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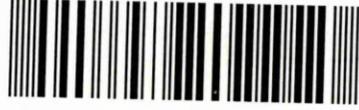
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**Towards Patient-centric food services in Acute NHS Hospitals**  
**A case study approach**

**Michel Altan**

*A dissertation submitted in partial fulfilment  
of the requirements of Sheffield Hallam University  
for the degree of Doctor of Philosophy*

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**Faculty of Organisation and Management**

## Abstract

*Background and aims:* Over the past decade, the feeding of patients in hospital has become a topical issue. Hospital food services have shifted from a product-orientation focus towards a patient-oriented focus. A holistic 'food experience' is progressively recognised as part of the treatment, even though little research has been conducted to understand patients' internal processes within the framework of hospital food and service management operations. This is despite the fact that psychological and social determinants are being recognised as a significant factor in developing positive food experiences.

The aim of this study is to develop an in-depth understanding of what constitutes patient-oriented food services in acute NHS hospitals where a private food and service management firm operates. The aim is to look at factors which facilitate or hinder such an approach. Various research objectives have been developed to achieve this aim:

- To provide an overview of food services in acute NHS hospitals where food services are outsourced to a private food and service management company.
- To analyse and assess the body of knowledge from the literature, focusing on (relationship) marketing, consumer food behaviour and factors that impede the implementation of patient-oriented strategies.
- To identify the patients' core psycho-social determinants leading to satisfactory food service experiences and investigate how these can be facilitated by the various stakeholders involved.
- To examine how a major UK food and service management firm aligns its marketing strategy, human resources and competencies with patient-centric policies developed by the NHS Estates and how this serves as guidelines for the providing contractors (the NHS Trusts).
- To develop a holistic theoretical model of the requirements of patient-centric experiences and satisfaction with hospital food services.

Looking at common elements between defining constructs of relationship marketing and psychosocial determinants related to food choice (*identified as values, trust, beliefs and involvement*), this study investigates whether these determinants might serve as the foundation to work towards consumer-centric food service experiences in a healthcare setting. When considering how such a consumer-centric approach might be facilitated across hospitals, the main impediments are identified as: culture, departmentalisation,

lack of patient involvement, lack of cooperation among all staff groups and the patient not being recognised as a customer.

*Methods:* The study uses an exploratory and descriptive qualitative case study approach, whereby five acute NHS hospitals in Central and South UK serve as individual case studies. These are firstly analysed as single cases and then cross-analysed to look for replication. Data adequacy is reached through:

- In-depth interviews conducted with 31 patients across hospitals,
- 10 focus group sessions with NHS staff involved in the food service process and staff from the private food service management firm,
- The collection of company documents and secondary data.

*Results:* The main contribution of this study is the contextualization of various factors affecting food services in acute NHS hospitals whereby a major private food and service management firm operates. Going beyond traditional boundaries, this study explores patients' value systems in detail, enabling the author to apprehend patients' food choices when hospitalised. Adding to the ones identified in the literature, this study identified a further six impediments to consumer-centric food service strategies:

- 1) A lack of empowerment of front-line staff from both NHS staff and staff from the private food service management firm,
- 2) A high employee turnover rate within the private food service management firm,
- 3) Insufficient involvement of line managers in the food service delivery process,
- 4) An overall top-down approach to planning within the NHS,
- 5) A lack of understanding of patients' soft factors by front-line staff involved in the food delivery process,
- 6) NHS staff looking down on the skills from the staff of the private food service management firm.

To solve the problems highlighted, this study confirmed the approaches identified in the literature: the creation of multidisciplinary teams as well as the need to provide information to the staff from the private food service management firm during the nurses' handover. Based on the data collected and analysed in this study, a holistic theoretical model of the requirements of patient-centric experiences and satisfaction with hospital food services was developed.

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## Acknowledgements

Welcome to my journey around the landscape of food provision in the NHS. The past few years have been a tremendous time for me writing this dissertation and I hope the reader will have the same pleasures and surprises. To gain some insights in to the theme, contents, the target groups and presentation style of this dissertation, I recommend you to read chapter 1. After reading this chapter, you should be clear about what to expect from this study and you can decide to go further on my journey with me or take another route. However, at this stage, I limit myself to thanking all those people who played an important and often challenging role during my journey.

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## **Declaration**

Whilst registered as a candidate for the degree for which submission is hereby made I have been a registered candidate for the award of Master of Arts in Social Science Research Methods at Sheffield Hallam University. The degree was awarded on 06 October 2005. But no material contained within this dissertation has been used to obtain the Master of Arts Degree or for any other submission for any other academic award.

Michel Altan

January 2009

## Abbreviations

BAPEN	British Society for Parenteral and Enteral Nutrition
BDA	British Dietetic Association
COE	Council of Europe
CRM	Customer Relationship Management
CRQ	Central Research Question
DoH	Department of Health
Efm	Estates & Facilities Management
ESPEN	European Society of Parenteral and Enteral Nutrition
HR	Human Resources
MUST	Malnutrition Universal Screening Tool
NEDPRO	Need for Nutrition Education Project
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NPSA	National Patient Safety Agency
PEAT	Patient Environment Assessment Team
PFI	Private Finance Initiative
RCN	Royal College of Nursing
RCP	Royal College of Physicians
RIPH	Royal Institute of Public Health
RM	Relationship Management
RQ	Research Question
SHU	Sheffield Hallam University
TQ	Theory Questions

## Glossary of terms

Catering staff	staff from the private food and serving management firm participating in the present study
Codes	sections of text in a document (transcript) that are stored in nodes, using the NVivo software for qualitative data analysis in this study
Efm	Estates and Facilities Management covers the whole range of services that support clinical care, including soft components like hotel services
Malnutrition or at risk	has eaten little or nothing for more than 5 days/or is likely to eat little or nothing for the next 5 days or longer
NHS Estates	this government executive agency is responsible for providing advice and guidance on all aspects of estates and facilities
NHS staff	within this study, NHS staff is considered to be all staff under NHS contract, involved in the food service process
Node	an object in a project which represents anything the researcher wishes to refer to, such as people, concepts, places, etc.
Nutrition assessment	a comprehensive evaluation to define nutrition status, including medical history, dietary history, physical examination, anthropometric measurements and laboratory data, by a health professional with skills and training in nutrition and nutrition support
Nutrition screening	a rapid, simple and general procedure used by nursing, medical or other staff, often at first contact with the patient, to detect those who have significant nutritional problems or significant risks of such problems, in order that clear guidelines for action can be implemented
Nutrition support team	a multidisciplinary team with dietetic, nursing, pharmacy and medical expertise to provide safe nutrition support
Elderly people	within this study, people over the age of 65 years are referred to as 'Elderly people'
Parenteral nutrition	the provision of nutrition through intravenous administration of nutrients such as amino acids, glucose, fat, electrolytes, vitamins and trace elements
Primary care	healthcare delivered to patients outside the hospitals. Primary care covers a range of services provided by GPs, nurses and other healthcare professionals
Research Ethics Committee (REC or Corec)	an independent committee that scrutinizes proposals for research to ensure they are ethically acceptable

# Chapter one: Introduction and motivation

## 1.1 Background to the research

The food industry has traditionally embraced transaction marketing (Barry et al., 1992; Barkema, 1993), but a multitude of changes has led the industry to embrace relationship marketing. These changes include rising incomes and levels of living, consumerism, ethnic diversity and the development of technological tools to support more personalised marketing approaches. This is reflected in all areas of the industry including hospitals where the 'patient is king' (Bolton, 2002). Hudak et al. (2003) describe how, especially in the U.S. contemporary medical literature (Annas, 1995; Segal, 1997), health care is conceptualised in business terms. The author questions whether what is applicable to the food industry in general is applicable to food provision in acute NHS hospitals? After all, the NHS is known for long waiting times, a rather variable quality of care and the low quality of food provided. In the future, hospitals will experience increases in patient age and acuity level and a continued population shift from inpatients to outpatients. To face these trends, various changes in the delivery of care have been developed and are based on empowerment, cross-functional training and decentralisation. These approaches aim to reduce length of stay of patients, benchmark internally and with competitors, and develop or maintain financially viable organisations (Puckett, 2004). These pressures within the health care environment have forced (food) providers to learn and implement new skills in order to make their operations more cost-effective while maintaining quality standards. Among these responses has been the development of a marketing approach for food service providers, who must design services with the opinions and perceptions of their consumers in mind. Part of the NHS Plan in 2000 set out a blueprint for the revitalisation of NHS catering, reflecting the trend towards consumerism. Precisely at the heart of this Plan was the need for services to be designed around the needs of the consumer, as a means to improve service provision. Approximately fourteen years ago, Avis et al. (1995) thought consumerism in public policy was gaining greater emphasis. This is illustrated by the fact that public sector service users are increasingly being referred to as 'customers' (Keaney, 1999). This consumer-customer concept is relatively new in the health sector, and illustrates how the concept of healthcare as a business is becoming the norm for survival in an increasingly competitive environment. When considering food services in the NHS and the emergence of relationship marketing within the food service industry, the background of the research lies in the growing emphasis on consumerism.

---

## 1.2 Central theme of the research

The central theme of this study is the food service experience of patients in five acute NHS hospitals which work with private food and service management firms. Through PFI (Private Finance Initiatives) or other initiatives in the NHS, the collaboration between public and private parties is a rather topical issue, as some service components like food (services) are increasingly privatised or combine government and private services. The central theme of this study is looked at from an informational perspective with insights from the three disciplines of marketing, consumer food behaviour and human resources/marketing strategy implementation dyads.

This study predominantly addresses the patients' perspective, but hospital food could also be addressed from the perspective of nutritionists focusing on nutritional intake or from the economist who looks at the costs and wastage levels. The foundation of this study is to be found in a quote from Graham Walker, the former representative of the Better Hospital Food project (BHF). The project, launched in 2001, aimed to improve food quality in the NHS, instead of focusing on nutritional intake only. After several years of implementation, Walker (2004, p. 16) quoted:

*"There is a consensus that the BHF targets have been achieved. Now the programme must move towards nutritional outcomes and improvements in food delivery to enhance the patient meal experience. We must move more towards a guest-host relationship with our patients, to give an extra comfort factor that will improve outcomes".*

Meals are often the highlight of a patient's day (Kipps and Middleton, 1990) therefore the total food service provision should aim to provide a healthy and nutritionally balanced diet. It should meet patient expectations and satisfaction, fulfilling both their physiological and psychological requirements (Hartwell, 2004). In this regard, hospital food services have followed a major marketing trend in society, characterised by the development of relations not only between staff and patients, but also amongst staff members belonging to different staff categories. This study aims to understand and develop these 'relations' between patients and staff, as well as those between NHS and so-called 'catering' staff working for private food and service management firms actually delivering food services within NHS hospitals. For convenience of the reader, a brief outline of major private food and service management firms operating in NHS hospitals is added to this study as Appendix E.

### 1.3 Rationale of study

As outlined by Corish and Kennedy (2000), there is a substantial body of published work describing the impact of oral nutritional supplements and artificial nutritional support on the outcome of hospitalised patients (Bastow et al., 1983; Stephen et al., 1998). Fewer studies investigate the service quality of hospital food, a component that has gained momentum in fulfilling nutritional requirements of patients. Considering this aspect, this study will often refer to the recent work of Hartwell (2004) and Hartwell et al. (2006, 2007) throughout the literature review. However, with the purpose of this study being to investigate factors beyond pure food quality aspects, the focus will lay on psychosocial determinants leading to positive food service experiences and customer satisfaction. Key researchers in this field are Dubé et al. (1994), Furst et al. (1996) and Connors et al. (2001), who have investigated personal value systems from the perspective of food choice leading to satisfaction. The literature offers models of personal value systems when considering food choices, but not from the perspective of healthcare operations. This is an obvious gap in the research on 'soft' factors of nutritional behaviour in a healthcare setting, not to mention in acute NHS hospitals operating with private food and service management firms.

Another dimension that has not been explored relates to the perception of children towards food services in healthcare. This particular consumer group will be touched upon in this study. Understanding patients psychosocial determinants needs to be addressed if hospital food service is to fulfil both the nutritional and psychological requirements of patients. Taking this research one step further, the author also aims to investigate how front-line staff groups involved in the food service process (both NHS and staff from the private food and service management firm) facilitate the delivery of patient-oriented food services.

## 1.4 Contribution of this study

This study makes an original contribution to theory in the subject area of patient-oriented food service experiences and its possible impediments, as well as a methodological contribution in this particular area. Produced are practical recommendations for the food and service management firm in relation to the conceptual framework, market segmentation and operational considerations. Having investigated the patients' psychosocial determinants and the related implementation dyads of patient-focused strategies, a comprehensive conceptual framework illustrating the determinants leading to satisfactory food service experiences for patients, as well as the impeding factors is available. An additional contribution to theory is methodological. The proposed alternative lays in a qualitative case study methodology, focusing on the development of patient-oriented food service experiences within the NHS. This need for developing a holistic insight in the external reality by collecting phenomena is the main argument in favour of using a qualitative case study approach. This enables the author to build a bridge between inductive research (patients needs and wants in terms of hospital food service experiences) and deductive research (acting upon the impediments that form a barrier to the former).

## 1.5 Aim, objectives and outline of the thesis

### 1.5.1 *Aim and objectives*

The aim of this study is to develop an in-depth understanding of what constitutes patient-oriented food services in acute NHS hospitals, where a private food and service management firm operates. The focus will be on the interaction between patients and front-line staff involved in the food service process.

To achieve this aim, various research objectives and questions have been developed (Table 1.1). Studying food services in healthcare is a complex issue, as various stakeholders are involved in this process. What makes it more complicated is the outsourcing of food services to private food and service management firms. The stakeholders involved in this study are predominantly 'front-liners'; patients, NHS staff involved in the food service process, staff from the private food and service management firm (called

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“catering staff” in this study), and finally managers of a major private food and service management firm committing to this study. The author has split the objectives and questions into constituent parts of the research aim and stakeholders involved in Table 1.1, with an indication of relevant chapters focusing on particular research objectives and questions.

**Table 1.1 Research objectives and research questions**

Objectives (A to E) and eventual Research Questions (numbered)	Chapter	Focus
A. To provide a critical evaluation of food services in acute NHS hospitals, where food services are outsourced to a private food and service management company	2	General overview NHS
B. To analyse and assess the body of knowledge from the literature, focusing on (relationship) marketing, consumer food behaviour as well as on factors that do impede the implementation of patient-oriented strategies	3	Patients as well as staff
C. To identify the patients’ core psycho-social determinants leading to satisfactory food service experiences and investigate how these can be facilitated by the various stakeholders involved 1. How do patients in acute NHS hospitals experience food services delivered by a private food and service management firm? 2. Can patient profiles be developed, relating to specific patterns of food acceptability, choice and satisfaction? 3. Can common defining constructs of relationship marketing and consumer food behaviour serve as a foundation to underpin the development of patient-centric approaches to food services in acute NHS hospitals? 4. Is a personalised food service experience focusing on the development of relationships between patients and medical or non-medical staff likely to achieve increased satisfaction levels, eventually leading to a shift of attitude towards hospital food services?	3,6,9&10  6  6, 9  3, 9  9, 10	Patients
D. To examine how a major UK food and service management firm aligns its marketing strategy, human resources and competencies with patient-centric policies developed by the NHS Estates and serving as guidelines for the providing contractors (the NHS Trusts) 5. Do private food and service management staff and NHS staff interact in a way that enables the needs and wants of the patients to be fulfilled?	8, 9, 10  7, 8, 9	Catering staff
E. To develop a holistic theoretical model of the requirements of patient-centric experiences and satisfaction with hospital food services	9, 10	Answers to all RQ (9) and objectives (10)

### 1.5.2 Outline of the thesis

The structure of the thesis is in three major parts. Part A goes from the introduction up to the methodology chapter (chapters 1 to 4), laying the foundations for the data analysis that is handled in part B. Part B comprises both single- and cross case analysis of the hospitals involved in this study (chapters 5 to 8). Finally, part C relates to the summary and discussion of the findings (chapters 9 and 10). In part C the research questions and objectives will be answered and final conclusions drawn. This study will finish with the limitations of the research, implications for practice and personal reflections from the author. Table 1.2 provides an overview by chapter.

**Table 1.2 Thesis outline**

P	Chapter	Title	Purpose
A	1	Introduction and motivation	Introduction, motivation and positioning of the research
	2	NHS Hospital food services in context	Analyse and evaluation of the evolution of hospital food services in healthcare: history, overview of stakeholders involved and hospital-operated versus outsourced food service operations
	3	Literature review	Express the state of knowledge pertaining to relationship marketing, consumer food behaviour with a focus on healthcare and finally implementation dyads between marketing and human resources
	4	Research methodology	Justify the research methodology used: multiple case study (5 hospitals) approach integrating patient interviews, focus group sessions with staff groups and documentary information
B	5	Reporting and presentation of the research findings	Outline of the analysis process developed in chapters 5 to 8 Present the hospitals' characteristics and secondary sources of information collected for this study Develop a brief 'within-case analysis' per hospital
	6	Cross-case analysis of patients	Report the findings from the patients' interviews, comparing and looking at common patterns or emergent themes between hospitals
	7	Cross-case analysis of NHS staff	Report the findings from the focus group sessions conducted with front-line NHS staff involved in the food service process, comparing and looking at common patterns or emergent themes between hospitals
	8	Cross case analysis of food and service management staff	Report the findings from the focus group sessions conducted with catering staff, comparing and looking at common patterns or emergent themes between hospitals
C	9	Discussion based on inter-hospitals comparisons from various perspectives	Discuss the case study work by integrating the three perspectives discussed in chapters 6, 7 and 8 and reflects upon existing concepts and theories outlined in chapters 2 and 3
	10	Conclusions and the implications for professional practice	Draw the threads of the previous chapters together, answering normative questions about policy recommendations and conclusions, implications and contributions for practitioners, as well as the study's limitations. Outlined are recommendations for further research

## 1.6 Personal motivation to conduct the research in the area of food services in healthcare

The author has spent the majority of his working life in the hospitality industry, predominately in banqueting, conference and sales and marketing departments. From these experiences, a particular interest has raised in marketing techniques focusing on the improvement of customer service. As an enthusiastic reader of marketing books, the author often questioned the significant gap between theory and practice. Why do companies proclaim to develop so-called 'customer centric' processes, while the gearing of all their operations towards maximizing efficiency and productivity is merely asking for the end user's opinion? Over time the author got interested in the medical world, questioning how food services in hospitals could be improved not only in terms of production, but also in delivering patients enjoyable 'meal experiences' that might contribute to a more efficient recovery. The author strongly believes that much can still be done to food services in hospitals. The focus should not only be on the efficiency of food production processes, but could emphasise the patients' needs and wants in terms of food products and its servicing. The budgets allocated to food products in hospitals are small and fixed, emphasising the importance of patient service as a means of gaining competitive differential between hospitals, in order to develop a sustainable competitive advantage. The author's key focus lies in the development of 'customer-centric' food delivery to patients in hospitals. This entails that (private) food and service management firms have to know what the patient requires in terms of food and service, build up a relationship with him and involve other parties in the process of delivering food and services. Developing this alternative framework to the current 'compartmentalisation' amongst departments or different stakeholders involved in one way or another in the food service delivery process implies that this marketing concept has to become part of many functions in the hospital, Trusts or even on a national level through the DoH.

# Chapter two: NHS Hospital food services in context

## 2.1 Introduction

According to the first objective of the thesis, this chapter will analyse and evaluate the evolution of food service operations in healthcare. This will be done by critically reviewing the literature on hospital food services. The purpose of this review is to create awareness for the particular characteristics of food services in healthcare, and to develop an understanding of the way these food service operations are managed. The role of food as a key element for the patients' satisfaction and recovery will be emphasised. The existing body of knowledge will help to shed light on the problem at hand, and give insights on how best to study it and what some limitations might be.

The review of food services in healthcare presents five areas of emphasis. The first draws upon the history of hospital food service operations in the U.K. The next section presents an overview of all stakeholders involved in the food service production and delivery process. The roles and responsibilities of key players will be defined where food service operations are outsourced or contracted internally. The third area of study presents key characteristics of hospital-operated versus outsourced food service operations. It is important to focus on the core product before moving on to service aspects of hospital food, therefore the various food service systems used in the U.K. healthcare sector will be described in the fourth area of study. Finally, the fifth area of study will outline the current developments of food services in healthcare, which emphasise a focus on customer-orientation.

The synthesis of the context of food service operations in healthcare is presented on the following pages, where the complexity of food service operations in this particular context is shown. It is a complex environment to operate in because of the huge scale of production, interaction between culturally diverse staff groups and the vulnerable position of patients.

## **2.2 Historical overview of hospital food service operations in the U.K.**

### **Before the creation of the NHS**

Until 1948 when the NHS was formed, hospitals were public institutions. These were run voluntarily and cared for the sick and the poor. Such institutions were overseen by a matron who was responsible for all domestic activities, including care of the linen, cleaning, maintenance of food stores, cooking and distribution of food (Dickerson, 1989). As developed in Hartwell (2004), maintaining patients' strength through food was crucial as only limited medical intervention was in place (Wood, 1998). In 1935 the British Dietetic Association was founded, raising awareness for the importance of proper diets in healthcare.

### **The early days of the NHS: towards a separation of duties**

With the foundation of the NHS in 1948, the nurses still served the meals to patients, even though facility and catering managers were responsible for food purchasing, preparation and distribution. After 1948 catering officers were appointed and some of these were UK-qualified dietitians (McGlone et al., 1995) who became responsible for dietetic advice in the management of disease and the provision of special diets. In 1966 the implementation of the Salmon Report (Ministry of Health, 1966) extended nursing involvement in the feeding of patients and reduced their involvement in the meal distribution process (McGlone et al., 1995). The distribution of meals and the collection of empty plates were no longer a nursing duty, but tasks to be performed by ward 'domestics' or 'waitresses' (Hartwell, 2004). The nurse was identified as having 'sapiential authority' on all things which promoted the well-being of the patient (Hartwell, 2004). The four areas which were identified in the report as 'non-nursing' duties (catering, domestic cleaning, linen and laundry) only compounded the situation.

