls on site are effective in stopping cross-contamination of food with Listeria'. In a separate question, 54% reported being fully aware of the risks associated with chilled ready-to-eat foods and Listeria.

Over half (56%) of all settings reported that the maximum temperature that chilled ready-to-eat foods reached, from supply of chilled ingredients until the point of sale or service, was 5°C, which is in line with the FSA good practice guidelines. Just under a half (46%) of all settings reported that the maximum temperature that chilled ready-to-eat foods reached during storage in areas for patients or residents was 5°C, again in line with FSA good practice. Food reaching a temperature of 8°C for over four hours at any point in the supply of ingredients to point of sale / service was reported by 1% of settings, and by 2% of settings during storage in areas for patients / residents.

Only 54% of settings agreed that they carry out regular sampling for Listeria. 29% disagreed. There was also disagreement by 14% that the maximum shelf-life for ready-to-eat sandwiches sold or distributed on site was day of production plus 2 days.

Just over three-quarters (77%) of all settings have a food safety management system (FSMS) based on hazard analysis critical control point (HACCP) principles. Just over one in ten (13%) did not have such a system in place and a further 10% were unsure whether they did or not. However, it should be noted that settings may have said 'no' as they are unfamiliar with the term HACCP but use guidance that ensures practice is based on these principles. Community care settings were more likely to report that they did not have an FSMS in place based on HACCP principles (45% vs. 5% of healthcare and 5% of social care settings).

Perceptions of the guidance

Ninety-five per cent of settings who were aware of the guidance felt it was effective in reducing the risk of vulnerable groups contracting listeriosis. Just a small proportion (3%) thought it was not

effective. Similarly, 92% of settings who were aware of the guidance claimed that the guidance clearly distinguishes between legal requirements and good practice.

Parts of the guidance which were mentioned by settings as being useful in reducing the risk of listeriosis in their setting included information around temperature control and fridges (cited by 14% of all settings aware of the guidance), checklists for preventative practice (12%), information on cross-contamination / infection control (8%) and content on cleaning standards (8%).

Suggestions for improvements to the guidance included that it be made easier to read (11%), be updated more often (5%) or be made more accessible (4%). Beyond improving the text itself, there was also some call for raising awareness of the guidance (4%).

Differences by setting type

Healthcare settings were more likely than social care or community care settings to know a lot about the guidance and to be fully aware of the risks associated with chilled ready-to-eat food and Listeria. They were also more likely to find many areas of good practice easier to implement. Community care settings, by contrast, were more likely than both healthcare and social care settings to feel that a number of areas of the guidance were difficult to implement.

Local Authority and Primary Authority (PA) relationships in England and Wales

Fifty per cent of settings in England and Wales reported they were registered with their local authority but did not have a PA relationship, whilst 18% reported they were registered with their local authority and had a PA relationship and 13% reported that they did not know. However, 20% of settings reported that they were not registered at all with their local authority.

The 20% of health and social care settings who reported not being registered with their local authority were compared with the Food Hygiene Rating Scheme (FHRS) listings to ensure the reliability of this unexpected finding. However, the results of this investigation were inconclusive.

NHS Trusts findings

Ninety-two per cent of NHS Trusts said their settings were using the FSA guidance on listeriosis before taking part in the survey, with 3% reporting they were not using the guidance and 5% unsure. 97% of NHS Trusts said their kitchen staff had received training about how to control the risk of Listeria. 89% reported that their service and food retail staff had received the same training. However, fewer Trusts (55%) had trained ward staff.

Around four in five Trusts reported having fully implemented the good practice outlined in the guidance with regards to control of contamination (82%), with slightly fewer having fully implemented good practice in terms of control of growth and management controls (73% each).

The NHS survey asked Trusts to consider barriers which made it difficult for them to implement the FSA guidance in full. From a prompted list, almost a third (31%) of settings agreed they had a lack of control over food service, a quarter (25%) felt they had a lack of control over their supply chains and just over one-fifth felt that their high staff turnover (22%) or lack of control over food storage (22%) were barriers to implementing the FSA guidance.

Over eight in ten (84%) agreed that ‘cleaning of all food contact surfaces controlled the risk of L. monocytogenes effectively in the Trust’. There were also high levels of agreement with regards to food safety in the Trust being effective in stopping cross-contamination of food with Listeria, with 97% agreeing with this statement.

Around seven in ten (71%) reported that the maximum temperature that chilled ready-to-eat foods reached, from supply of chilled ingredients until the point of sale or service, was 5°C, which is in line with the FSA good practice guidelines. Over half (57%) reported that the maximum temperature foods reached was 5°C during storage in areas for patients or residents.

Nearly all NHS Trusts (97%) reported having a food safety management system based on HACCP principles. Agreement was high among Trusts with regards to monitoring and recording throughout the cold chain, with 95% agreeing with this statement. Around eight in ten NHS Trusts (79%) agreed that the maximum shelf-life for ready-to-eat sandwiches sold or distributed in the Trust was day of production plus two days, whilst 13% disagreed with this statement. 51% agreed that their Trust carried out regular sampling for L. monocytogenes compared to 38% who disagreed.

NHS Trusts generally found the guidance to be clear and informative. However further guidance was asked for on food being brought into the premises by relatives and on what was an acceptable standard of cleaning to ensure control of contamination.

Three Trusts wanted further training to be provided to nursing staff. While they were confident that their catering teams were well trained, these Trusts felt that training amongst their nursing staff could be strengthened.