### **1970's Onwards: when nurses took responsibility over complex food service operations**

Contradicting the trend towards departmentalisation of the food service process, The United Kingdom Central Council for Nursing (1997) emphasized the responsibility of nurses in meeting the patients nutritional requirements. Nutrition Guidelines for Hospital Catering (Department of Health, 1995a) stressed the importance of hospital food as an integral part of the patient's treatment, emphasizing the important (interactive) role of other stakeholders (dietitians, catering staff, nursing and patient representatives) when considering food provision. The publication of 'The Patient's Charter and You'

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(Department of Health, 1995b) was made in respect of hospital patients' and hospital food, but it appeared patients knew very little regarding the contents of the Charter (Farrell, 1999).

Interestingly, the NHS Plan 2000 focused on the 'new' housekeeper role and aimed to revitalise NHS catering across the country. The main point within the document was the need for services to be designed around the requirements of the customer (the patient), as a means to improve service provision. On 1<sup>st</sup> October 2004, the NHS Estates published the document 'Getting over the wall, how the NHS is improving the patient's experience'. The findings of this report contributed to the growing body of evidence that demonstrates the benefits of patient and public involvement into developing customer-focused NHS plans and strategies. The NHS improvement plan, 'Putting people at the heart of public services' was therefore launched in June 2004.

In summary, the importance of food in healthcare has been recognised from the beginning of the 20<sup>th</sup> century. However, the active role of nursing staff towards food and patient feeding has shifted throughout the second part of the 20<sup>th</sup> century. The involvement of nursing staff and their responsibility in meeting patients' nutritional needs has been recognised as an important role, in cooperation with other stakeholders involved in the food process. Understanding the functions of the various stakeholders involved in this process is of paramount importance to assess and improve the current situation. Therefore, the role of the ward housekeeper as well as other stakeholders is analysed below. There has been a blurring of roles concerning responsibility for nutrition in the past. Officially today, nursing staff have accountability and mediate between the caterer and patients. The ward hostesses and housekeeper are responsible for the food service, but the nursing staff have overall responsibility.

## 2.3 Major stakeholders involved in hospital food

### 2.3.1 *Who is in charge: catering or medical staff (nutritionists and nursing staff)?*

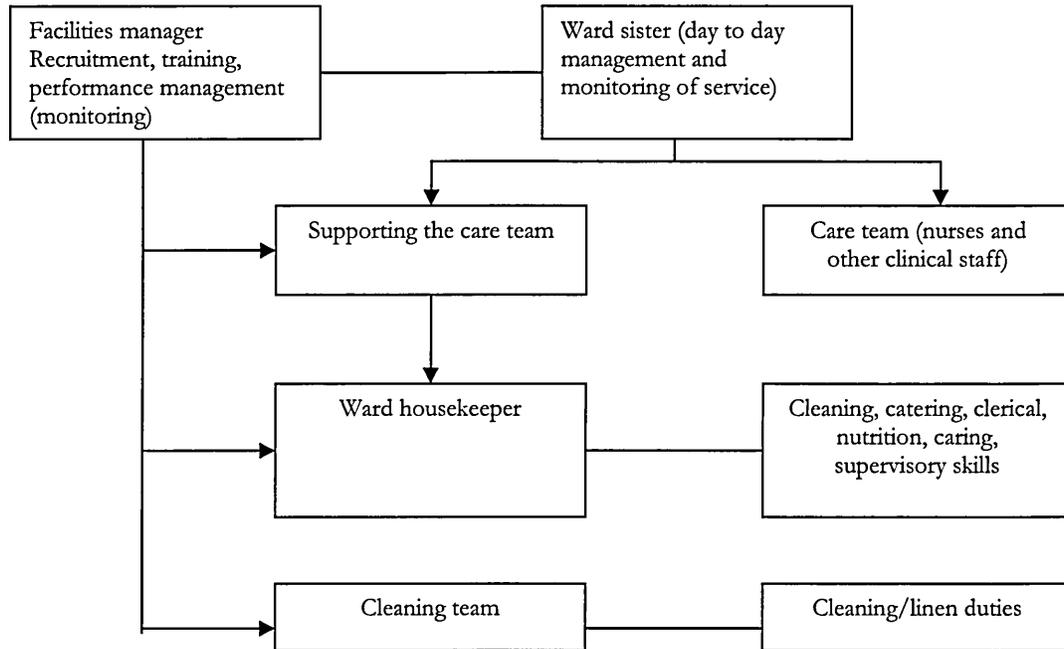
In Europe, the figures of hospitals offering a dedicated nutrition team to patients vary from 2 to 37% (Allison, 2001). Catering has become more and more the responsibility of the catering officer, despite the recognition that a multidisciplinary approach towards patients achieves satisfactory nutritional quality. This multidisciplinary approach was already advocated in 1982 (Tredger, 1982), and is still a top priority today. In spite of this, caterers still often see nurses as having a major responsibility for the distribution of food (McGlone et al., 1995), an approach endorsed by The United Kingdom Central Council for Nursing (1997).

### 2.3.2 *The ward housekeeper and ward sisters: function and benefits*

The underlying philosophy behind the introduction of ward hostesses is to increase patient contact with food service personnel who have a service background. In doing so, nursing staff are released for clinical duties. Benefits of the hostess programme have been identified as being: a reduction in plate wastage from 35% to 12%, increased provision of hot meals for patients not on the ward at lunch time, the identification of malnourished patients, increased patient satisfaction and a reduction in complaints from relatives of the patients (Waite et al., 2000 in Hartwell, 2004).

The ward housekeeper is a ward-based non-clinical role. The role is focuses on cleaning, food service and maintenance to ensure that the basics of care are right for the patient. According to May and Smith (2003) the housekeeper role is highly valued by ward clinical staff and welcomed where it has been introduced. The guidance (NHS Estates, 2001) suggests there could be possible relationships between the facilities manager, ward sister and ward housekeeper. These relationships are illustrated in the figure 2.1 below.

**Figure 2.1 Suggested relationships between facilities manager, ward sister and ward housekeeper**



*Source: NHS Estates, 2001 (in May and Smith, 2003)*

Figure 2.1 illustrates how the issue of food services is in the hands of the Ward Sister, even though it is taken care of by the Ward Housekeeper and nursing staff. A case study conducted in several NHS hospitals (May and Smith, 2003) shows that the housekeeping service is more effective when wards have a dedicated and permanent housekeeper. This is because the housekeepers are able to take ownership of the ward, which develops their pride in the service they deliver and helps to nurture trust between themselves and the ward staff. They report that being committed to a ward also allows for more continuity with patients during their stay, getting to know their particular needs (e.g. diets). It also allows the housekeeper to understand the culture and routines of the ward, ultimately providing a better service to the patients.

## 2.4 Hospital-operated versus outsourced food service operations

From the mid-1980s, hospitals in the UK have been obliged to participate in compulsory competitive tendering (Kelliher, 1996), which means putting their domestic services out to tender. All hospitals have to invite outside as well as 'internal' firms to submit tenders for catering, domestic and other services every 3, 5 or even 10 years. The aim of this tendering policy is to reduce cost and increase efficiency in the provision of ancillary services (DHSS, 1983a).

Currently, there are around 500 NHS Trusts in the UK where most of them control between one and five hospitals each. It is frequently argued that for the buyer, outsourcing could advance the core competency by leverage of the provider's core abilities. However, the NHS is seen by Bell (1998) as one of the more cautious organisations when it comes to outsourcing. Bell (1998) notes an 'in-house' domination of the service market, with only 20 per cent external penetration. Bell (1998) blames this on the protective attitude of NHS executives to outsource responsibility to private food and service management firms.

Competitive tendering is linked to the development of private finance initiatives (PFI) schemes whereby private organisations are awarded contracts to operate hospital support services. Using PFI, the government avoids a capital cost, which is replaced with a rental agreement spread over 30 years or more (Shapiro and Shapiro, 2003). Interestingly, when considering the role of PFI initiatives from the perspective of HR in the NHS, May and Askham (2005) noted such initiatives were contributing to a perceived lack of job security within NHS Estates and facilities management jobs. A more positive element identified by May and Askham is the fact that staff from hotel services tend to view their job as a route into nursing and clinical careers. But when looking at the broad picture, the role and value of PFI has been questioned recently, with the Commons public accounts committee stating that the NHS has lost more than £100 million because of bad PFI deals (Staines, 2007). Table 2.1 gives an overview of the aspects of a tender and adapted from Barrie (1996), which are usually considered by assessment panels when making recommendations to a specific Trust.

**Table 2.1 Aspects of a tender usually considered**

<p><b><u>Commercial</u></b>          Previous and existing catering services          Satisfactory performance references          Hospital catering experience</p>	<p><b><u>Nutritional assessment</u></b>          Nutritionally adequate          Meeting requirements of special diets          Compliance with district food policy          Menu planning          Staff available</p>
<p><b><u>Financial evaluation</u></b>          Comparison of tenders          Redundancy and retirement costs if contract awarded externally          Cost of monitoring          Equipment cost          Turnover and liquidity position</p>	<p><b><u>Technical considerations</u></b>          Safety of (eventual) mixed food production methods          Twenty-four hours service          Training and supervision arrangements</p>
<p><b><u>Personnel evaluation</u></b>          Staffing proposals          Employment terms and conditions          Employment policies          Training policies</p>	<p><b><u>Monitoring and quality control</u></b>          Internal inspections          Implementation of hazard analysis critical control point          Microbiological assessment          Documentation and review of monitoring          Staff induction and training          Costs</p>

*Source: adapted from Barrie, 1996*

Even though the reasons defined in Table 2.1 have sometimes led to the development of outsourcing food services in NHS Hospitals, we might speculate about the effects this has on service levels. Is there a real congruity between the goals of food and service management firms and the goals of the contractor, focusing on patient-centered care? This key aspect will be investigated in this study.

**Advantages defended by outsourcing companies:**

Outsourcing companies claim they can lower operating costs for hospital food-service operations. This allows the often cash-strapped facilities to focus additional resources on their core mission which is caring for patients. Food and service management firms also boast that their expertise can turn hospital food service operations into money-makers by providing options that attract visitors and employees on a regular basis (lobby cafeterias, complete food courts with well-known brands).

**Disadvantages of private food and service management firms versus self-operation:**

Kelliher (1996) argues competitive tendering has not achieved the results required because there has been no major cost savings, industrial relations have not been reformed and staff morale has lowered. Conflict has arisen with dual lines of authority where the objectives and goals of food and service management companies and nursing staff have not always been aligned. Other potential areas of tension are in the

diversity of personnel. Co-ordinating such a complex facility represents a challenge. Hiring a food and service management firm also means relinquishing some control of the food service operation. Employees report to the manager of the food and service management firm and are not part of the organisation. Figure 2.2 illustrates the structure of outsourced food service operations in NHS hospitals.

**Figure 2.2 Representation of food services in hospitals outsourcing food and service management operations**

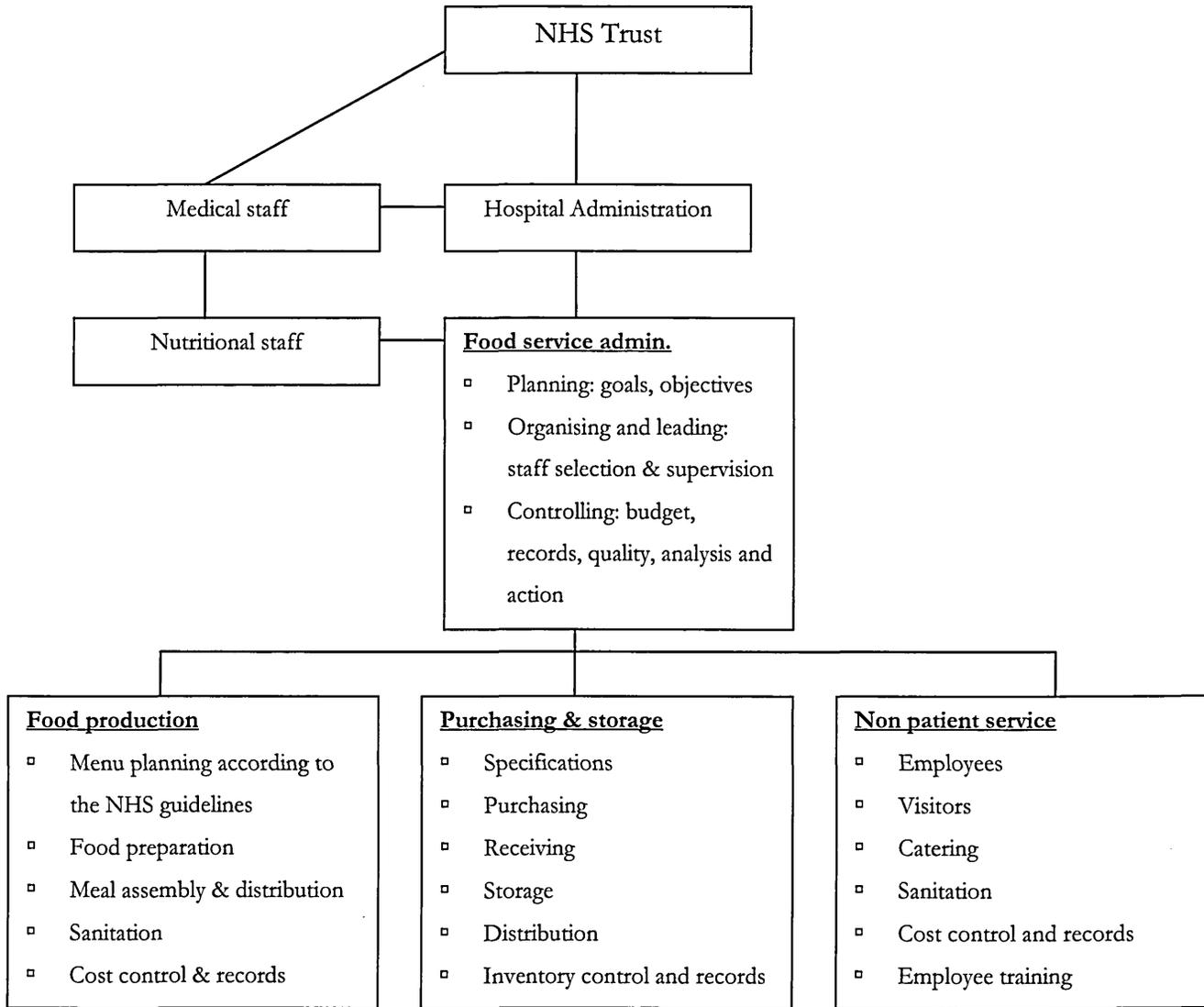


Figure 2.2 reflects a situation where various services are outsourced by the Trust: food production, purchasing, storage and non patient services. However, generally only part of these services are provided by a private food and service management firm, depending on the characteristics of each hospital belonging to a particular Trust. This research will analyse the advantages and disadvantages of having

food and service management firms operating in acute NHS Hospitals, inspired by the advantages and disadvantages of in-house provision and outsourcing as outlined in Table 2.2 below.

**Table 2.2 Advantages and disadvantages of in-house provision and outsourcing**

Advantages	Disadvantages
<b>In-house</b>	
Control	High overhead and management costs
Reliability	Costs inflexible if requirements change
Flexibility (resources can be reallocated)	Limited economies of scale
Accumulated experience	Lack of access to new technologies and ideas
Quality control	Lack of specialist skills
<b>Outsourced</b>	
Easy to expand or reduce resources	Loss of in-house expertise in key areas
Access to specialist suppliers	Need for contract management skills
Reduction in in-house fixed costs	Possible loss of quality control
Overall cost savings	Possible loss of short-term flexibility

*Source: Martin, 2001*

Building further on the description of food services in hospitals, its major stakeholders and also the particulars of outsourcing food and service operations, key characteristics of various food production methods are considered below.

## **2.5 Hospital food service systems**

### **2.5.1 Food production**

Four 'traditional' categories of food service systems are in use within the NHS; cook-serve, cook-chill, sous vide and cook-freeze (Hartwell, 2004). A combination of steam and micro-wave cooking was developed in 2004 and is now in its implementation phase within various NHS hospitals across the country. The categories of food service systems are briefly outlined below.

#### **Cook-Serve**

A cook-serve system is a food service operation where food is prepared and cooked on site (Hartwell, 2004). The food is then distributed to the wards, either already plated or in bulk. Unfortunately there can be a substantial time delay between production and consumption as wards are often situated a great

distance from the kitchens. This often leads to temperature, texture or nutrient losses. Another weakness of this method is that patients often have to make their selection 24 hours before consumption and without the sensory advantage of experiencing the food. Problems arise where a patient receives a meal ordered by the previous bed occupant, when patients are undergoing some medical tests when the food is delivered or when the patient was not present when menu cards were collected. The soup, the main course and the ice-cream are offered on the same tray leaving the patient with a dilemma; should the soup be eaten before it cools or the ice-cream before it warms (Kipps and Middleton, 1990)?

### **Bulk trolley service**

This is a more flexible operation where food is transported to the ward in bulk. Meal selection can be made at the point of consumption and ward staff can be attentive to the various needs of their patients. Ideally, this situation would avoid the scenario of meals being returned uneaten after being presented to the patients (Association of Community Health Councils, 1997).

### **Cook-Chill**

With the cook-chill method, food is cooked and held at a temperature of 70-75° C or more for at least two minutes (Hartwell, 2004). Chilling then occurs within 30 minutes of cooking and the temperature of the food is reduced to 0-3°C within 90 minutes. This temperature is maintained throughout the storage and distribution cycle until the food is regenerated. Regeneration can be carried out at ward level or in a central kitchen. Shelf life is about 4 to 5 days maximum.

### **Cook-Freeze**

This system is similar to cook-chill. But instead of being chilled the food is simply frozen (Hartwell, 2004). Once cooked, dishes are blast-frozen to a temperature of -20°C and kept at this temperature until required (Hartwell, 2004). Storage at frozen temperatures can be extended up to two years.

### **Sous Vide**

Sous vide is a variation of the cook-chill operation as described above. Systems are based upon large scale production methods and the use of vacuum packaging. In the sous vide method, the food is placed into heat stable, air and moisture high barrier plastic bags or pouches (Hartwell, 2004). Air is then removed, which creates a vacuum with subsequent sealing of the pouch. A pasteurising cooking process then takes place followed by rapid chilling to 0-3°C within 90 minutes (Hartwell, 2004). The product must then be stored within this temperature range until required for consumption, but within five days of the date of

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production (Department of Health, 1989 in Hartwell, 2004). This technology is proving to be the least controversial and most widely accepted by both food service professionals and customers (Pucket, 2004).

### **Steam and microwave**

The commercial application of this system to healthcare operations was developed in 2004. The ingredients are raw, part-cooked or fully cooked, and presented on plastic plates with lids incorporating steam-release valves. These valves cause the packs, when microwaved, to pressure-steam the food. Patients choose on the day of consumption, from an unvarying list of hot main meals. Each ward kitchen has a few standard commercial microwave ovens, plus a refrigerator to hold the chilled meal packs.

### **2.5.2 Comparison of systems**

Bulk systems give the opportunity for the patient to select portion size and to decide if gravy is required with the meat. At the moment this is not possible with the 'steam' system. According to Williams (2002) and as outlined by Hartwell (2004), menus from hospitals using cook-chill systems do provide a greater choice of hot menu items. However, these menus do not necessarily support improved dietary intake by patients (McClelland and Williams, 2003). The main weakness of cook-chill food safety design lies in the impact of the numerous steps in the production process coupled with the potential unevenness of temperature distribution and product deterioration during storage of the products (Rodgers, 2005).

Back in 2000 and before the introduction of Steamplicity, the traditional cook and serve system of food production used to be the most popular system in medical food services (Silverman et al., 2000 in Hartwell, 2004). This is especially true with smaller hospitals which have less than 100 beds (Mibey and Williams, 2002). Hartwell (2004) also outlines that cook and serve is considered by the Audit Commission (2001) to be the cheapest at £2.20 per average spend compared to £2.40 for a NHS operated cook-chill/freeze service. In the U.K., a meal assembly catering system is increasingly being used where food preparation is outsourced to external companies (Hartwell, 2004). This leaves the hospital operation to focus on assembly, regeneration and service. About 20 to 25% of hospitals in the NHS do actually purchase their meals from specialised food manufacturers, and this trend is likely to continue in the future (Hartwell, 2004) as the cook-serve system appears to be more expensive. With regard to the steam system which was implemented in 2004, this has various limitations. The system does not allow proper

preparation of fried food (e.g. chips), and meals are rather inflexible because patients cannot modify accompaniments or portion sizes.

### **2.5.3 *Key numbers about food provision in the NHS***

In England and Wales it has been estimated that in the state sector the NHS spends approximately £270 million a year on hospital catering (Audit Commission, 2001). More recent data suggests the figure is in the region of £500 million (www.betterhospitalfood.com, 2004). The NHS produces approximately 220 million meals per year, 71 % of which are produced by in-house catering departments (Audit Commission, 2001). As a result, the NHS is the third largest purchaser of catering services in the U.K., exceeded only by business and industry and local authority education catering (National Health Service, 1994). But the NHS faces significant financial constraints, with budgets for hospital food ranging from £1.50 to £8.40 per person per day. This includes three meals, seven beverages and snacks if desired. It is worrying to note such little budgets are allocated to food provision in hospitals as malnutrition has been identified as an independent factor in increasing morbidity, mortality, length of stay and expenses (Jeejeebhoy, 2003).

## **2.6 Current developments: towards a customer-oriented focus in healthcare**

The hospital food service environment has radically changed over the past decade. One key factor is the focus on financial profits, with an increased emphasis on the catering department to operate as a profit centre rather than as a cost centre (Santoro, 1999). Another key trend strongly emphasised by the NHS Plan (2000) is a customer-oriented food service where the meal follows the patient rather than the food served at a set time on a given ward. Patients should also be provided with a reasonable choice and increasingly be informed about the dietary value and composition of the meals. But the need to focus on the patient as the customer requires a fundamental change in NHS culture (Carr, 1992; Bolton, 2002). Over the past few years, several strategies have been developed about how best to bring together multi-disciplinary approaches to food and food service in hospitals. Nurses, housekeepers, dieticians and hotel service managers looked for synergies between their work areas to improve productivity. This was to ensure that patients would experience a seamless service from the different departments involved in providing high-class, modern meal services in hospitals. In 2003 The Better Hospital Food program

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(BHF) and the Council of Europe resolution emphasised the developing focus on the patient food experience. Key elements of both programmes are outlined below, as well as a short paragraph outlining recent initiatives related to food services in healthcare

### **2.6.1 Better Hospital Food Project in the UK**

As outlined by Hartwell (2004), the Better Hospital Food Project was launched in response to the publication of The NHS Plan (Department of Health, 2000), with the principle aim of improving food quality instead of only focusing on nutritional intake. The NHS plan committed £38.5 million to assist hospitals in funding improvements to food services until 2005. Table 2.3 provides an overview of the implementation of the main BHF program elements, covering the period from 2002 up to 2004.

**Table 2.3 Implementation rates for BHF targets**

<b>Area</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Ward kitchen services	71.5%	89.6%	89.6%
Snack box	58.7%	71.4%	79%
Additional snacks	51.5%	65.3%	84%
Main meal evening	78.2%	91.6%	94%
Leading chef dishes	40%	59.9%	84%

*Source: BDA-HCA Seminar, November 2004*

Despite its termination in 2006, many resources were put in place by the BHF programme: improvement in procurement, food sourcing, recipes design as well as ingredient specifications. The programme raised awareness of the importance of hospital food and also improved its overall choice and quality.

In 2003, the Council of Europe resolution was published, defining guidelines on nutritional care in hospitals. In line with the BHF approach, the COE resolutions are shown below.

### **2.6.2 The Council of Europe resolution (COE), 2003**

Adopted by the Committee of Ministers on 12 November 2003, the Council of Europe (COE) defined the resolution ResAP (2003) on food and nutritional care in hospitals. The ResAP resolutions followed a data collection phase across European hospitals which was conducted from 1999 (Melchior et al., 2003). Five major problems seemed to be common in the context of food services in hospitals: lack of clearly

defined responsibilities, lack of sufficient education in nutrition, lack of influence of the patients, lack of co-operation among all staff groups and finally a lack of involvement from the hospital management. The resolution makes nutritional care a human rights issue, and illustrates how various countries across Europe are facing similar problems to the ones encountered in the UK.

The major COE standards are defined as follows:

- policy and strategy: the board of each healthcare area are to form a committee to follow the patient journey and consider the ethnic and religious elements as well as the financial framework;
- nutritional assessment of the patient: set up of an appropriate care plan that follows the patient right through to discharge;
- delivery of food and fluid: requires each hospital to have a menu planning group to oversee the development of menus;
- provision of food and fluid within each ward area: ensuring the patient gets the help they require to eat, and that their food is served at the right temperatures;
- communicating the standards of service on food and fluid to patients: education and training of patients and staff on food hygiene, nutritional screening and general nutritional issues.

### ***2.6.3 Other initiatives related to food services in healthcare***

Apart from the BHF programme outlined above, there is the ongoing Essence of Care work in nursing, the initiative of the Protected Meal Times and works like Quality Service on the Ward from the Hospital Catering Association. Protected mealtimes was emphasized by the launch in March 2005 of the nationwide protected mealtimes campaign by the HCA (Hospital Caterers Association), aligned with the BHF programme of NHS Estates (Davidson and Scholefield, 2005). The NHS Institute for Innovation and Improvement has also recently developed an interesting project called The Productive Ward. This enables NHS staff to be released more for patient care.

The Patient Environment Action Teams (PEAT) programme was established to assess NHS hospitals in 2000, and has been managed by the NPSA (National Patient Safety Agency) since 2006. The assessment teams consist of various categories of NHS staff, as well as patients, patient representatives and members of the public. In line with the approach of the Healthcare Commission, PEAT is a self-assessment process with validation visits to a small number of sites. The NPSA issues the assessment framework and timetable, and also gives guidance on the composition of teams.

In 2008, various pieces of work have been undertaken by the NPSA. These include work reviewing protected mealtimes, promoting awareness of nutritional screening on admission and reviewing implementation of the protected mealtimes initiative. The national averages of hospital food ratings since 2005 are shown below in Table 2.4, showing a clear improvement in the category of ‘Excellent’ ratings.

**Table 2.4 Hospital food ratings, UK averages**

% Hospitals	Excellent	Good	Acceptable	Poor	Unacceptable
2005	32.4%	51.5%	14.8%	1.3%	0.0%
2006	33.8%	57.8%	8.3%	0.08%	0%
2007	46.5 %	48.5%	4.5%	0.5%	0.0%

*Source: National Patient Safety Agency (<http://www.npsa.nhs.uk/corporate/news/peat-results>)*

Another scheme currently in place is ‘The Red Tray’. This scheme identifies patients that need help with eating and drinking. Serving their food on red trays allows all staff to easily recognise who needs help at mealtimes, and doesn’t compromise the dignity of the patient. Patients needing help with eating are identified by having a red dot sticker placed on their menu sheets. The red dot indicates to the catering department that the meal should be served on a red tray. When the meal trolley arrives on the ward, staff are able to identify the individual patients requiring assistance.

Age Concern has also been involved in recent initiatives. With the launch of the campaign ‘Hungry to be heard’ in 2006, Age Concern has focused on various concrete steps to help make sure older people are not going hungry in hospital. Age Concern works with the Healthcare Commission to improve its assessment process of NHS trusts, as well as with the Royal College of Nursing to develop and distribute resource packs to hospitals to help promote good nutrition. Interestingly, the Royal College for Nursing has now developed its own campaign aiming to improve standards of nutrition in hospitals, called ‘Nutrition Now’.

In partnership with the Council of Europe Alliance UK, the University of Dundee has recently designed a project called Nedpro, or Need for Nutrition Education Project. The focus is on nutritional training for doctors and medical students, following a study from Nightingale and Reeves (1999). The study identified the nutritional knowledge and practical skills were far below what could be expected in a sample of doctors and medical students. It is surprising to note this observation, especially as there is a plethora of training on nutrition available from organisations such as Sustain, BAPEN, the RIPH or the NHS Core Learning Unit. The NICE (National Institute for Health and Clinical Excellence) do provide guidelines

and recommendations related to nutrition, but only the technology appraisals are compulsory and the guidelines outlined carry no force of mandate.

The Nutrition Action Plan was published by the Department of Health in 2007 to address nutrition of older people in care. This action plan defined a set of priorities, supported by a range of actions:

- Commitment from the Nursing and Midwifery Council (NMC) that Nutrition principles will be assessed in practice as part of student nurse training from September 2008;
- Largest study ever undertaken on malnutrition on admission to hospital and care homes - conducted by the British Association for Parenteral and Enteral Nutrition (BAPEN);
- Training programme on nutritional care and assistance with eating will be available to all NHS and social care staff from May 2008;
- Tougher regulation and inspection, building on the work already done by CSCI (Commission for Social Care Inspection) and the Healthcare Commission . The DoH will work with regulators to ensure that standards of nutrition and dignity are central to quality inspections;
- Development of a range of good practice on nutritional care by the DoH and the Social Care Institute for Excellence.

As part of the plan, the Government and stakeholders will also be encouraging the NHS to use the Council of Europe Alliance (UK) "10 Key Characteristics of Good Nutritional Care" - a landmark document which creates a common understanding of what good nutritional care looks like in hospital settings (Source: [http://www.dh.gov.uk/en/Publicationsandstatistics/Pressreleases/DH\\_079964](http://www.dh.gov.uk/en/Publicationsandstatistics/Pressreleases/DH_079964)).

## 2.7 Conclusions

The chain of food production to consumption in hospitals is complex and needs the co-operation of all stakeholders involved; from front-line employees (ward sisters, domestics and assistants) to management at administration level. Nutrition in hospitals has been a subject of concern for many years now, and constitutes the core function of hospital food services. Despite an increased awareness of the issue, there is little evidence of general improvement in U.K. practice. The lack of status afforded to the whole area of food and nutrition in hospitals has been highlighted in the literature, together with a blurring of roles concerning responsibility for nutrition and overall service to patients. This is a surprising observation, knowing that the 'U.K. Guidelines for Hospital Catering, 1995' already stressed the importance of good inter-disciplinary communications (Department of Health, 1995a). It would seem that there is potential for operational tension unless roles are clearly defined and communicated. This appears to apply in a situation where food services are outsourced, as well as in a situation where food services are contracted internally. Even though ward housekeeper positions have been developed to relieve the medical staff from food service tasks, it appears that nurses still have accountability and act as an interface between the food service management staff and patients.

However, overall, the installation of ward housekeepers has led to an increase of patient satisfaction levels and has been welcomed by clinical staff. Within this context, only 20 to 29% of hospitals in the U.K. outsource their food service provision to private food and service management firms. The supply of food is often the result of the most cost effective tender, even though the competitive tendering scheme has not achieved the results hoped for. The 'traditional' food service systems have been in place for the last 50 years, and it was only in 2004 that a new steam system was developed by a private food and service management firm. The literature on the various food service systems does not provide clear insight into the system leading to the highest degree of patient satisfaction.

## Chapter three: Literature review

### 3.1 Introduction

In relation to the second research objective of this study, the purpose of the literature review is to outline the state of knowledge pertaining to (relationship) marketing, consumer food behaviour and factors that do impede the implementation of patient-oriented strategies. The latter will focus on the marketing of services, which will look at relationship marketing as well as the implementation dyads between marketing and human resources as identified in the second research objective below:

- B. To analyse and assess the body of knowledge from the literature, focusing on (relationship) marketing, consumer food behaviour as well as on factors that do impede the implementation of patient-oriented strategies

The sections on marketing of services and consumer food behaviour aim at developing an in-depth understanding of possible expectations, requirements and behaviours that patients have when admitted to hospital. The section regarding the interface between marketing and human resources aims at developing an understanding of possible impediments that do not allow appropriate implementation of patient-oriented food services in a healthcare context. The existing bodies of knowledge help to shed light on the problem when considering patient-focused food services in acute NHS hospitals, spanning the multiple disciplines defined above. The overarching theme and theoretical underpinning over these three areas is the focus on a holistic understanding of business processes. This is based on the central idea of relationships, networks and interaction as developed by the Nordic School of Marketing.

The first section of this chapter will discuss the evolution of marketing towards concepts of value co-creation, along with exploring and defining constructs of relationship marketing. A patient-centric management model of food service operations in NHS hospitals will be developed. The area of relationship marketing is explored in this study for the reason that in 2004 the English representative of the Better Hospital Food (BHF) programme stressed the development of a guest-host relationship between catering staff and patients was a key factor in enhancing the overall meal experience, as outlined in chapter 1.

The second section presents an analysis of the literature on consumer food behaviour in a healthcare context. The third area of study presents the implementation problems between marketing strategies and human resources, focusing on the context of healthcare. The synthesis of these three bodies of literature is presented on the following pages.

## **3.2 From marketing services towards value co-creation**

### ***3.2.1 Introduction***

Gummesson (2002a) states that the literature contributing to a relationship management theory generation is primarily found in services marketing, the network approach to business marketing, quality management and finally the new trends in organisation theory. The literature relating to these components will be analysed and a scheme providing a global overview of relationship marketing disciplines will be developed. The main approaches towards relationship marketing will be critically reviewed and topical concepts beyond 'traditional' relationship marketing will be identified. The benefits for the end-user and the company will also be examined. Finally, marketing developments in the NHS will be analysed with a special focus on the role of patients. A patient-centric management model of food service operations in NHS hospitals will be developed. But firstly, the overarching framework of services marketing will be posed.

### ***3.2.2 The emergence of service management and marketing***

Currently, services are provided by private firms, governments (and its operating bodies like the NHS in the U.K.) and voluntary organisations. The academic study of services started in the early 1970's and originated in three main areas: service management, service marketing and service quality. From the beginning the interconnection of the service and marketing field brought together management, marketing, consumer behaviour, operations management and quality, psychology, communication theory, and finance. A remarkable aspect of service studies is the cross functional approach. Marketers write about service management, economists about service quality, operations specialists write about strategic management and quality specialists about marketing. However, all various writers agree that the focus

should be on the customer and that the integration of the different organisational departments must work together to serve the customer. The different customer-oriented approaches can be described as 'customer centricity', a term developed by Drucker (1954).

### ***3.2.2.1 A definition and key characteristics of services***

There are significant differences between consumer goods and services. When purchasing a service, there is no tangible item that exists to help the consumer make decisions. As Gummesson (1993, p. 22) puts it:

*“a service is something that can be bought or sold, but which you cannot drop on your foot”.*

Key characteristics that tend to influence marketing of services are often referred to as heterogeneity, inseparability and perishability. However, in recent years these attributes of services have been questioned by authoritative marketers, such as Lovelock and Gummesson (2004). A central part of service marketing is based on the fact that the consumption of a service is process consumption rather than outcome consumption. This implies that the consumer perceives the production process to be part of the service consumption and not just the outcome of that process. Because the implications of the key distinctions between products and services are not restricted solely to the area of marketing, research on services should definitely be interdisciplinary. This is re-ascertained by Martin (1999), who stated that services marketing issues are inseparably intertwined with a host of other functional areas of business, most notably operations and human resources. This will further be developed when considering the HR and marketing implementation dyads in section 3.4.

### ***3.2.3 The emergence of relationship marketing***

Relationship marketing is related to services marketing because of the interaction that often happens between the customer and the service provider. As modern economies become mainly service-oriented, many companies have increasingly gained revenue from creating and maintaining long-term relationships with their customers.

### 3.2.3.1 *Brief history of relationship marketing*

Today, relationship marketing has established itself as an underlying paradigm in modern industrial marketing and services marketing. Bund Jackson (1985) was the first person to use the term relationship marketing (Gummesson, 1987). But according to Grönroos (2004), even before 1985 an explicit relationship perspective in marketing was inherent in the Nordic School of thought (see Grönroos, 1980; Gummesson, 1983, 1987). Instead, terms like long-term interactive relationships, marketing through networks and interactive marketing were used.

### 3.2.3.2 *Definitions of relationship marketing*

Today, relationship marketing stems from a number of different streams of research in marketing (Lindgreen, 2001). Each tradition provides a particular and partial view of its focal phenomena, dependent on both its ontological and epistemological assumptions. Different applications of relationship marketing make finding a common definition complicated. Even today in 2009, it appears there is no well defined consensus as to what relationship marketing constitutes. Various definitions of relationship marketing are chronologically outlined in Table 3.1.

**Table 3.1** Definitions of relationship marketing

Year	Definition and author
1990, p. 7	Marketing is to establish, develop and commercialise long-term customer relationships, so that the objectives of the parties involved are met. This is done by a mutual exchange and keeping of promises (Grönroos)
1994, p. 3	RM is "An emergent disciplinary framework for creating, developing and sustaining exchanges of value, between the parties involved, whereby exchange relationships evolve to provide continuous and stable links in the supply chain" (Ballantyne)
1994, p. 80	Relationship marketing is marketing seen as relationships, networks and interaction (Gummesson)
1997, p. 407	RM is the process of identifying and establishing, maintaining, enhancing, and when necessary terminating relationships with customers and other stakeholders, at a profit, so that the objectives of all parties involved are met, where this is done by a mutual giving and fulfillment of promises (Grönroos)
1998	Depicts CRM as a combination of business process and technology that seeks to understand a company's customer from the perspective of who they are, what they do, and what they are like (Couldwell, in Chen and Popovich 2003)
2002, p. 3	Relationship marketing is marketing based on interaction within networks of relationships (Gummesson)

Most definitions listed above have in common that relationship marketing is described as being longer in duration (than transactional marketing), reflecting an ongoing process (Dwyer et al., 1987, p. 12). According to Grönroos (2004), the focal relationship is the one between a supplier or provider of goods

or services and the buyers or users of these goods or services. Relationship marketing is primarily geared towards the management of this relationship.

Successful marketing means involving many stakeholders (suppliers, distributors, the client's customers and sometimes even political decision makers) in the management of the relationship in a network of relationships. As the NHS is part of a large and complex network of patients, service users, suppliers, competitors and other stakeholders involved in the food service process, this study will refer to the approach of the Nordic School to further develop relationship marketing concepts.

### ***3.2.3.3 The Nordic School of Marketing***

The designation 'Nordic School' was originally conceived for services marketing in the early 1980s. The Nordic School is characterised by innovative thoughts on marketing, pioneering a paradigm shift from goods and services in focus to value in focus and the integration of the marketing function with other functions and general management (Gummesson, 1996).

According to Gummesson (2002a), the Nordic School has broadened its domain from initially services marketing to merge services marketing with the network approach, to business-to-business marketing, traditional marketing management and other disciplines within management. For example, quality has resulted in a generalised approach where relationships, networks and interaction appear as central concepts (Gummesson, 1994; Gummesson et al., 1997; Grönroos, 1997). The key aim of this study is to allow a holistic understanding of business processes and a special focus on the patient. Consequently, the following relationship marketing definition has been adapted as an overall framework, in line with the network and relationship approach as developed by the Nordic School of Marketing:

*"Relationship marketing is seen as relationships, networks and interactions" (Gummesson, 1994)*

This definition is the most appropriate to the complex contextual and relational elements of food operations in healthcare. It requires co-operation of various stakeholders intervening in the food production and service delivery process. The relationship philosophy of the Nordic School also relies on co-operation and a trusting relationship with customers. This is in collaboration within the company instead of specialisation of functions and the notion of part-time marketers spread throughout the organisation. To be successful, the supplier or service provider has to align its resources, competencies and processes with the consumer's value-generating processes. It is the aim of this study to analyse, in

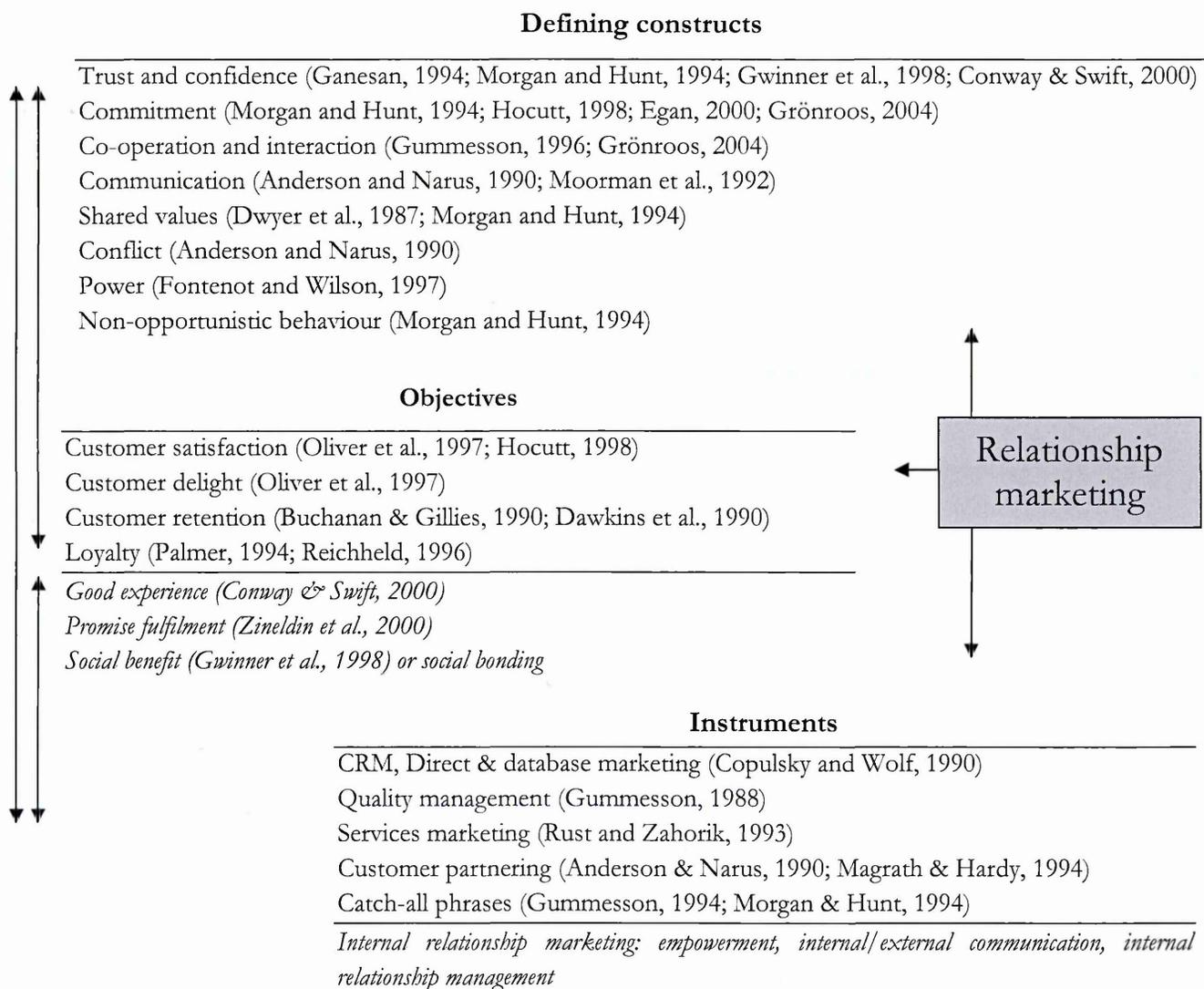
depth, the patient's value generating process by focusing on psycho-social determinants of his/her food service experience.

Adapted to the UK healthcare context, the author suggests a need for the existence of relationships with the media, competitors, local governments (government and society), as well as relations with internal customers and end-users (referred to as the 'internal environment' below). The various categories are integrated in Figure 3.12 that concludes the literature review.

#### ***3.2.3.4 Components of relationship marketing***

The introduction of relationship marketing has produced a rather harmonious view of relationships, with constructs of (Dwyer et al., 1987; Ganesan, 1994; Lindgreen, 2001) concern, commitment, service, promises and trust. These defining constructs, along with other key constructs identified in the literature on relationship marketing are further developed below, and combined in Figure 3.1. The overview of relationship marketing determinants will focus on the approach of the Nordic School, but will not be limited to this perspective. The most complete model of these relationship marketing disciplines comes from Lindgreen (2001). His model is represented in the figure 3.1, with various additions (*in italic*) as a result of the literature review.

**Figure 3.1 Breakdown of relationship marketing into objectives, defining constructs and instruments**



Source: expanded on Lindgreen, 2001

**The defining constructs of relationship marketing**

As shown in Figure 3.1, approximately ten defining constructs developed by various authors form the foundation of relationship marketing. It is difficult hereby to isolate specific components. But although most constructs will be touched upon in this study, the focus will be on the constructs of communication, trust and commitment.

## Communication and dialogue through interactions: paving the way to co-operation and trust

A productive two-way communication process between the customer and the company is essential in developing strong relationships. This relationship dialogue also forms the basis for building trust and confidence between exchange partners. Developing an in-depth understanding of internal values is of paramount importance for both customers and providers, whether it be in a healthcare or in a more traditional business environment. The intent of this interactive process is to build shared meanings and get insights into what the two parties can do together and for one another. This is achieved through access to a common meaning or shared field of knowledge (Bohm, 1996), as developed by Grönroos (2004). This study aims to understand if such common meaning is currently developed between private food service providers and patients in acute NHS hospitals.

### Trust

Trust has been confirmed as a key aspect of relationship marketing (Dwyer et al., 1987; Anderson and Weitz, 1992; Ganesan, 1994), leading to high levels of loyalty and profits. Trust is built upon experience, satisfaction and empathy and is likely to bring a more positive attitude. Conversely, low trust can have the opposite effect (Conway and Swift, 2000). Grönroos stressed the need to use all resources of the seller (personnel, technology and systems) in a way that the customer's trust in the resources and in the company itself is maintained and strengthened at the same time. Trust is seen as encouraging partners to co-operate, seek long-term benefits and refrain from opportunistic behaviour (Anderson and Narus, 1990; Anderson and Weitz, 1992; Morgan and Hunt, 1994). Honesty, safety, credibility and previous experience are among several dimensions of trust (Egan and Greenley, 1998). Various definitions of trust are outlined in Table 3.2 below.

**Table 3.2** Definitions of trust

Author	Definition
Moorman et al., 1992	A willingness to rely on an exchange partner in whom one has confidence
Lacey, 2007, p. 317	The expectations held by the consumer that the firm is dependable and can be relied on to deliver on its promises
Zboja and Voorhees, 2006, p. 382	Trust exists when one party has confidence in an exchange partner's reliability and integrity

In this study, the author will refer to Moorman et al.'s. (1992) definition of trust. This definition means there has to be a belief in the other partner's trustworthiness, resulting from the expertise and reliability of that partner. This study focuses on developing an understanding of who patients trust with regards to food when hospitalised in acute NHS hospitals, where a private food and service management company

is in charge of food provision. When considering the negative expectations from patients towards hospital food and the issues of malnutrition outlined in the literature, it is not surprising to anticipate a loss of trust in the hospital as a nourishing environment (according to de Raeye, 1994). As addressed by Bélanger and Dubé (1996), it is helpful to place negative expectations towards hospital food services in a broad context of situation-attributed negative emotions towards hospitalisation itself. As developed in the following paragraph, trust is most frequently considered to be a mediating variable and determinant of commitment (Morgan and Hunt, 1994; Chaudhuri and Holbrook, 2001).

### **Commitment**

The development of a strong relationship also depends on the level of commitment a partner feels towards that relationship. Hocutt (1998, p. 195) views commitment as:

*“an intention to continue a course of action or activity such as maintaining a relationship with a partner”*

Trust and commitment often come together in the literature on relationship marketing, with very few researchers discussing one without the other. Egan (2000) suggests that commitment is central to relationship marketing, in line with Conway and Swift (2000) who feel that the level of commitment a partner feels towards that relationship is of great importance in developing that relationship further. Both trust and commitment are invariably associated with the prerequisite that the relationship is of high importance to one or both parties (Morgan and Hunt, 1994). This study aims to investigate if some patients feel more committed than others to the relationship with catering staff, and whether this type of relationship is of any importance for patients.

### **Key objectives of relationship marketing**

#### **The customer's value-generating process**

The core of the objectives shown in figure 3.1 is the creation of value for both the customer and the firm. Interestingly, value is not only an objective of relationship marketing, but also one of its core defining construct. This is a logical fact, as it would be difficult for a firm to deliver any form of value to customers without knowing what the values of these customers are. Considering this, Ravald and Grönroos (1996, p. 19) quote that:

*"Value is considered to be an important element of relationship marketing and the ability of a company to provide superior value to its customers is regarded as one of the most successful strategies..."*

Value is transferred to and created together with the customers through interactions with a firm. The Nordic School of Marketing has extensively looked at the customer perception of value created in ongoing relationships which emerge over time. The way firms strive to fulfil customer's needs has been labelled the 'customer's value-generating process' (Grönroos, 2000a). Little is known about value processes of patients towards food when admitted in hospital, hence this study aims to fill in this gap.

Apart from the relationship aspect of delivering value for customers, value is also partly created by customising products or services. In many service industries, customisation requires interaction between the seller and the customer, where service-oriented companies depend on their front-line staff to deliver the customised product or service. If the supplier or service provider successfully aligns its resources and competencies with its customers' internal processes, this value base is turned into customer perceived value. Applied to acute NHS hospitals where patients consider the food served is not what it should be, this study aims to investigate whether patients still find compensation in the relationship they have with the catering staff serving the food.

### **Promise fulfilment**

Keeping promises is seen as a core objective in relationship marketing and can be used as a measurement to see whether a relationship is to continue or come to an end. If a company cannot keep a promise made to a customer, this will also dissatisfy employees who are in contact with the customers. Fabien (1997) explicitly warns that the personnel who are in contact with the customers can become dissatisfied if the promises the company made to them are not fulfilled. The employees who feel ill-prepared to meet customer expectations experience more frustration than satisfaction in the workplace, resulting in high turnover of staff and customer dissatisfaction.

Claycomb and Martin (2001) also highlight the link between trust and promise: in the service sector trust is particularly relevant, because customers often do not buy service per se but rather buy a promise of service. It is necessary to fulfil promise by actions. As Zineldin and Jonsson (2000) state:

*"trust and commitment between business companies can only be built on actions rather than promises".*

This study aims to investigate whether food related promises are made to patients upon admittance on the wards and if these promises are fulfilled.

### **Good experience**

Developing and retaining long term relationships implies good experiences for the customers. Negative experiences may hinder the relationship or even lead to customer defection. Conway and Swift (2000) suggest that in order to reach the required overall level of satisfaction and develop the relationship further, both parties must have positive experiences.

### **Customer satisfaction**

A great deal has been written on satisfaction as an important outcome variable to a successful relationship. It has links with experience, trust, commitment and fulfilment of promise. Hocutt (1998) proposes that trust directly influences commitment. The author also sees the relationship between trust and commitment as being mediated by both satisfaction with the service provider and relative dependence. From the customer's point of view, Gwinner et al. (1998) conclude that relationship marketing could bring customers confidence (reduce anxiety, faith in product or service provider, feeling of trustworthiness of the provider), social benefits (personal recognition by employees, the customer being familiar with employees, the development of friendship with employees) and in some cases a special treatment (extra services, higher priority). This study aims to investigate potential benefits of relationship marketing which are experienced by patients in acute NHS hospitals.

### **Social bonding and loyalty**

Bonding is described as the dimension of a business relationship that results in buyers and sellers acting in unison toward a desired goal. The dimension of bonding, as it applies to relationship marketing, consists of developing and enhancing consumer loyalty. This results in feelings of affection, a sense of belonging to the relationship and a sense of belonging to the organisation (Sin et al., 2002). Commitment does not equal loyalty. Liljander and Strandvik (1993) define loyalty as only repeat purchase behaviour within a relationship. A negatively committed customer shows a negative attitude but might still buy repeatedly because of bonds.

This also means that customer loyalty is not always based on a positive attitude, and long-term relationships do not necessarily require positive commitment from the customers. This distinction challenges the idea that only customer satisfaction leads to long-lasting relationships, as satisfaction is only

one dimension in increasing relationship strength (see figure 3.2 below). It is important to note that the use of contextual barriers can generate latent dissatisfaction, which emerges as the importance of contextual bonds (for instance the legal or practical bonds binding patients to designated hospitals) decreases.

**Figure 3.2 Link between customer satisfaction and relationship strength**

Customer satisfaction	Relationship strength	
	<i>Weak</i>	<i>Strong</i>
<i>Low</i>	Expected outcome	Contextual or perceptual bonds outweigh the lack of satisfaction
<i>High</i>	Low customer commitment. The relationship is not perceived as important by the customer	Expected outcome

As most patients would prefer not to be in hospital, it is assumed they are committed to it because of perceived and contextual bonds that function as exit barriers.

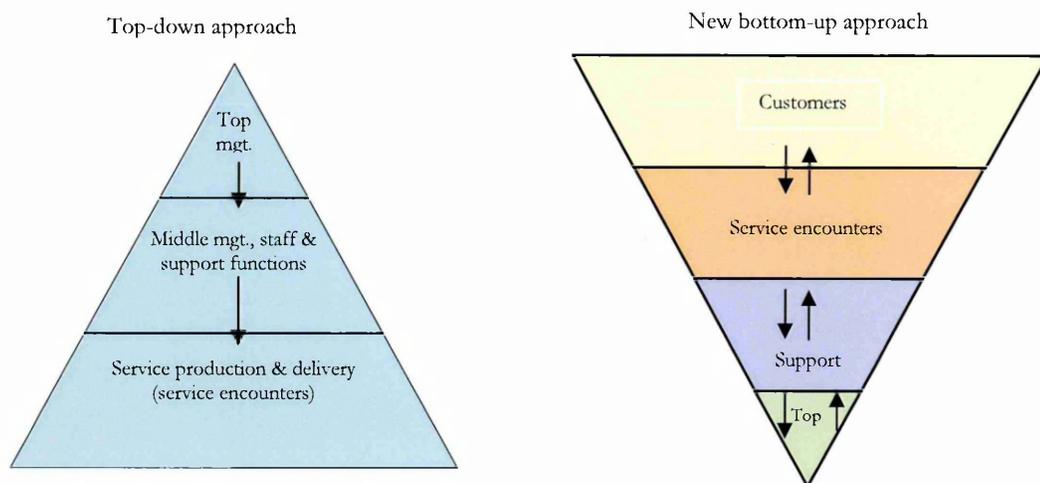
### Key instruments of relationship marketing

#### **Internal marketing: the role of part-time marketers**

In service encounters both the customer and the employee play a key role. When the employees are literally the face of the company, giving a poor service can seriously damage the image customers have of the company. This is why Normann (1984) called these encounters ‘moments of truth’. The concept of relationship marketing is especially relevant for these situations where the provision of both goods and services are intertwined. In the relationship marketing view developed by the Nordic School, all employees are considered as ‘part time marketers’ who represent the firms core values. According to Gummesson (1987) part time marketers are employees who are not part of the marketing department but represent the company by interacting with internal or external customers. They outnumber the ‘full time marketers’ many times over. This applies to healthcare, where front line staff who interact with patients largely outnumbers the few sales and marketing staff...if any! It is interesting to consider all employees as ‘part-time marketers’ who possess the company’s (NHS or private food and service management firm) core values. Consumers reach a judgement about a certain service by the outcome of various interactions they have with the staff supplying the service.

Ideally, the front line employee should create value for the customer and be supported by the rest of the organisation (back office and management staff). This approach contradicts with the usual top-down approach often seen in industries. The old traditional view of the organisation and the modern service-oriented approach are shown as pyramids in Figure 3.3.

**Figure 3.3 Service-oriented organisational structures**



*Source: based on Grönroos 2000b, p. 305*

According to the principles of service management, Figure 3.3 illustrates how the interaction between buyers and sellers is placed at the top of the organisational hierarchy. The new model implies more responsibilities for front-line staff and requires a flat organisational structure. Developing strong relations with customers means strong relations within the company (NHS Trust, the hospital and the private food and service management firm) must be developed. These relations are often referred to as ‘internal relationship marketing’, which is further developed below.

### **Customer relationship management (CRM)**

Peppers and Rogers (1999) refer to customer relationship management as an aspect of relationship marketing that uses technology-enhanced customer interaction in order to shape appropriate marketing offers. CRM retains customer data that has been gained from all customer touch points where the customers interacts with the firm. Profiles of key customers can be identified and their purchasing

patterns can be predicted. In accordance with Goldenberg (2000), the author believes that CRM is not merely technology applications for marketing and service.

When fully and successfully implemented, CRM can be used for a cross-functional, customer-driven, technology-integrated business process management strategy. As stated by Payne and Frow (2005), successful implementation of CRM plans depends on a successful combination of processes, people, operations and marketing capabilities.

### ***3.2.4 Beyond relationship marketing***

#### ***3.2.4.1 Customer as co-creator of value within complex networks of relationships***

Over the past few years, various authors have developed theories which show the new type of society we are moving towards. The role of the customer in creating value together with the service provider has been emphasised throughout. In the value constellation approach by Normann and Ramirez (1993), the customer is an interactive co-producer of value, but value is also created independently by both the provider and the customer. Quinn (1992) believes the future society gains value from managing knowledge in service based systems, even if this value is created through the traditional idea of manufacturing or services.

Pine and Gilmore (1999) developed the 'experience economy' concept, in which the customer is permitted to experience products and services himself, developing his own value judgements. In an article on the concept of imaginary organisations and following Hedberg et al. (1997), Gummesson (1998) emphasised the importance of the customer's role in creating both quality and productivity in services.

Using the network approach developed earlier, it can be concluded that modern corporations form a network of relationships where all members of the network influence quality and productivity. It is quite surprising, when thinking about the above, that customer centricity has only recently been taken on by the business community. In the 2003 Gartner Group Report, it was thought that by the end of 2007 less than 20% of a thousand global marketing organisations would have grown enough to be able to influence customer-centric, value-added processes and capabilities to their own advantage. Most companies do not have the needed customer centricity to understand the benefits of a continuing dialogue across all customer touch points and personalised treatment of valuable customers (Shah et al., 2006). When

thinking about hospital patients who do interact with catering staff, nurses and doctors, this study aims to investigate whether patients are becoming co-producers of value in the medical system?

### ***3.2.4.2 An integrative concept: towards customer-centric business processes***

In line with the customer-oriented relationship marketing concepts developed by the Nordic School of Marketing, 'customer-centric business processes' (CCBP) have been identified as a culturally-focussed approach which genuinely attempt to put the needs of the customer at the heart of core business processes (Bolton, 2004). The aim of CCBP is to know and understand customers, to treat them with respect, gain their trust, to anticipate their needs and to respond positively to their actions. Those which deal directly with the customer have a 'special relationship' and a special responsibility. The notion of 'part-time marketers' developed by Gummesson (1987) clearly re-appears here. CCBP is not sector-dependent but part of the UK (e-)Government agenda for the public sector to adopt increasingly customer-centric approaches to the provision of services.

### ***3.2.5 Customer-centric processes in the NHS***

#### ***3.2.5.1 Introduction***

The concepts of relationship marketing, customer-centric business processes and value co-creation have been discussed above. Within this section, the author will analyse how these marketing concepts can be transferred to hospital food service operations. According to the second research objective, the current evolution of the distribution and business model from hospital food service operations will be analysed. The focus will rest on the interrelationships between the various stakeholders involved. Moving towards a customer-centric approach in healthcare implies the need to differentiate 'patients' and 'customers', and eventually re-define those who are traditionally considered as the 'customers' in healthcare. Taking this into consideration an alternative business model will be developed, whereby the patient is considered as an active customer and placed in the centre of all food service operations in hospital.

### ***3.2.5.2 Dealing with 'patients' or 'customers': similarities and differences***

Traditionally, patients are viewed as passive people who subject their bodies to treatment carried out by experts. The more active connotation associated with the term customer or consumer emphasises and acknowledges patients' views about their own health and what is expected with regard to treatment. Customers are classified as external and internal. In the healthcare system, external customers are the inpatients, outpatients and their families. Internal customers are the individuals who provide direct service to the external customers. They belong to the organisation that produces the service (employees, suppliers, physicians, nurses and all other health care providers).

When thinking in terms of patient-oriented processes, it is important to outline the major similarities and differences between patients and so-called 'customers'. This is further developed below.

#### ***3.2.5.2.1 Similarities***

In the U.S., patients under private insurance cover tend (like customers) to shop around. They may seek the opinions of other health professionals if they are not satisfied with the service provided. According to Hudak et al. (2003), many patients also wish to consider their choices of treatment and to be involved in decision making (Deber et al., 1996). Furthermore, in the contemporary western world, both patients and customers expect that, regardless of their sex, ethnic background, or other personal characteristics, they will receive fair and equitable consideration by health professionals. This does not apply as much within the NHS, where a major part of medical expenses are paid by governmental bodies and where patients are generally not empowered to shop around when it comes down to being referred to a specific hospital.

#### ***3.2.5.2.2 Differences***

In health care systems that are partly paid for by a third party, many patients do not think about health care in terms of the value they get for the money being spent (Hudak et al., 2003). Patients and health professionals may develop personal relationships, which for some patients involve an element of wanting to please and perform well for the health professional. The most important difference between business and health care contexts relates to their primary goals. In commercial operations, sales people value customer satisfaction with a product or service and this is associated with repeat purchases, decreased rate of returns and positive word-of-mouth. Health professionals, in contrast, work in environments where the primary aim is to provide quality care in order to improve or maintain patients' health. Satisfying the

patient has traditionally been a secondary aim for health professionals. Increased sales and profits are not meant to be the primary goal, because the goal of satisfaction in some cases may actually conflict with practice guidelines, evidence-based practice, or effective resource utilization (Carr-Hill, 1992). As seen above, the marketing literature uses the term 'bonds' to explain why customers maintain a relationship with specific institutions. This is because of factors where satisfaction does not play a major role. This is a suitable marketing approach which applies to the case of patients in healthcare, and is developed further below.

#### ***3.2.5.2.3 Patients as captive customers: bonds as switching barriers***

NHS patients in acute hospitals are not always empowered to choose the institution they are to be treated in. As such, patients are often considered as a captive audience. Liljander and Strandvik (1999) propose that ten different types of bonds can be identified in the consumer market: legal, economic, technological, geographical, time, knowledge, social, cultural, ideological and finally psychological. Liljander and Strandvik (1999) argue that the first five bonds (legal, economic, technological, geographical and time) represent effective exit barriers for the consumer. The customer may therefore be loyal to one specific NHS hospital because of the lack of perceived alternatives, regardless of relationship strength with that particular unit. Even though analysing the bonds between patients and hospitals is not the purpose of the present study, it is important to understand which factors do lead patients toward specific hospitals. In perspective of the above, bonds between patients and hospitals can be defined as economical, technological, geographical, knowledge and social.

#### ***3.2.5.2.4 Marketing ethos in the NHS Plan: considering patients as customers***

Because of the current emphasis on increasing competition between hospitals, effective marketing planning is becoming a necessity for the public healthcare sector in the UK. In the NHS Plan, the marketing ethos is well defined as a 'patient-oriented' approach with regard to health care and food services. However, a marketing function is not developed within individual NHS Hospitals. In line with the marketing ethos developed by the NHS, (private) food and service management firms currently develop patient-centered food service approaches, with a partiality on the implementation of relationship marketing. As consumerism in public policy is gaining greater emphasis (Avis et al., 1995), the views and demands of patients are affecting the NHS managers' choices and are influencing the health care delivery system. Pucket (2004) even identified seven customer groups in order to determine customers wants and

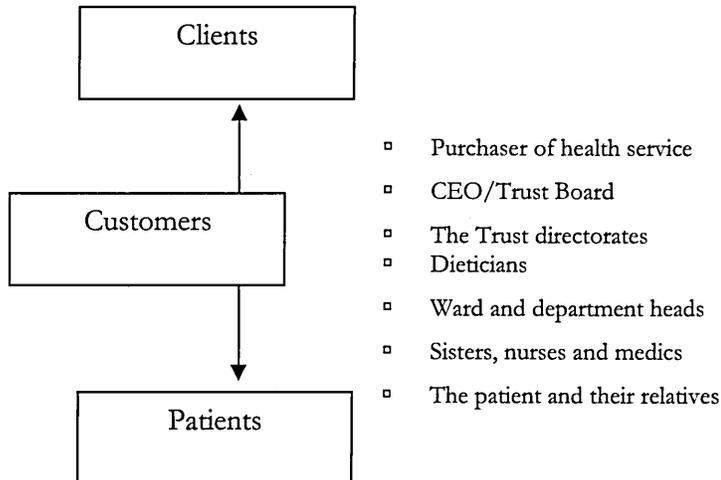
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needs: patients, family and visitors, physicians, employees, volunteers, vendors, and payers. Customer-centric processes and value co-creation involving these customer groups are at the heart of this study.

### 3.2.5.3 Patient-centric management model of food service operations in the NHS

As a consequence of the approach to place patients in the centre of all food service processes, it is necessary to review the current model in operation. This is shown in Figure 3.4, together with a schema illustrating customer-centric food service processes. In chapter two the various stakeholders involved in the food production and service process were outlined. Moving towards a patient-centric orientation implies redefining the way operations are conducted internally. When researching service provider/customer relationships, it is important to understand any differences that may be present when studying 'internal' service providers (Hudak et al., 2003). Within the NHS there is a danger that internal service providers see their customers purely as colleagues instead of customers. This detracts the focus of the department away from the patients' requirements. In the provision and delivery of meal services to patients in a NHS hospital, the customer spectrum extends from the health service purchaser as the ultimate client, through a variety of other functional and professional customers, to the consumer, the patient (Akhlaghi, 1997). This is illustrated in Figure 3.4 below.

**Figure 3.4 The facilities customer spectrum**

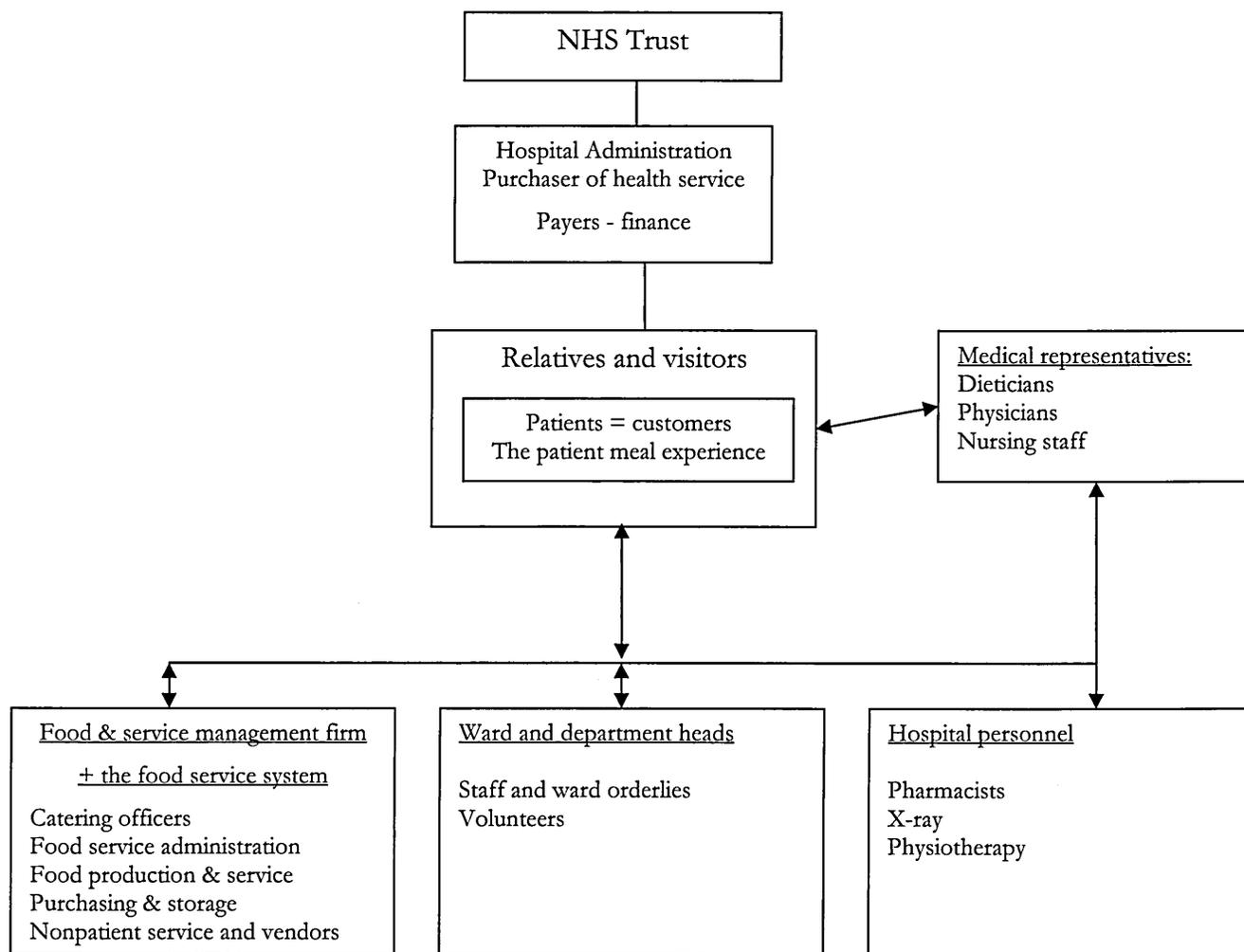


*Source: adapted from Akhlaghi (1997)*

With this 'traditional' perspective in mind whereby the intermediaries are considered as the customer, it is possible to design a new conceptual model where all stakeholders work towards the patients who are considered as the ultimate customer. This model is a logical consequence of the NHS orientation towards

patient-oriented healthcare policies, as well as the increase of patient involvement in their treatment. Figure 3.5 is an attempt to place the patient meal experience at the centre of a conceptual model of food service operations.

**Figure 3.5** Placing the patient in the centre of food service operations



### 3.2.6 Conclusion

In the 1980's, relationship marketing emerged as a popular new paradigm in the service marketing literature. This was due to a shift in focus from customer acquisition to customer retention. The definition developed by Gummesson (1994) will be referred to in this study, as it considers relationship marketing as relationships, networks and interactions. This approach to (relationship) marketing emphasises that services marketing issues are intertwined with other business areas such as human resources. This is the major constituent of this study as HR enables the implementation of patient-

oriented services which lean on relationship marketing. The marketing approach to networks was already touched upon 26 years ago by Tredger (1982) in the literature on nutritional intake of patients in hospitals. The author considered the feeding of patients to be a 'team effort' with a complex interaction of many professionals all affecting the nutritional intake and satisfaction of patients. When looking at present programmes such as 'Nutrition Now' developed by the Royal College of Nursing, it appears the NHS has merely evolved. There is still a stringed need to inform nursing staff about their responsibility to provide person-centred care focusing on the person's individual needs.

This study has a partiality to the framework developed by the Nordic School of Marketing. The School focuses on the value created in the interaction process between customer (patient) and supplier. The literature offers models to analyse the 'added value processes' in the interaction between customer and supplier (Grönroos 2004). However, little research has been conducted to understand the customer's internal processes. This is especially true within the framework of hospital food and service management operations. As identified in the literature the main defining constructs of relationship marketing are trust, values, co-operation and communication/interaction. These defining constructs aim to fulfil customers' needs and wants, with major objectives focusing on customer satisfaction, good experience and value.

Upcoming 'customer-centric' approaches identified in the literature are built on a stronger respect for the customer and place greater trust in the relationship with the organisation. It recognises that all individuals and all business processes should be focused on the customer in an ongoing value-adding circle, with according changes in business processes and business/organisational culture reaching every part of an organisation.

Consumerism in public policy is definitely a topical issue today. Projects like the BHF and resolutions like those provided by the COE in 2003 are attempting to implement food service systems in healthcare where the patient is considered as the supreme 'customer'. Significant progress has already been achieved in this and marketing concepts like 'customer-centric' and 'value co-creation' are encompassed within the strategic NHS plans. Little qualitative research has been conducted into the peripherals of food service operations in hospitals focusing on the patient experience. Therefore, the time has come to take a more holistic approach and consider the barriers to fulfilling patient experiences. As initially outlined by Avis et al. (1995) and Ferguson et al. (2001), patient satisfaction is more and more considered to be an independent outcome of healthcare.

### 3.3 Consumer food behaviour in a healthcare setting

#### 3.3.1 *Introduction*

Paragraph 3.2 above illustrates how the NHS is willing to move towards a customer-oriented service system, whereby positive 'food experiences' form a key strategic component of the NHS Plan. However, developing customer-centric processes entails understanding the patients' specific needs and wants and acting on it. This review is dedicated to analysing the existing literature on customer's nutritional behaviour, focusing on a healthcare setting and providing the reader with a detailed insight of the process patients are going through. The review, however, is not limited to this specific context.

Firstly, the developing of various concepts relating to nutritional behaviour determinants and outcomes of the framework for this study will be set. After that, there is a discussion of relevant determinants of nutritional behaviour. Four main parts guide the reader through the consumer' food behaviour process: aspects related to food, psychosocial determinants, the patient meal and finally behavioural issues. As this study focuses on soft factors leading to positive food service experiences for patients, the aim of this paragraph is to identify eventual psychosocial determinants that act as the makeup of customer-centric food service experiences in a healthcare context. Then it will be possible to compare these determinants to the determinants of relationship marketing as identified in the previous paragraph.

#### 3.3.2 *Overview of the determinants related to food choice and consumer attitude*

When considering food behaviour, factors of interest come down to choice, purchase or consumption. Even though with a composition of classes of measurement by overt behaviours on one hand and attitudinal measures on the other (Cardello and Schutz, 1996), the outcome aimed for lies in satisfaction of the consumer. The present study will not only use frameworks developed within food choice models pertaining to the measurement of overt behaviours, but also integrate verbal behaviour as expressed by patients in order to get insights into attitudinal factors.

Human food choice, in general, is a complex process, which includes a multitude of influences (Eertmans et al., 2005). Adapted to healthcare, these models also emphasize the multi-factorial nature of food choices. Investigating existing food choice models do provide an understanding of the factors influencing

the consumer's food intake and overall satisfaction. A major issue encountered along the literature review is the complex relationship between food choice, intake and overall satisfaction as experienced by patients in hospital. The conducting of research on satisfaction of the whole meal experience is rather small, the focus being on nutritional intake over the past decades. Hartwell et al. (2006, 2007) has stressed the complex relationship between satisfaction and intake, bringing forward the supposition that there might be a threshold of consumption in hospital, whereby the barrier to nutritional intake is...hospitalization itself. The investigation of satisfaction as a major and complex component of healthcare catering management is a recent development in the literature, leading to interesting conceptual models (Hartwell et al., 2006). Nevertheless, before investigating these matters of importance to this study, we will start with a short introduction to sensory sciences, followed by the key determinants of nutritional behaviour identified in the literature.

### ***3.3.2.1 Historical perspective***

Sensory science has a multidisciplinary character that brings together specialists from different fields such as food chemistry, food technology, nutrition physiology and psychology in their search for understanding eating and drinking behaviours and applying this knowledge to enhance food products (Koster, 2003). Regarded as a pioneer in the field, Lewin (1943) considered nutritional behaviour as a complex process involving cultural, social and psychological factors (Winter Falk et al., 1996 and Furst et al., 1996). Various authors focusing on specific determinants of human nutrition behaviour have built further on Lewins' foundations and contributed to the literature over time.

### ***3.3.2.2 Determinants and outcomes in the literature on food consumer behaviour***

The main determinants developed in the literature on human nutrition behaviour are nutritional aspects, psychological determinants, food quality, socio-cultural determinants, environmental determinants and finally food service factors. Even with extensive literature written on the subject, a key question that remains unsolved to this day is whether customer satisfaction is due to food quality, food service aspects or both.

As outlined by Hartwell (2004) and Hartwell et al. (2007), some studies report that food quality is the most important indicator (Dubé et al., 1994; O'Hara et al., 1997; Lau and Gregoire, 1998; Hwang et al., 2003), whilst other studies suggest that 'interpersonal' or service aspects are the most relevant (DeLuco and Cremer, 1990; Gregoire, 1994; Bélanger and Dubé, 1996). Another categorisation that follows a

similar distinction has been described as food-internal stimuli or food effects (sensory aspects of food) versus food-external stimuli or non-food effects (cognitive information, the physical environment, social factors) (e.g. Rozin and Tuorila, 1993; Eertmans et al., 2001). However, until today and as suggested by Hwang et al. (2003), it appears that no consensus has been reached on the dimensionality to be used to measure quality, since varying factor-loading patterns and inconsistencies in the number of factors have emerged from previous research. This study does predominantly focus on so-called 'soft' factors leading to patient satisfaction, but without denying the importance of food quality aspects.

In the general literature on nutritional behaviour, various authors have looked at the food process from different perspectives. Apart from a focus on 'soft' or 'food quality' aspects, numerous authors have focused on different possible outcomes of the food consumption and food service experience. These possible outcomes or dependent variables can be categorised as follows: food in terms of nutritional intake, food quality, food acceptability, customer satisfaction and food choice.

Table 3.2 provides an outline of the different approaches to nutritional behaviour identified in the literature. As nutritional intake remains the top priority in hospital today, the vast majority of the literature dedicated to a healthcare setting focuses on this particular outcome.

**Table 3.2 Food choice characteristics: dependent and independent variables**

<b>Dependent variable: the outcome</b>	<b>Independent variable: factors leading to the outcome</b>	<b>Key authors</b>
<b>Food intake &amp; related</b>	<b>Factors leading to increased food intake</b>	
Food intake	Contextual influences	Rozin and Tuorila (1993)
Food intake	Environmental factors promoting a positive mealtime experience Social facilitation  New food production methods	Hotaling (1990) Elmstahl et al. (1987) Gibbons and Henry (2005) Hartwell and Edwards (2000) Edwards and Hartwell (2006)
Nutritional behaviour	Multilayer process: biological, anthropological, economical, psychological, socio-cultural, home economics...all leading to an individual situation	Gedrich (2003)
Food consumption and eating patterns	Pleasure, health, convenience and tradition	Rappoport and Peters (1988b)
Nutritional intake	Patient feeding is a 'team effort' involving professionals from various departments	Tredger (1982)
Food intake	Patients tend to make up their nutritional intake with food brought from outside the hospital. Exception: elderly patients	Frost et al. (1991)
Under-nutrition	Inappropriate food service delivery Problems with ordering, quality, quantity, inappropriate meals, lack of choice, timing, positioning, utensils, physical problems, medication, environment and lack of assistance	Allison (2003) Cortis (1997)
<b>Food quality</b>	<b>Factors leading to an increase in perceived food quality</b>	
Food quality	Sensory characteristics, flavour, appearance, temperature and texture	Cardello and Maller (1982) Clark (1998)
Food quality experience <i>perception &amp; evaluation</i>	Taste, odour, labelling information, attitude, memories of previous experiences	Imram (1999)
<b>Food acceptability</b>	<b>Factors leading to food acceptability</b>	
Acceptability	Texture and flavours	Szczesniak (1972)
Acceptability	New food production method	Edwards and Hartwell (2006)
Acceptability	Visual sensation and image	Hetherington and MacDougall (1991)
Acceptance	Eating environment	Meiselman et al. (2000)
<b>Customer satisfaction</b>	<b>Factors leading to satisfaction</b>	
Satisfaction	Staff interpersonal skills	Ferguson et al. (2001)
Satisfaction	Cognitive aspects (food quality, temperature and texture) + customisation, staff attitude, timeliness, reliability Role of emotions linked to hospitalisation in general Role of emotions linked to food services during hospitalisation	Dubé et al. (1994), O'Hara et al. (1997) Dubé et al. (1996) Bélanger and Dubé (1996)
Satisfaction	New food production method	Edwards and Hartwell (2006)
Satisfaction	Variety and menu size	Stanga et al. (2003)
<b>Food choice</b>	<b>Factors leading to specific food choices</b>	
Food choice	Observes a clear resemblance in habitual fat and food intake between parents and their adolescent children and between spouses	Feunekes et al. (1998)
Food choice	Food choices are based on taste, enjoyment, nutrition and energy	Brown (1976)
Food choice	Food choice as a function of eating occasion and physical location, termed 'location' by the authors	Marshall and Bell (2003)
Food choice	Personal value systems, multi-dimensional approach	Rappoport & Peters (1988a) Rappoport et al. (1993) Connors et al. (2001) Furst et al. (1996)

Key researchers, going beyond food quality aspects and focusing on psychosocial determinants leading to positive food service experiences and customer satisfaction are Rappoport and Peters (1988a), Dubé et al. (1994, 1996), Connors et al. (2001) and Furst et al. (1996). These authors have investigated personal value systems from the perspective of food choice leading to satisfaction. Even though a hospital is a physically constrained location almost dictating food choice through the menu presented, this research will use the outcome of food choice in order to analyse the patient's personal value systems. It is useful here to cite Brown's (1976) definition of what food choices mean:

*"The food that people choose to eat, the reason for their choices, and their eating patterns (frequency, location) are termed food choices."*

The body of knowledge on personal value systems, although not viewed via the healthcare perspective, stems from the general literature on consumer behaviour. This will form a key contribution of the present study to the existing body of knowledge. As this study proposes to contribute to better patient food service experiences that increase satisfaction levels, the relationship between food choice and satisfaction must be analysed.

Table 3.2 lists dependent and independent variables identified in the literature on nutritional behaviour. However, the description of the link between the different dependent variables is not thorough in the literature. This study will endeavour to look at the link between food choice, food intake and satisfaction. Currently, the overall approach to food in acute NHS hospitals does focus on nutritional intake. Even though this approach is justified, it easily leads to the false assumption that more money and nutritional knowledge are all that are necessary to eliminate the problem (according to Rappoport and Peters, 1988a) of under-nutrition in hospitals. Allison (2003), focusing on nutritional intake of elderly patients, stressed the food preferences and requirements of each patient group must be addressed if the hospital menu is to be made more appropriate to the needs of the sick. Complementing this focus on types of foods chosen, the present study endeavours to understand the underlying causes leading to specific food choices. When considering patient-oriented food processes, the most obvious outcome aimed for should be patient satisfaction. However, the literature focusing on satisfaction as outcome of healthcare experiences does not provide appropriate frameworks to analyse psychosocial determinants in a non-restrictive qualitative manner that leaves enough space to investigate the food experience with an open mind. Hence the focus on food choices, as this body of knowledge has looked at psychosocial determinants and value systems, but not in a healthcare context.

A similar approach to a holistic understanding of determinants but leading to satisfaction has been developed in the marketing literature, whereby various elements comprise customer satisfaction along with factors as outlined by Hartwell (2004): technical and functional quality (Grönroos, 1984), performance-delivery quality (Parasuraman et al., 1991) as well as product, behaviour and environmental factors (Philip and Hazlett, 1997). The determinants related to food choice and consumer attitude are integrated into one conceptual model (figure 3.9) and developed below in different sections: aspects related to food, psychosocial determinants, the patient meal and finally behavioural issues.

### ***3.3.2.3 Food-related aspects***

#### ***3.3.2.3.1 The impact of food service systems on patient consumption***

As mentioned by Hartwell (2004) who focused on meal delivery in U.K. hospitals, a bulk trolley bedside service is the favoured meal distribution method (37%) and is recommended by The British Association for Parenteral and Enteral Nutrition (BAPEN). This system allows the patient to select portion sizes according to appetite and needs (Allison, 2003). However, although satisfaction is significantly improved with the trolley system, energy intake appears to remain the same when comparing the system with plated food (Folio et al., 2002; Hartwell and Edwards, 2003). Lambert-Lagacé et al. (1996) found that changing the food service systems may not necessarily enhance the perceived meal experience of patients, but this finding was contradicted by Wilson et al., (2000) who found energy, protein, fat and carbohydrate intakes were significantly higher with the trolley method of delivery. According to Shatenstein and Ferland (2000), staff using the trolley method tend to serve larger portions. Overall, there is no unanimous agreement among caterers as to whether bulk or plated systems are better. But as evoked by Hartwell (2004), whatever the mode of distribution is, the ultimate goal of any hospital catering system is to provide food which is appropriate, palatable, of the correct temperature, attractive, nutritious and free from contamination (Barrie, 1996). In this respect, the steam-microwave system developed as from 2003 offers good potential to increase patients' satisfaction.

Table 3.3 below summarises key characteristics of plated food, trolley service and the newly developed steam system.

**Table 3.3 Summary of food distribution by service systems**

Factor	Plate service	Trolley service	Steam
Menu selection	Up to 24 hours before	Choice at the point of consumption or 24 hours before	Choice one hour before
Portion control	Effective	Haphazard	Effective
Food service personnel	Catering staff/domestics	Nursing staff	Catering, nursing or domestic staff
Person to person interaction	Minimal	Communication is Essential	Potential for communication
Meal distribution on ward	Quick	Time consuming	Quick
Awareness of patient need	Easily overlooked	Observed	Little space for adaptation to specific needs and wants
Sequence of courses	All arrive at the same time	Potential to be Staggered	Potential to be staggered
Size of helping	Less adaptable	Can be varied	Not adaptable
Presentation	Variable	Attractive	Attractive
Temperature of food	Poor	Better	Good
Plate wastage	More plate waste	Less plate waste	Reduced wastage
Type of food	Almost any food can be produced	Almost any food can be produced	Limitations: english pies, fries or some meat can't be steamed
Patient experience	Institutionalised	More like home	Institutionalised, but potential to create 'at home' feeling
Patient Satisfaction	Adequate	Better satisfied	Improvement regarding satisfaction

*(Source: expanded from Hartwell, 2004 and initially adapted from Dickerson and Booth, 1985)*

### ***3.3.2.3.2 Determinants of food quality and food preference***

Perceptions of a food product have been shown to be affected by many individual factors including taste, odour, information from labeling, attitudes and memories of previous experiences (Imram, 1999). Sensory characteristics such as appearance, flavour, texture and temperature have been found to be most important to hospital patients when judging food quality (Clark, 1998). In general, there is evidence for the interaction of sensory characteristics of food (Prescott, 1999). Briefly outlined below are the main sensory characteristics. Visual sensation was researched by Szczesniak (1972), and this was further investigated by Hetherington and MacDougall (1991) who found that perception of quality is dependent on the visual image. Directly connected to food consumption is smell, thus being affected by prior food intake and how hungry the consumer is.

Repeat presentation of the food leads, according to Hetherington et al. (2001), to consumers disliking the products presented because of monotony or stimulus satiation. This phenomenon is influenced by a variety of different factors including characteristics of the food and characteristics of the exposure period (interval, duration and number). Menu fatigue is frequently addressed in institutional settings by menu rotation and latterly in the Better Hospital Food project by the introduction of celebrity dishes and the development of the flexi-menu project (BHF, 2004). 'Standardisation syndrome' is another factor prevalent in institutional types of food service. There is a clear relationship between variety, menu size and patient satisfaction (Stanga et al., 2003). It is worth noting that British food tastes are highly conservative, with as a vast majority of patients preferring traditional British food. In this regard, strategies like the 'leading chefs' menus developed within the BHF program, are often described as a governmental 'public relations' stunt by hospital catering professionals (Research Forum, London, June 2005).

### ***3.3.2.4 Psychosocial determinants and attitudes towards hospital food***

#### ***3.3.2.4.1 Main underlying models to consumer nutritional behaviour***

From a purely psychological point of view, the stimuli-organism-reaction (S-O-R) model traditionally explains nutritional behaviour. Shepherd (1990) describes the division of the mental processes involved into activating ones (emotions, motives, attitudes) and cognitive ones (perceiving, thinking, and learning). Bélanger and Dubé (1996) noted the predictive power of emotional experience associated with consumption, as it can override the effect of cognitive components in satisfaction judgements. Motives

are emotions with a certain orientation towards an action, needs, ambitions, wishes or yearnings that trigger behaviour. There are motives that often compete when influencing people's food choice, e.g. enjoying taste, relieving hunger, expressing fellowship, representing social status, maintaining health or fitness, saving money or sticking to habits (Connors et al., 2001 and Pudel and Westenhöfer, 1998). The intention of this study is to investigate what motives patients have towards food when admitted in hospital. Finally, attitudes are a combination of motives and the assessment of the connection of certain objects with these motives (Shepherd, 1990). Closely related to the concept of attitudes are opinions, which are verbal expressions of attitudes. In order to understand peoples' behaviour, the use of attitudes is an important key factor (Pudel and Westenhöfer, 1998). Generally, it was found that attitudes form only good predictors for cognitively well-controlled behaviour, which does not generally hold true for nutrition. Further defining attitudes adopted towards hospital food is another objective of this study, looking at the link between motives and attitudes patients have.

Among the cognitive processes, perception refers to the absorption, selection, organisation and interpretation of information. It also provides a personal, non-objective image of the external reality. Thinking, (the second cognitive process), is a way of internal process and mental process of information that is independent from external stimuli. Lastly, learning is the process of mentally saving and retrieving information. In this context, the continuous process of learning is the eating. It is a recurring training by experiences, which leads to a stable habitual behaviour (Pudel and Westenhöfer, 1998). On this conceptual basis, psychology of nutrition generally interprets persons' specific food choices as an individually optimized decision, assessing all the advantages and disadvantages of motives or values relevant to the specific situation (Winter Falk et al., 1996, Furst et al., 1996 and Pudel and Westenhöfer, 1998). Overall, the satisfaction within a hospitality experience is a sum of satisfactions, with the individual elements or attributes of all the products and services that make up the experience (Edwards and Hartwell, 2006), founded on the activating and cognitive processes defined above.

In line with the disconfirmation theory looking at satisfaction in consumer behaviour research, Mela (1999) argues the 'assimilation model' best explains sensory acceptance of food. The fact that hospital food has a negative reputation (with patients having low expectations), one can only hope that the intrinsic quality of the food is high (leading to a state of positive disconfirmation). But even in this situation and according to the assimilation model, perceived acceptability should assimilate the lower expectations and liking will decrease. So if expectations towards hospital food could be elevated, then acceptance should increase (Hartwell, 2004). Although the NHS Plans' strategies are ambitious in terms

of enhancement of the food experience, patients often reflect a negative attitude towards the quality and acceptability of these foods. Studies of consumer attitudes towards institutional food have shown that negative and poor expectations of the food have a profound effect on acceptability (DeLuco and Cremer, 1990). Therefore, would positive experiences with hospital food change the perception and expectation from patients towards the meals on offer? It is relevant to mention the work of Watters et al. (2003) in this respect, as generally patients found the food was better than expected and had improved from past experiences.

#### *3.3.2.4.2 Psychological factors leading towards positive food service experiences*

In line with the approach of Dubé et al. (1994), O'Hara et al. (1997), Lau and Gregoire (1998), Cardello (2003) and Hwang et al. (2003), meal acceptance (as part of the whole meal experience) is not only a result of the intrinsic quality of the food. Cardello (1995) stated meal acceptance is relative to person, place and time. This observation emphasises the need to consider each patient as an individual with specific needs and wants, as the psychological effects on one single consumer may cause the meal service not to meet his or her expectations (Hwang et al., 2003). However, we still know relatively little of how meals are characterised by patients. This gap in the literature is obvious in research on nutritional behaviour in a healthcare setting, not to mention in acute NHS hospitals. Another dimension unexplored relates to the perception of children towards food services in healthcare. Jones and Evans (2003) have described food service processes in a children's hospital within the framework of the 'Essence of care' (2001) quality initiative, but it remains a pretty isolated attempt to focus on children's specific nutritional requirements.

The research of this particular consumer group in this study is alongside their parents or legal carers that accompany their journey in hospital.

As outlined by Hartwell (2004), emotional states like anger, fear, sadness and joy do influence eating behaviour (Macht and Simons, 2000). Perceived control over a situation (Bélanger and Dubé, 1996) in healthcare implies increased patient involvement and influences satisfaction. As illustrated above, emotional feelings and experiences are essential in the determination of satisfaction judgements by the patients. In addition to the determinants provided by this traditional psychological approach, there are others also considered as important for the explanation of consumer and nutritional behaviour. Among them, for instance, are values (Connors et al., 2001, Winter Falk et al., 1996 and Furst et al., 1996), trust (Frewer et al., 1996), beliefs or expectations regarding the possible outcomes of a certain behaviour (Cardello, 2003), intentions (Kronld, 1990) and finally involvement (Bell and Marshall, 2003). Meiselman

also argues there is a sufficient amount of research investigating sensory and internal physiological mechanisms in control of food intake, but the possibility of other situational and social factors have been largely ignored (Meiselman, 1992). This issue needs to be addressed if hospital food service is to fulfil both physiological and psychological requirements (Hartwell, 2004), which form the key components of 'patient-centric' meal experiences. As this study aims to develop a thorough understanding of such 'soft' determinants, the related literature will be reviewed in detail below.

#### ***3.3.2.4.3 Psycho-social determinants, focusing on social facilitation***

A topical example when considering the influence of psycho-social determinants on nutritional intake in healthcare is the issue of social facilitation. Because of financial, time and constraints of scope to work with a large sample in this study, it is difficult to focus on patients belonging to a particular community. The focus is on the determinants of social facilitation instead, as developed below.

Nutrition provides an impression and gives affiliation to a group, of which the definition is by social stratum, regional provenance or nationality. So, when in hospital, do patients actually use food as a communication tool towards staff, friends and family? As they enjoy a limited choice and generally cannot choose which patients they share a room with, is this possible?

When looking at socio-cultural determinants in a healthcare context, it appears hospitalisation can be a socially isolating event where person to person interaction positively influences satisfaction judgements (Folio et al., 2002). The eating environment has been acknowledged as a factor affecting food consumption (Gibbons and Henry 2003, 2005) and eating is a social activity which may be enhanced if patients sit together (Hotelling, 1990; Allison, 2003). Social facilitation has further been observed by various authors like Goldman et al. (1991) and Berry et al. (1985) and in a non-healthcare context or laboratory studies (Clendenen et al., 1994). The latter has studied the role of social facilitation within social networks (family and friends in a non-healthcare context).

Nurses are not exactly dining companions, but this study will investigate whether relationships patients develop with fellow patients or staff involved in the food process does influence nutritional intake. Developing relationships requires some time, so the focus will be on long-stay patients providing the sample allows this.

There appears to be a positive correlation between the number of people present, the strength of the relationships with these people and the amount of food consumed. Preliminary indications from research conducted in hospitals suggest that the hypothesis is also true within institutions, where consumption of meals in a social situation around a dining table increases energy and macronutrient intake (Hartwell and

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Edwards, 2000). In this perspective, the Council of Europe Resolution (2003) states that that the focus should be on the presence and support of other people, which means, patients should have the option to sit at a table when eating their main meals. In terms of quantification, De Castro and Brewer (1991) even developed a power function to help evaluate the amount of food eaten. However, one can imagine the difficulty of applying this type of equation when considering the various types of relationships patients might develop during their journey in hospital. In this respect, the importance of nurses' company at mealtimes has been identified by de Raeve (1994), and was further developed by Wykes (1997) who emphasized the presence of nursing staff during meal times as a way of benefiting the nutritional (and nursing) care of patients. This research intends to investigate not only the psychosocial determinants defined above, but takes into account biological requirements. The overall framework for the research is in line with what Rappoport and Peters (1988b) called the bio-psychosocial approach to the analysis of food choices...with the focus on the psychosocial components.

The above has reviewed various psychosocial determinants and attitudes towards food in general and hospital food in particular. However, as pointed out by Feunekes et al. (1998), the extraction of social influences in an experimental situation to investigate social influences in real life is virtually impossible. Embedded into everyday behaviour is social influences and looking into this from the perspective of hospitalised patients in about five different settings does not make quantification any easier. The ensuing conclusion is that this study does not focus on quantification per se, but rather on a more in-depth understanding of patients' attitudes towards food services and common themes on nutritional aspects eventually emerging across the hospitals under scrutiny.

#### ***3.3.2.4.4 Common elements between relationship marketing and consumer food behaviour***

When looking at common elements between defining constructs of relationship marketing and psychological determinants related to food choice, the elements of trust, involvement and values are identified. These elements are listed in Table 3.4 below.

**Table 3.4 Common aspects of relationship marketing and consumer food behaviour**

Relationship marketing disciplines	Determinants related to food choice
Defining constructs of relationship marketing	Psychological
Communication Empathy Interdependence <b>Trust</b> , confidence <b>Shared values</b> <b>Commitment &amp; involvement.</b> Co-operation, co-creation and interaction	<u>Mental processes:</u> Activating: emotions, motives and attitudes Cognitive processes: perceiving, thinking, learning <b>Trust</b> <b>Values</b> <b>Involvement</b> Beliefs
<div style="text-align: center;"><b>Objectives</b></div> <ul style="list-style-type: none"> <li>▫ Customer satisfaction</li> <li>▫ Customer delight</li> <li>▫ Loyalty</li> <li>▫ Good experience</li> <li>▫ Promise fulfilment</li> <li>▫ Social benefits</li> <li>▫ Value</li> </ul> <div style="text-align: center;"><b>Instruments</b></div> <ul style="list-style-type: none"> <li>▫ Database management</li> <li>▫ Quality management</li> <li>▫ Services marketing</li> <li>▫ Customer partnering</li> <li>▫ Internal relationship marketing</li> </ul>	Socio cultural and psychosocial determinants
	Group norms and social facilitation Identity Communication Community Spirituality
	Atmosphere and environment
	Location Ambiance Light, colours, TV Imitation free-living environment Food quality
	Leading to satisfaction
	Customisation Staff attitude (contact personnel) Meal service timeliness and reliability

These common determinants are analysed on the following page, in the perspective of the literature on nutritional behaviour.

### **Involvement**

One area that has received considerable attention in the food intake literature is that of involvement (Van Trijp et al., 1993; Bell and Marshall, 2001, 2003; Faulkner, 2001, 2001b, 2001c; Olsen, 2001). Olsen (2001) presented a theoretical model of involvement based on the expectancy-value theory, incorporating into the model negative feelings, social norms and moral obligations. Olsen (2001) stated that involvement has a strong, significant and expected consequence for frequent food behaviour (at least when considering the consumption of fish). Candel (2001) however, found a negative relation with food products to the perceived convenience orientation of an individual. To date, the literature does not offer a clear and uniform definition of an individual's person involvement as it relates to food or any consistent method by which to measure it. However, consumers experiencing 'customised' service encounters will be more satisfied with the interaction than those experiencing 'standardised' encounters (Bettencourt and Gwinner, 1996 in Hartwell, 2004). It is predicted that where patients have increased involvement with the process

of food service (possibility to choose meals, portion size, flexibility of service), satisfaction would be increased. For patients, food service, to a certain extent, provides one of the few hospital experiences that they can control. The identification of patient empowerment, as a tool in the provision of a quality service is seen (Faulkner, 2001, 2001c). The NHS Guide (DoH 2000), which emphasises patient control and the right of patients to be involved in the decision-making process further support this approach to patient-centred services.

One way to increase perceived control is to give as much responsibility as possible to every patient in making choices. Within the framework of this study and starting with the perspective of general nutritional consumer behaviour, the author will refer to the definition of Bell and Marshall (2003) who have emphasised the importance of involvement as a variable in food choice. Involvement is defined as the level of importance of food in a person's life and operations as the extent to which people enjoy talking about food, entertain thoughts about food during the day, and engage in food-related activities all along the five phases of the 'life cycle of food' (acquisition-preparation-cooking-eating-disposal; Goody, 1982). The five phases will be used as a reference in this study, allowing to classify patients as 'traditional' or 'experiencers' in regards to their food behaviour patterns.

Marshall and Bell (2004) developed a food involvement scale (FIS) as a reliable Likert scale to measure an individuals' level of food involvement with, or perceived level of importance for foods on a continuum. Comparing the FIS with other constructs scales measuring someone's level of involvement like the Personal Involvement Inventory (PII) and the Varseek Scale (VS), Marshall and Bell (2004) found a high degree of correlation.

It appears that from a sensory, food quality and eating behaviour perspective, consumers who are more highly involved are more sensitive to sensory and hedonic differences between similar samples (Bell and Marshall, 2001, 2003; Marshall and Bell, 2004). The effects of food involvement can also extend to include the possibility that more highly involved individuals tend to make healthier food choices (Marshall and Bell, 2004). So how do patients experience the variable 'involvement', as their responsibility and possibility to exercise control over the provisioning task is rather limited?

## **Values**

Within a marketing framework, Schiffman (2007, p. 8) defines value as being "The ratio between the customer's received benefits (economic, functional and psychological) and resources (monetary, time, effort, psychological) used to obtain those benefits". Whilst developing a value proposition is the core of successful positioning (Schiffman, 2007, p. 9), relationship value has a deeper meaning. As the

relationship develops, the buyer starts to feel safe with the supplier and the trust is developing. The term 'value', however, has a different significance when considering consumer food behaviour.

In the general literature on food choice, values are often defined as the enduring beliefs guiding and motivating behaviour and are important in self-definition (Kahle and Timmer, 1983). According to research from Connors et al. (2001) into the topic, values are identified as being of significant importance in food choices (Reaburn et al., 1979; Sims, 1978; Harrison et al., 1982; Lennernäs et al., 1997), and provide scripts for food behaviours (Grunert, 1993). This study is focusing on the way patients manage food-related values in food choice leading to satisfaction. The goal is to expand the literature of determinants leading to patient satisfaction. The study will focus on personal food systems patients develop in making food choices and investigate if the food and service provided in hospital does fit the personal food systems of patients. A specific interest goes towards understanding the thoughts and consideration that patients use when selecting and eating foods, along with the strategies they employ to simplify their food choices. The author aims to further develop an understanding of patients by evaluating their goals, aspirations and sense of purpose within a larger life context, as a means of tailoring empowering strategies as advocated by Faulkner (2001) in the context of patient empowerment.

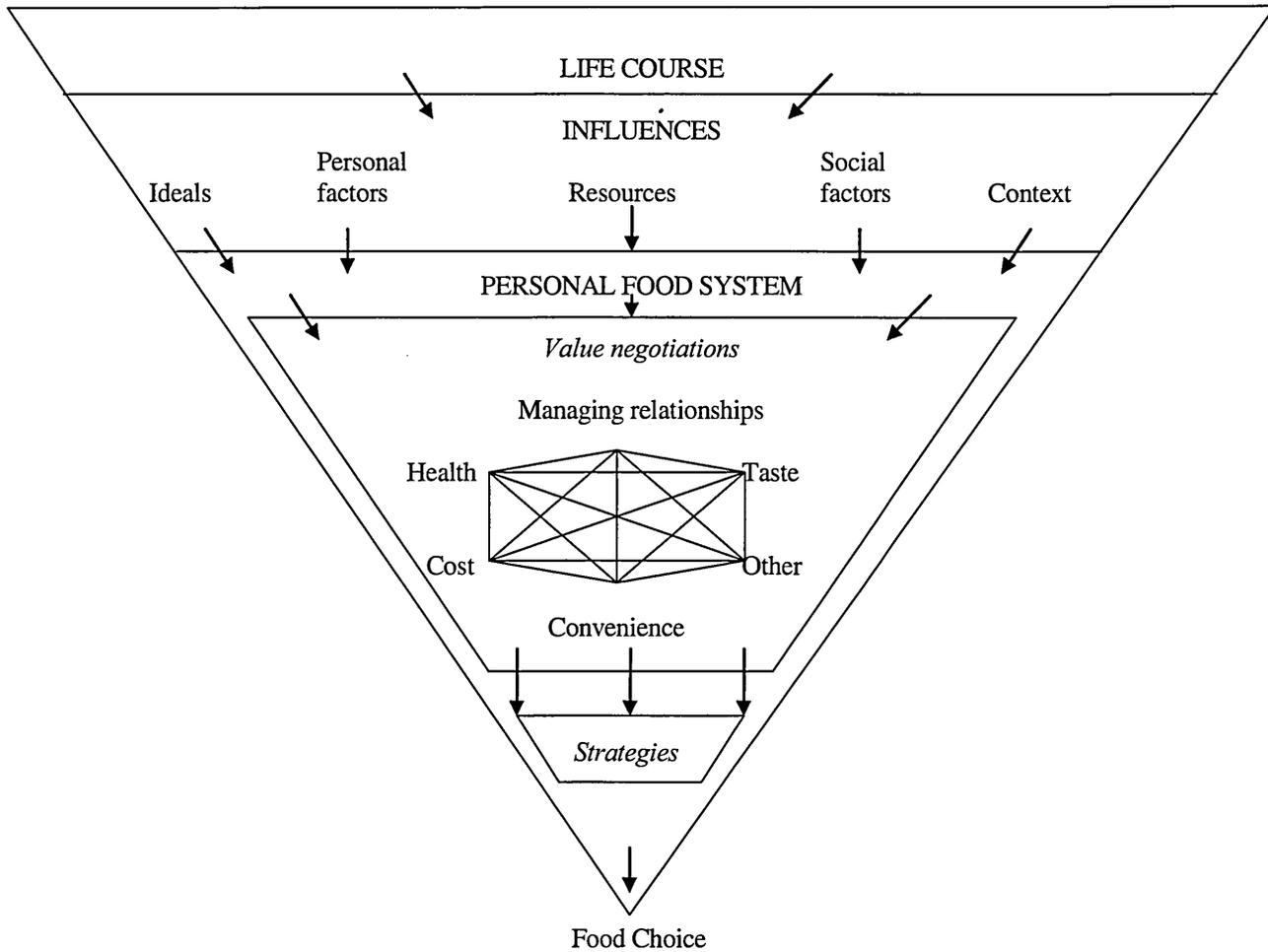
Even though the present study does not solely focus on patient empowerment, an in-depth understanding of patients' values is essential in developing patient-oriented food services.

The model of Winter Falk et al. (1996) and Furst et al., (1996) illustrates an approach to food choices, but does not focus on a healthcare setting (figure 3.6). Seen in this model, are that events and experiences over the life course and viewed as shaping current food choices through the influences of an individual's ideals, personal factors, resources, social relationships and food context. According to the model, most relevant values people place in food choice decisions are health (physical well being), taste (sensory perceptions), cost (monetary considerations), convenience (time and effort), and managing relationships (interpersonal interactions). Anterior research from Rappoport and Peters (1988a) not focusing on a healthcare context has identified constructs similar to values that also guide food choice behaviour: pleasure, health, convenience and tradition. These authors used unstructured exploratory interviews to determine what people had eaten and why they had eaten those foods.

In this study, the model (figure 3.6) of Winter Falk et al. (1996) and Furst et al., (1996) will be used to understand the values patients handle when making food choices. Since food related values might conflict, this study aims to broaden our understanding of how patients negotiate values in personal food systems

and how they solve value conflicts. According to the findings of Connors et al. (2001), consumers create a comfortable, workable personal food system that meets their values based on (i) categorising food and eating situations, (ii) prioritising conflicting food-related values for each eating situation, and (iii) balancing strategies and priorities across eating situations to meet significant values. These three components are further developed below.

**Figure 3.6 The food-choice process model**



*Adapted from Furst et al. (1996) and Winter Falk et al. (1996)*

### **Categorising food and eating situations**

Categories are the interface between personal values and the food itself and are based on the major values of taste, cost, convenience, healthiness of food as well as fitting in with the social eating relationship. This study aims to develop an understanding of how patients categorise food and eating situation. There is a cost issue however, as patients in NHS Hospitals do not have to pay for their meal. What about the value

of healthiness: does the situation they are in influence their decision and related satisfaction as to which food suits them best in terms of health? It would be helpful to broaden our understanding of how the relationships consumers develop in a hospital setting determines food choice and leads (potentially) to increased satisfaction. This applies to relationships with relatives, as well as relationships with the various staff categories involved in the food service process.

### **Prioritising conflicting food-related values for each eating situation**

Values often conflict in food choice contexts, making it necessary to prioritise values. This study aims to understand which values patients do prioritise in the particular setting of a NHS acute hospital. Do these consumers try to accommodate the needs of other people in the hospital or in their social circles and place the management of their social relationships above all of their other food specific values? While investigating the values of children towards food, it might be interesting to see if this particular group does accommodate the needs of other people, whether it is parents, relatives or medical staff. Are social relationships in a hospital setting sometimes in conflict with taste preferences? Did the 'change in the consumer's life' of being hospitalised bring specific value conflicts leading to temporary disruptions in personal food systems? It is a key issue here to see how patients manage value conflicts by eventually re-prioritising values or developing new strategies that allow food choice to become manageable again. Understanding if these new food choice strategies lead to satisfaction is another key question to investigate.

### **Balancing strategies and priorities across eating situations**

Connors et al. (2001) described balancing as another process part of the personal food system, used especially when values are conflicting. The author will investigate how patients 'balance' food choices and manage their food system, as the food offered in hospital is rather standardised and limited.

### **Trust**

Only a minimal amount of research has been conducted on 'trust' in relation to food services. It is essentially the dimension of trust in the paragraph on (relationship) marketing that will serve as foundation for the development of research questions related to this particular dimension.

### **3.3.2.5 Patient meal**

#### **3.3.2.5.1 Situational variables**

As outlined by Hartwell (2004), the physical environment influences customer's satisfaction and the perception of service quality (Nguyen and Leblanc, 2002). In consumer research, the study of the atmosphere surrounding the consumer-related place is well established (Stroebele and De Castro, 2004). Rozin and Tuorila (1993) even concluded that:

*"to ignore contextual influences on food choice and intake is to risk misinterpreting the meaning and significance of human food choice".*

In essence and as outlined by Stroebele and De Castro (2004), it is important to consider ambient influences on food intake and food choice in order to understand and modify eating behaviour when required (Elmstahl et al., 1987; Areni and Kim, 1993; Whitten, 1996). According to McKenzie (2003), buildings design also influences patient recovery time, and has a positive impact on staff morale (in Hartwell, 2004). However, while food and environment play an important role during the stay, they soon fade from the patients' minds on leaving hospital. Complaints by patients actually in hospital relate to tangible aspects whereas letters of complaint received after discharge relate almost exclusively to the intangible aspects of care (Tomes and Chee Peng Ng, 1995).

#### **3.3.2.5.2 Food service factors contributing to patient satisfaction in healthcare**

By investigating customer satisfaction in commercial operations, Pine and Gilmore (1999) argued that satisfaction comes from the peripherals that surround the core service. Within a healthcare context, Dubé (Dubé et al., 1994) not only emphasised the importance of cognitive aspect in food quality, but also stressed the importance of so-called 'soft factors' in leading to customer satisfaction. These 'soft' factors have been identified as customisation, staff attitude, timeliness and reliability (Hartwell, 2004). Customisation has been developed further in the paragraph on psychological determinants, under the factor 'involvement'. The other factors are briefly outlined below.

### *3.3.2.5.2.1 Attitude of staff who delivers the menus*

The service attitude of staff is a fundamental dimension in providing satisfactory food service experiences to consumers in a healthcare setting. Allison (2003) stressed the importance of this factor in relation to malnutrition, as she states that a major cause of undernutrition in institutions is not the failure to provide food, but to deliver it in a manner appropriate to the particular customer. Meals can be unpalatable or served in a way that makes them inaccessible, either being wrapped, making it hard to access or placed outside the reach of the patient (Corish and Kennedy, 2000). The service attributes of staff (warmth, attentiveness and courtesy, number on duty, attentive, clean, smart, friendly, courteous, helpful, efficient and attentive to detail) are significant for the quality of the meal experience, contributing to patient satisfaction with nutrition services (Ferguson et al., 2001). Bélanger and Dubé (1996) found that patients perceive and benefit from the emotional support that they receive from staff, and transfer this 'added value' to their satisfaction judgements.

As outlined by Hartwell (2004), delivering proper hospitality based service requires server predispositions that are different from those for medical provision. Food service employees should be flexible, show empathy and demonstrate what Winsted (2000) calls 'emotional intelligence'. Lashley (2000) stressed how food service staff should be empowered to accept responsibility for the service encounter, interpret and deliver the customer service required. Alas, unfortunately, hospital food is prepared by people who have no direct relationship with those who are served (de Raeve, 1994). As ward hostesses tend to take over the servicing function in the NHS, this category of employees should benefit from appropriate training in line with job characteristics as defined above. This study will investigate whether the NHS enables interaction between the staff group serving the food to patients and whether this is in line with the key characteristics, which eventually lead to patient satisfaction as developed above.

According to Gregoire (1994), motivation towards providing a good service does not differ between food service and nursing staff. But as summarised in Table 3.5 below, significant differences have been observed for certain dimensions. A key question here is to understand the healthcare consumer's perception towards the staff serving the food, whether it be employees of the private food and service management company, or NHS staff. We have to ask ourselves if the service characteristics developed above apply in an acute NHS Hospital setting and also are there any factors that do not allow proper consumer satisfaction?

Table 3.5 summarises the key job dimensions appropriate to catering and medical staff.

**Table 3.5 Characteristics service dispositions medical versus hospitality staff**

<b>Nurses</b>	<b>Hospitality workers</b>
<i>Disposition</i>	<i>Disposition</i>
<i>Competence</i>	<i>Competence</i>
<i>Affinity</i>	<i>Affinity</i>
<i>Deference</i>	<i>Deference</i>
<b>Medical</b>	<b>Restaurant</b>
Caring	Careful
Sincere	Attentive
Pleasant	Pleasant
	<b><u>Effective delivery of hospitality based services requires:</u></b>
	Flexibility of behaviour
	Ability to empathise with the customer
	Emotional intelligence
	Accept responsibility over the service encounter (requiring empowerment)

Finally, and in line with the Council of Europe Resolution (2003), it is recommended that meal times should be spread out to cover most of the hours spent awake. Patients could be made to feel more relaxed if mealtimes were as close as possible taken to those at home (McGlone et al., 1995).

### **3.3.2.6 Behaviour**

#### **3.3.2.6.1 Consumption: nutritional status and malnutrition of patients**

The application of the NHS Plans oriented towards positive 'food experiences' is further contradicted by the issues of malnutrition identified in the literature. BAPEN MAG (2003) provides the following definition of malnutrition:

*“A state of nutrition in which a deficiency, excess or imbalance of energy, protein and other nutrients causes measurable adverse effects on tissue/body form (body shape, size, and composition) and function and clinical outcome.”*

Malnutrition is a major issue in hospitals around the world and has formed a topical issue for many decades. It is surprising to observe malnutrition has not satisfactorily been dealt with ever since it was acknowledged by Florence Nightingale in the Crimea in 1859 (Holmes, 2007). According to Kubrak and Jensen (2007), the proportion of acute care patients affected by malnutrition varies from 13 to 78%. A more precise proportion of patients suffering from malnutrition (28%), is provided by the BAPEN National Nutrition Screening Week 2007, with the screening of 9.336 people on admission in hospitals

([www.bapen.org.uk](http://www.bapen.org.uk)). Quite interestingly, malnutrition appears to be considerably greater in hospitals with more than 1000 beds, compared to those with less than that number (38% versus 26%). Women are more often facing malnutrition in comparison to men, just like patients over 65 years of age compared to the below-65 (Russell and Elia, 2008).

Because of malnutrition, patients have lowered resistance to infections, delayed wound healing (Casey, 1998), reduction of functional capacity and a general weakness. Any of these impairments can impede recovery and cause serious complications (Bankhead, 1995). Mortality in the malnourished patient has been found to be 8% greater and hospital costs increased up to 309% (Correia and Waitzberg, 2003). Beese (1997) identified the psychological effects of malnutrition as apathy and depression, that in turn lead to a loss of morale and the will to recover. This observation is in line with Sullivan et al. (1990), who note that the length of time taken by malnourished patients to return to their usual lives is longer. Under-nutrition therefore prolongs recovery, increases the need for high-dependency nursing care and ultimately promotes a reduced quality of life for the patient (Council of Europe, 2001; Merriman, 2008). Consequently, the cost of treating a malnourished patient developing complications is between two to four times more than a well-nourished patient with no complications (Edwards and Nash, 1997). But malnutrition also affects children, even though this remains largely unrecognised by the medical and nursing staff caring for them (Hendrikse et al., 1997).

Table 3.6 below provides an overview of the consequences of malnutrition, summarising the various elements outlined above.

**Table 3.6 The consequences of malnutrition**

Physical consequences include:

Impaired immune response, predisposing to infection  
Reduced muscle strength and fatigue  
Impaired thermoregulation  
Impaired wound healing resulting in prolonged recovery and increased length of hospital stay

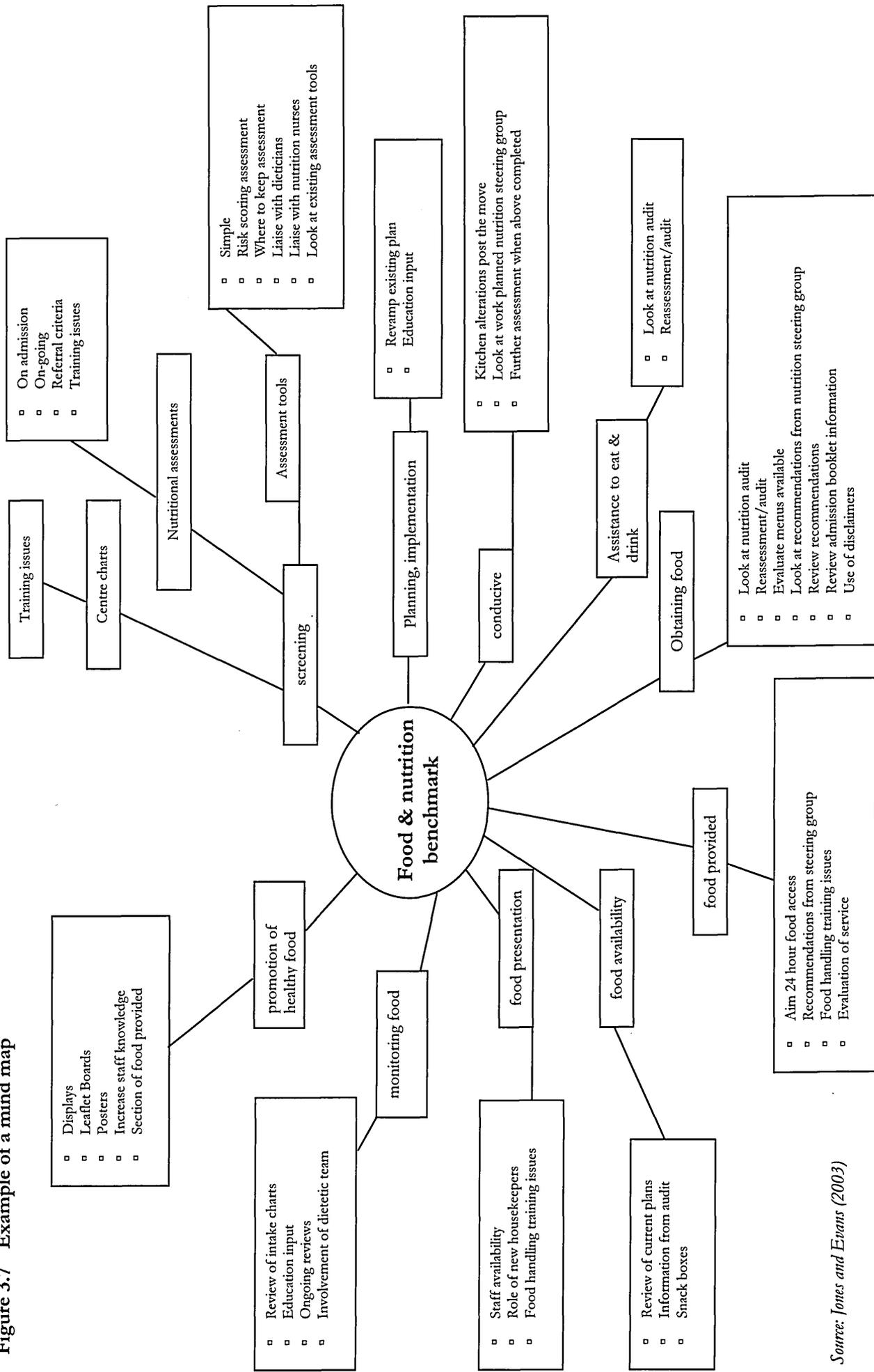
Psychosocial consequences include:

Apathy  
Depression  
Self-neglect  
Loss of libido  
Deterioration in social interactions

Source: adapted from Rollins, 2001

Overall, nutritional intake is generally the core focus of research conducted on hospital food services. An interesting model developed by Jones and Evans (2003) and conducted within the benchmarking approach appropriate to the Essence of Care (2001) quality initiative is the mind-map in Figure 3.7. Although the model focuses on the specifics of children's nutrition to prevent pressure ulcers, it offers a comprehensive overview of the multidisciplinary approach eventually leading to satisfactory nutritional intake.

Figure 3.7 Example of a mind map



Source: Jones and Evans (2003)

This study will not focus on nutritional issues faced by patients who have a problem with allergies.

### *3.3.2.6.1.1 Malnutrition and specific patient groups*

Malnutrition mostly affects two specific patient groups. First, long-stay patients staying more than 7 to 14 days in hospital. According to McGlone et al. (1995), patients who spend extended periods in hospital rely almost entirely on the food provided. In line with Hartwell (2004), there is a clear relationship between under-nutrition, prolonged hospital stay (Royal College of Physicians, 2002; Pichard et al., 2004) and greater risk of complications (Braunschweig et al., 2000; Williams and Barbul, 2003). Edington et al. (2000) found the average stay for malnourished patients was 8.9 days, significantly longer than patients who were not malnourished and who stayed for 5.7 days.

As emphasised by Hartwell (2004), patients in European hospitals stay between 5 and 10 days, and patients who are nutritionally 'at risk' remain in hospital for longer (Beck et al., 2001; Johansen et al., 2004). Inevitably, longer lengths of stay are also associated with significantly higher requirements for prescriptive drugs and cost the NHS an estimated £300 million a year (Lipley, 1999). BAPEN (2005) estimates the cost of malnutrition in the UK to £7.3 billion per annum (more than twice the cost of obesity, according to Merriman, 2008), with £3.8 billion spent on treating malnourished patients and £2.6 billion in long-term care facilities.

Apart from long-stay patients, Kyle et al. (2002) defined the geriatric person as another group of patients of concern. These patients often rely solely on the food provided by the institution and do not make up any deficit with food brought in from outside (Frost et al., 1991). It must be emphasised, however, that the observation from Frost et al. (1991) is based on a small sample of 30 to 40 elderly patients from 2 NHS hospitals. But the study is supported by more recent research. Six out of 10 older people are at risk of becoming malnourished, or their situation getting worse in hospital and patients over 80 have a five times higher prevalence of malnutrition than those under the age of 50 (BAPEN, 2003; Age Concern, 2006). A study conducted by Breemhaar et al. (1990) provides an interesting profile of elderly patients, observing they have less knowledge about medical subjects, regulations and facilities in hospital irrespective of demographic variables and their amount of hospital experience. Elderly patients also have a more external locus of control, are more fearful of complaining and show more gratitude. Elderly patients have a stronger wish not to bother others and stronger feelings of powerlessness. They can easily be called the 'good hospital patient' (Taylor, 1979), doing precisely what is being told in order to increase chances of recovery.

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In terms of participation of elderly patients in questionnaire research, they tend to give more socially desirable responses or attitude, which might reflect on higher satisfaction levels.

In summary and according to Kowanko (1997), patient outcome can be improved and costs reduced if appropriate nutrition is ensured in hospital. The cost of treating a malnourished patient developing complications is two to four times greater than treatment of a well-nourished patient with no complications (Edwards and Nash, 1997). Various tools like Bapen's Malnutrition Universal Screening Tool (MUST) or the Mini Nutritional Assessment (MNA) theoretically enable Trusts to achieve nutritional screening upon admission in hospital. However these tools have been found to be too complex to be used in a specific trusts where only 20% of patients were weighted on admission (Foster et al., 2005). These negative comments on MUST are contradicted by Merriman (2008), who found that 90% of respondents in six social service care homes were satisfied with its ease of use. Nutritional screening tools were developed in accordance with key initiatives such as the National Framework for older People or the Care Homes for Older People (Care Standards Act). It is interesting to note individual Trusts' initiatives developing their own nutritional screening assessment tools, together with financial initiatives for ward staff who use the tool consistently (Foster et al., 2005).

#### ***3.3.2.6.1.2 Barriers to complete nutrition***

Various factors acting as a barrier to nutritional intake are outlined in Table 3.7 below.

**Table 3.7 Barriers to complete nutrition**

Barrier	Underlying reason & potential solutions	Source
Ordering of food	Help may be required due to language, disability or illiteracy. Menus lacking in clarity. Patients' orders not checked	Allison, (2003) Cortis, (1997)
Menu choice and inappropriate meals being served	Little account taken of patient preferences, poor portion control	(Cortis, (1997)
Poor presentation of food, poor quality and quantity	Due to lengthy transportation	O'Hara et al., (1997) Cortis, (1997)
Disruption of mealtimes	Ward rounds, investigations or medical procedures	Allison, (2003)
Nil by mouth	Extended unnecessarily	Hung, (1992)
Timing	Inflexible, lack of access to snacks, long gaps between evening diner and breakfast	McGlone et al., (1995) Cortis, (1997)
Medication	There is a lack of clarity about responsibility for planning and managing nutritional care. Physical effects of medication.	Holmes, (2007) Cortis, (1997)
Assistance for disabled, treatment of particular illnesses, malabsorption/digest.	Nurses too busy, lack of staff to help with feeding Inadequate food consumption and/or provision of inadequate diet Failure to record food and fluid intake	Corish and Kennedy, (2000), Holmes, (2007) Cortis, (1997)
Chewing and swallowing difficulties	Inadequate education about nutrition among staff groups	Holmes, (2007)
Sensory loss of the patient	Insufficient cooperation between staff groups, lack of influence from patients	Holmes, (2007)
Positioning	Food and drinks out of reach of the patients	Cortis, (1997)
Communication	Lack of communication on nutritional intake between catering and NHS staff	Cortis, (1997)
Ward environment	Medical conditions of other patients, ambience social facilitation	Cardello et al., (1996b) Cortis, (1997)

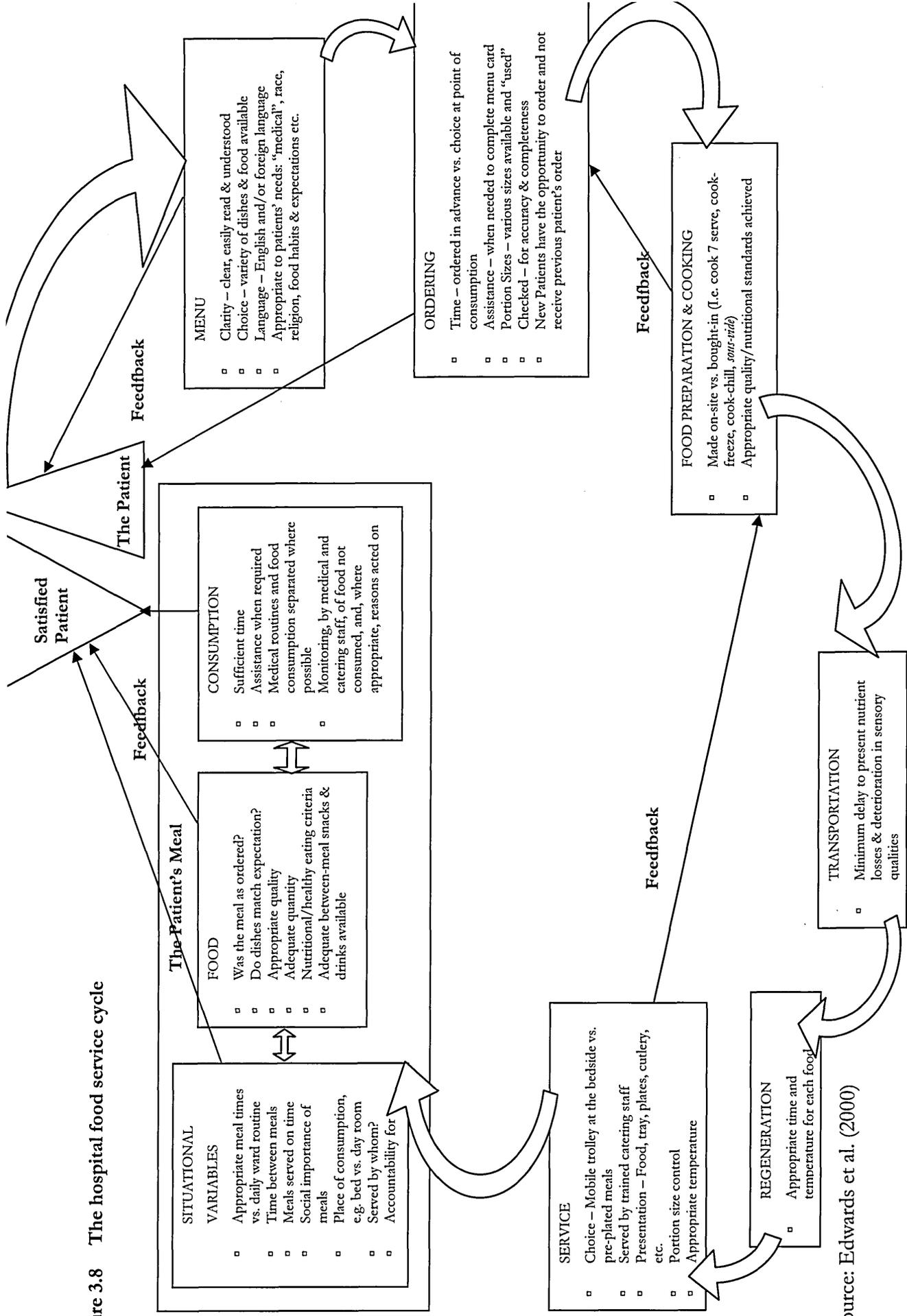
Source: adapted from Hartwell (2004) and based on Allison (1999, 2003), Cortis (1997) & Holmes (2007)

The most pertinent barriers to the implementation of patient-oriented food services include a lack of involvement from hospital administration staff, a lack of clearly defined responsibilities in planning and managing nutritional care, a lack of education about nutrition and lastly a lack of communication between service groups (Melchior et al., 2003; Holmes, 2007). Quite unfortunately, many of the issues outlined in Table 3.7 above have been repeatedly mentioned in the literature, without significant improvement in the field. In some cases, the situation has even deteriorated even though NHS-wide initiatives were put in place to offer potential solutions. In this regard, the latest State of Healthcare Report (2007) states that 20% of hospital inpatients who indicated that they needed help eating said that they did not get enough help, up from 18% in 2005.

### *3.3.2.6.2 Patient response and rating: 'perceived food quality' or 'satisfaction'?*

Based on the work of Orsingher and Marzocchi (2003) who have differentiated the concepts of satisfaction and perceived quality, Hartwell (2004) has described satisfaction as experiential and linked to emotional feelings while perceived quality is mainly the result of a cognitive process. Parker and Mathews' (2001) definition of satisfaction that will further be referred to in this study, lies in the underlying conceptualisation that satisfaction is a factor of both pre and post experience evaluative judgements, leading to an overall feeling about a specific encounter. Over the past decade and according to the research of Hudak et al. (2003), measurement in health had focused on patient preferences (Wright, 2000; Krahn, 2000), health outcomes (Kempen et al., 1998; Van der Meer and Mackenbach, 1998; Fried et al., 1999) patient satisfaction (Mitchell-DiCenso et al., 1996; Avis et al., 1995) and quality of life (Wood-Dauphinee, 1999; Dougherty et al., 1998). Perception of patient satisfaction has become a highly desired outcome of a health care encounter, even though Avis et al. (1995) stress the multi-dimensional nature of satisfaction and question the meaning of this concept for patients when evaluating their care. The present study clearly focuses on satisfaction as the outcome of patients' interaction with the stakeholders involved in the food service system. Various models focusing on food service management in hospitals have been developed, focusing on processes leading to patient satisfaction (Avis et al., 1995; Edwards et al., 2000). The existing models however, do not focus on psychosocial determinants, a gap this study aims to fill. This study builds further on the model (Figure 3.8) developed by Edwards et al. (2000) illustrating the issue and is a schematic representation of the hospital food service cycle. The overall purpose of the study that led to the model was to quantify food wastage at ward level. The social importance of meals is recognised within the situational variables that contribute to the patient meal experience, but without going in depth into patient values, involvement or trust issues. In a study conducted 6 years later (Hartwell et al., 2006), the hospital food service cycle was put in a broader framework that includes all stakeholders involved in the food service process. A theoretical model of patient experience and satisfaction with hospital food service was developed, even extending to the Primary Healthcare team.

Figure 3.8 The hospital food service cycle



Source: Edwards et al. (2000)

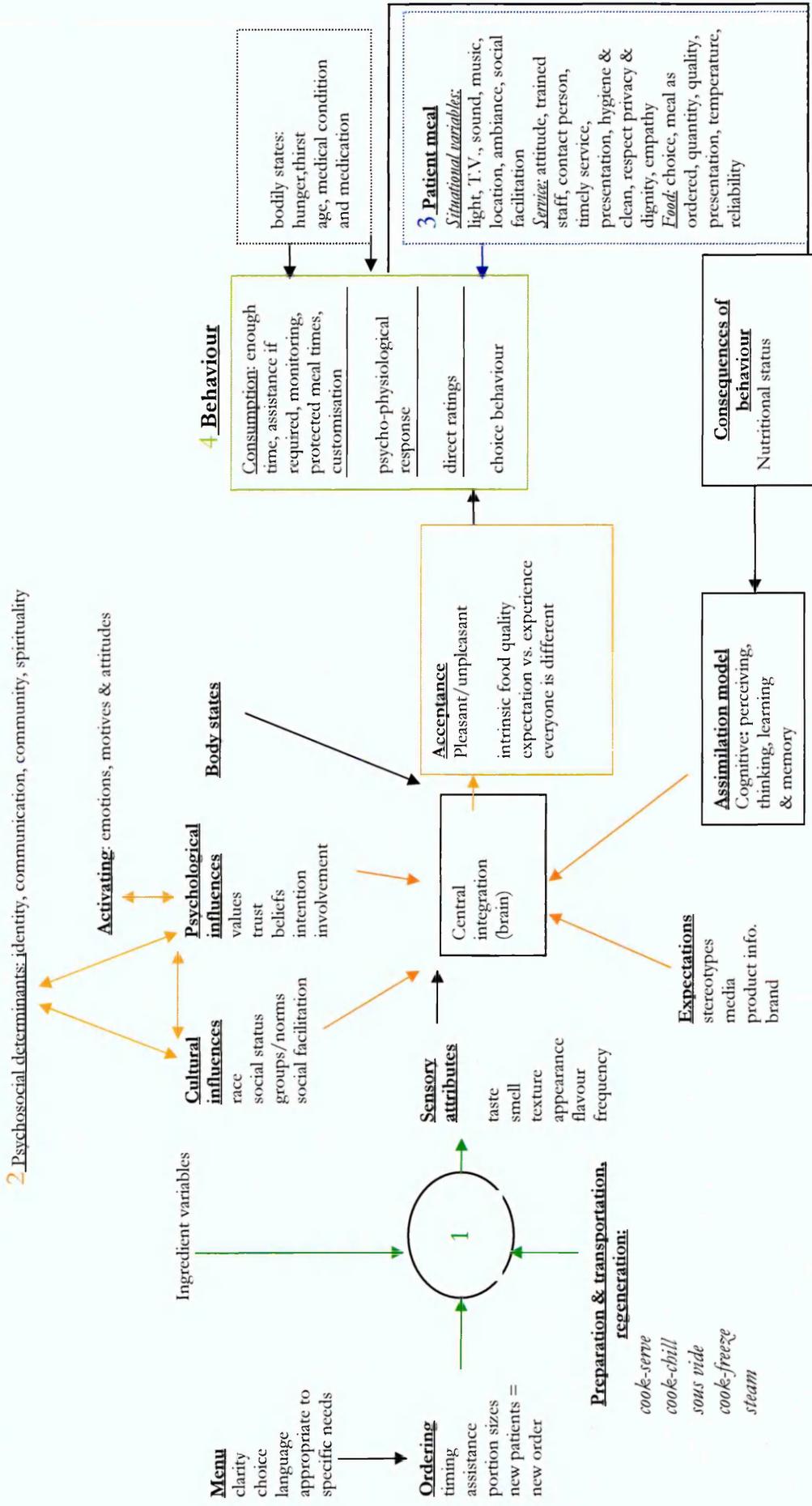
In accordance with the Better Hospital Food guidelines that aim at developing integral service experiences, the research will not limit itself to the investigation of cognitive processes and the amount of food consumed. The research will focus on the concept of customer satisfaction as a dependent variable, by investigating the food process on two distinct levels. Firstly, patients needs and wants related to food will be researched and secondly the interaction between patients and the food service system as a whole will be analysed.

### **3.3.3**      *Conceptual model*

A model is a useful tool for conceptualising and explaining abstract material, illustrating causal relationships and interaction amongst variables also in identifying moderating variables. The author has developed a research model (Figure 3.9) on nutritional behaviour adapted to a healthcare setting, based on the model developed by Imram (1999) and illustrated in Hartwell (2004). The attempt is to provide an appropriate balance between simplicity, accuracy and generality by grounding the research model in the extensive theory on nutritional behaviour in healthcare. In regards to the multitude of nutritional as well as service determinants leading to consumer satisfaction developed above, it appears no single metric can adequately measure or capture the contributions of food service components. The literature review on nutritional behaviour presents a vast array of determinants leading to satisfactory food service experiences. The model also integrates all relevant elements identified in the literature on nutritional behaviour in healthcare, as well as from the general literature on the topic that offers more insights into psychosocial determinants (with a focus on value systems).

In this study, the prevailing focus lies on psychosocial determinants influencing the patient meal experience. These determinants were described earlier (see paragraph 3.3.2.3), and are illustrated under (2) in Figure 3.9. It is relevant to note Hartwell et al. (2006) have recently investigated various soft factors that apply in the present study. Eleven out of the 16 variables used by the authors in 2006 in the research protocol for focus groups and interviews and looked at in the present study, add up to or are being part of the psychosocial determinants investigated.

Figure 3.9 Food choice consumer behaviour in healthcare, a multidimensional perspective



### **3.3.4 Conclusion**

Customer satisfaction with hospital food service appears to be multifactorial and difficult to assess, as each patient has his or her own expectations (Hartwell, 2004; Hartwell et al., 2007). Closely interwoven with patient satisfaction and perception of the food service are the social, physical and emotional aspects of the environment, apart from the quality of the food itself (Dubé et al., 1994). There is numerous research investigating sensory and internal physiological mechanisms in control of food intake. Largely ignored, however, have been the possibilities of other situational, psychological and social factors. The importance of psychological determinants emphasises the need to develop positive 'food experiences' for patients, leveraging their expectations towards hospital food. Today, there is no proper research investigating psychosocial aspects of patients leading to satisfaction, serving as a base to develop patient profiles leading to customer-centric food service experiences. The identification of values, involvement and trust are common determinants to nutritional behaviour and relationship marketing. These determinants will be analysed in depth during the research, complementing the existing literature on nutritional behaviour which has been integrated in Figure 3.9.

## **3.4 Human resources and marketing strategy implementation dyads**

### **3.4.1 Introduction**

The aim of this paragraph is twofold. Firstly, key HR policies as developed by the NHS Estates will be outlined. Secondly, general marketing implementation dyads will be looked at, before narrowing down the scope to marketing and human resources implementation dyads applicable to the NHS. A potential model to analyse the marketing/HR dyad in an acute hospital setting will finally be proposed, based on eventual gaps between the patient-oriented marketing strategies developed by the NHS Estates in terms of hospital food services and their implementation in the field.

Poor implementation of marketing strategies is a long outstanding concern first brought to light by early writers (e.g. Felton, 1959; Barksdale and Darden, 1971) and was labelled the “implementation problem”. It has often been argued for the past decade that the critical issue faced in marketing practice is implementation and the organisational change that is associated with implementation. The need to

integrate better planning and execution processes of marketing strategies has also often been brought up in the literature (Piercy, 1994; Cespedes and Piercy, 1996; Piercy and Cespedes, 1996). This is a surprising observation, as (according to Chimhanzi, 2004) strategy implementation has long been recognised as a critical tool for business success in both the strategic management literature (Carnall, 1986) and the marketing literature (e.g. Bonoma, 1984; Bonoma and Crittenden, 1988; Cespedes and Piercy, 1996; Piercy, 1997, 1998a,b; Sashittal and Jassawalla, 2001).

### ***3.4.2 Framework of HR policies developed by the NHS Estates***

#### ***3.4.2.1 Taskforce on staff involvement***

The NHS taskforce on staff involvement issued in 1999 ([www.dh.gov.uk](http://www.dh.gov.uk)) outlined key messages for ministers and the NHS. Firstly, it underlined the need for all staff who work in the NHS to be involved in decision making processes that affect them. Secondly, the development of partnerships, communication and teamwork was emphasised.

#### ***3.4.2.2 Shifting the balance of power in the NHS***

In January 2002 the document “Shifting the balance of power in the NHS” ([www.doh.gov.uk/shiftingthebalance](http://www.doh.gov.uk/shiftingthebalance)) was issued. The program of change was brought about to empower frontline staff and patients in the NHS and was part of the implementation of the NHS Plan. The main objective was to foster a new culture in the NHS at all levels which puts the patients first. Four key elements of the document must be emphasized when considering patient-focused (food) services in the NHS:

- Firstly, the empowering of front-line staff to use their skills and knowledge to develop innovative services, with more say in how services are delivered and resources are allocated;
- Secondly, the focus on patient empowerment to become informed with active partners in their care by involving them in the design, delivery and development of local services;
- Thirdly, the willingness to change the NHS culture and structure by devolving power and decision-making to frontline staff and PCTs (Primary Care Trusts) led by clinicians and local people along with building clinical networks across organisations. In terms of the employment culture, the plan aims a culture of values and personalised care and continuous improvement built on customer service, delegated team working, development of leadership at every level and

empowerment according to competence. In 2001, NHS Estates issued a document that was circulated to NHS Trusts as part of the PEAT initiative. This document set out the requirement to provide all estates and facilities staff with two hours of customer care training each year;

- Finally, engaging in creating networks for care with their external partners was also a major aim of the document, and is a key aspect this study aims to investigate.

Since 2002, there has been a significant devolution of power to NHS organisations in line with the document. The NHS is moving away from an emphasis on centrally prescribed national targets on doctor and nurse numbers, to a reliance on credible local plans that maximise workforce capacity to support delivery (Delivering the NHS improvement plan: the workforce contribution, 2004). This document also states the high impact policy changes the plan had on choice and personalised care, requiring NHS staff to engage differently with every single patient.

Considering the above, it appears the NHS Estates have developed HR policies and strategies that are patient-oriented and strongly rely on teamwork, cultural change and empowerment of front-line staff and patients. A culture of values and personal patient care is emphasised, without specification of the values to handle: the values of individual patients and the NHS Estates as an institution, or the values of the PCTs? The aim of the following paragraph is to identify the (relationship) marketing planning impediments as developed in the literature across various fields of specialisation, in order to place the impediments applicable in healthcare into a broad framework and develop a thorough understanding on the subject. This analysis of marketing implementation dyads will, according to the main objectives of the study, then further focus on the impediments not allowing proper implementation between (relationship) marketing and human resources. Once these impediments are identified, they will be compared with those applicable in the NHS.

### 3.4.3 Issues of (relationship) marketing implementation

#### 3.4.3.1 Approaches to the concept of marketing implementation

Due to the diversity of approaches to understand relationship marketing as developed above, no rules of best practice have been promoted when considering its implementation. Lindgreen et al. (2000) emphasized the term relationship marketing is used in so many different ways that 'confusion sets in' (Palmer, 1998, p. 106). The implementation as well as the monitoring of RM programmes has been questioned by authors like Cravens (1998) and Gummesson (1998). As covered in section 3.2 of this study, RM is a young discipline that is difficult to actually measure up. But the literature has consistently conceptualised implementation as the translation of strategic plans into an operational reality. Table 3.8 below outlines various approaches to marketing implementation found in the literature.

**Table 3.8 Approaches to marketing implementation**

Year/author	Approach and conceptualisation
Mintzberg (1978)	conceptualises implementation as the process whereby 'intended' or 'emergent' strategy translates to 'realised' strategy
Giles (1991, p. 75)	views implementation as being concerned with 'putting strategy into practice'
Bonoma (1984)	the author is concerned with 'the tactical execution of marketing plans, programmes or strategies'
Meldrum (1996)	takes implementation to refer to 'the actions performed as a consequence of policy decisions'
Sashittal and Wilemon (1996)	involves translating strategic intentions into action steps, assigning relevant tasks and actions to people, ensuring that the tasks are executed, and accomplishing the predetermined objectives

When considering the approaches above, it appears that successful implementation implies decision making plus actions which accurately reflect those decisions. Below, the author will look at the factors that interfere between decision making and actual implementation, focusing on the marketing literature.

### ***3.4.3.2 Overview of marketing planning impediments***

#### ***3.4.3.2.1 The existence of a marketing function in organisations***

When considering the NHS in respect of the existence of a marketing function, these are not developed within individual NHS Hospitals in the U.K. The marketing ethos is defined by the NHS Estates in the various strategic plans as defined above, and then supposedly instilled throughout the entire organisation by all stakeholders.

#### ***3.4.3.2.2 Impediments hindering marketing planning activity***

According to Simkin (2002a), for two decades the leading exponents of marketing planning have warned of the cultural, operational, managerial and communications factors which often do not allow for proper implementation of marketing decisions (Greenley, 1982; McDonald, 1992a,b; Piercy and Morgan, 1994; Simkin, 1996a,b; Cravens, 1998). More recent research indicates the components above continue to act as barriers to the implementation of marketing strategies and programmes (Simkin, 2002a), and these elements will be taken as reference within this study. But other authors argue current key marketing implementation dyads can be brought back to people and cultural prerequisites (McDonald, 1992a,b; Piercy and Morgan, 1994; Dibb, 1997), and are central to the tenets of relationship marketing and internal marketing (Gummesson, 1998; Lings, 1999). Table 3.9 provides a chronological overview of the impediments hindering marketing planning activities, based on the issues outlined in Simkin (2002a,b). In this table, the author has categorized major components hindering implementation in four parts: cultural, operational, managerial and issues related to communication.

**Table 3.9 Impediments hindering marketing planning activity**

McDonald's obstacles impinging on marketing planning – 1992	Dibb and Simkin's barriers hindering marketing planning, mid 1990s	Observed barriers in UK manufacturing and service sectors - 2002
<b>Cultural</b>		
An emphasis on too much detail in a rigid one-year planning ritual Planning for planning's sake	Planning activity fades out Lack of confidence and conviction	Current apparent business success/arrogance Lack of enthusiasm amongst non-marketers Resistance to change
<b>Operational</b>		
No plan for the planning activity Separation of planning from other functional areas in the business The delegation of marketing planning to planners Lack of knowledge and marketing skills Confusion between the planning process and its outputs	Little or no marketing analysis undertaken  Planning and personal overtaken by internal and external operations/organizational events Poor and inadequate marketing intelligence and MIS	Harmonising difficulties across sites and countries Marketing environment forces not monitored Inadequate information Lack of understanding of customers Monopoly market position and forces Time to conduct planning activities  Poor involvement of functions and teams
<b>Managerial</b>		
Lack of chief executive support Lack of support, resources and skills  Line management hostility The short-cut use of market share and sales in lieu of written marketing objectives and strategies Failure to relate marketing planning to corporate planning Confusion between the marketing function and the marketing concept	Inadequate understanding and support from senior management  Strategy determined in isolation of analysis or formulation of tactical marketing mix programmes Poor grasp of the marketing concept Blinkered view of the external marketing environment Little opportunity for lateral thinking	Senior managers lacking business skills Management's failure to see the whole picture Individual manager's empire building Top-down approach to planning Staff: lack of and turnover
<b>Communication</b>		
Confusion over technology, jargon and procedures	Little internal sharing of marketing intelligence Poor internal communications in marketing between functions/tiers	Inadequate communications

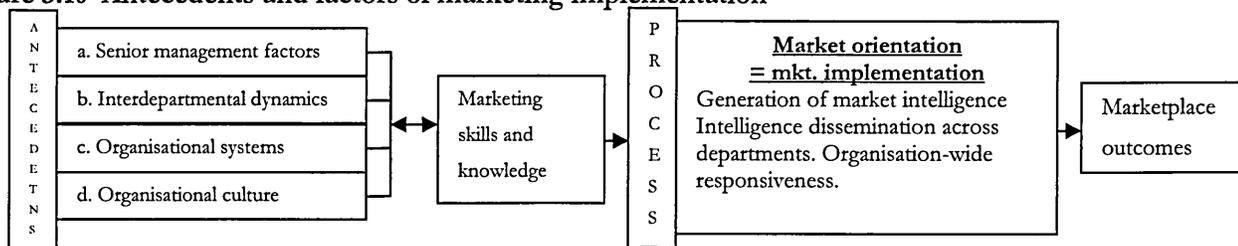
Source: adapted from Simkin, 2002a,b

Another relevant approach to marketing implementation considers marketing as only one of many departments within a network of relationships instead of focusing on dyadic relations, and is further developed below.

### 3.4.3.2.3 Antecedents of market orientation

Looking at the marketing implementation impediments as developed above does not directly offer alternatives for successful outcomes. Discussing the processes required for successful implementation, Kohli and Jaworski (1990) developed an approach of establishing antecedents which would affect the market orientation of an organisation. By market orientation, the authors mean the implementation of marketing, for which they identified three critical elements: the generation of market intelligence, the dissemination of such intelligence across departments and finally the organisation-wide responsiveness to intelligence dissemination across departments. Based on a model developed by Kohli and Jaworski (1990), Meldrum (1996) characterises the key antecedents proposed to influence the degree of market orientation as senior management factors, interdepartmental dynamics, organisational systems and finally organisational culture. Key antecedents and factors are represented in Figure 3.10 and further developed below.

**Figure 3.10 Antecedents and factors of marketing implementation**



Source: adapted from Meldrum (1996), initial model from Kohli and Jaworski (1990)

Key impediments developed in Table 3.9 (cultural, operational, managerial and communications) are also found in Figure 3.10, with interdepartmental dynamics and organizational systems going under operational impediments. However the model in Figure 3.10 is relevant, as it separates antecedents from processes (in comparison to the classical model developed by Simkin in Table 3.9), with marketing skills and knowledge forming a link between both components. The model, originally from Kohli and Jaworski (1990) is briefly explained below, starting with the antecedents of market orientation.

### **a. Factors of influence on the market orientation: senior management factors**

The problem when considering the implementation of marketing strategies is that most competences or capabilities are said to exist as complex bundles of knowledge and skills possessed by individuals, exercised through organisational processes and tempered by overall culture (Day, 1994; Leonard-Barton, 1992). Together, they can be described as the managerial capacities of an organisation's members (Lado et al., 1992). Key examples of skills and knowledge which are associated with competitive advantage are the ability to harmonise streams of technology, organise work and deliver value (Prahalad and Hamel, 1990), or the ability to improve market orientation (Day, 1994). Apart from the responsibility of the marketing specialists, the competences required by so called front line marketers spread throughout the organisation should also be investigated. Hence the relevance for this study to focus on process elements required from front line catering staff employed by a private food and service management firm working for the NHS, within the perspective of the Nordic School of Marketing and its part-time marketers spread throughout the hospitals. The issue of senior management support on the effectiveness of marketing implementation was also argued by Chen and Popovich (2003), in the context of CRM implementation. Dickie (1999) also warns against starting a CRM project if senior management does not fundamentally believe in re-engineering a customer-centric business model. We might wonder about support front line staff receive from their management across the hospitals involved in this study.

### **b & c. Interdepartmental dynamics and organisational systems: implementation within networks & interactions**

According to Ruekert and Walker (1987), the management of effective inter-departmental relations within companies tends to improve marketing implementation efforts. Using a different terminology, Webster (1992) stresses that firms need to operate on a network basis and develop long term relationships both internally and externally. This, he claims, will require increased skills of co-ordination, the development of strategic partnerships and a greater emphasis on relationship management abilities. Linking these marketing competencies with the network approach of the Nordic School of marketing is an easy thing to do. But the literature does not emphasise the skills required by all employees in contact with customers, the so called part-time marketers as defined by Gummesson in the tradition of the Nordic school of Marketing. According to Gummesson (2004), there is little research available on marketing planning in networks of relationships.

May and Smith (2003) illustrated the issue of co-planning within a network, identifying problems with recruiting housekeepers within the NHS. One recurring theme relating to recruitment was the importance of involving ward managers and if possible nursing staff in the process.

#### d. Organisational culture

Organisational culture is a major antecedent when considering the concept of marketing orientation as developed by Meldrum (1996), based on Kohli and Jaworski (1990). Culture impacts the behaviour of individual members, and often tends to become a major impediment to HR and marketing implementation (Piercy and Lane, 1996). The difference between a marketing culture and a market orientation is that cultural features will affect the way marketing tasks will be implemented, what was referred to as 'market orientation' in Figure 3.10 above. Various authors have looked at the concept of culture, with key approaches listed in Table 3.10 below.

**Table 3.10 Approaches to the concept of culture**

Year/author	Approaches to the concept of culture
Deshpande and Webster, 1989	culture is taken to mean the pattern of shared values and beliefs that help individuals make sense of their function and which provides them with norms for behaviour in the organisation
Narver and Slater, 1990	a marketing culture fosters a strong market orientation which will lead to 'behaviours for the creation of superior value for buyers and, thus, continuous superior performance' (p. 21)
Webster, 1992	a marketing culture is one which emphasises beliefs and values about those aspects of the business which will deliver success in the marketplace

Here again values are central and relate to cultural norms, forming a powerful tool in shaping the behaviour of employees (Schwartz and Davis, 1981). It has further been suggested that effective companies are the ones with 'distinguishing cultural profiles' (Dunn et al., 1985), whereby obtaining the proper 'state of mind' from employees was a key determinant of marketing effectiveness. When we look at the obstacles of a patient-centered service in the NHS developed above, the author will try to understand whether the organisation is still working in distinct operational silos, each one having separate goals and objectives with no common goal to strive to? This appears to be confirmed by the literature which states patients still do not appear to be recognised as customers, acute departementalisation is the rule, patients are not involved in food processes and a lack of cooperation amongst the various staff groups is daily practice. There appears to be a significant discrepancy between the NHS strategic plans and the day to day situation encountered within NHS hospitals in the U.K. Looking more in depth at the marketing/HR interface is required to understand how to achieve patient-oriented food services within the NHS, and is further explored below.

## **Marketing skills and process elements**

Each factor developed in Figure 3.10 has a process element in that they imply actions, which will determine the nature of market orientation for the organisation. The process elements required refer to the collection, dissemination and use of market based information, marketing skills and knowledge as developed by senior management.

### ***3.4.3.3 Marketing implementation and human resources***

#### ***3.4.3.3.1 General context: when marketing and HR are interconnected***

Investigating the marketing/HR interface is a key element in an effective marketing strategy implementation, as the 'people' area is its greatest constraint (Giles, 1991; Piercy, 1997). Some organisational features causing the implementation gap of marketing strategies are outside the direct control of the marketing function, but still need to be influenced by marketing principles. This is particularly true in the context of the NHS, whereby various stakeholders are involved in 'patient-oriented' service strategies. The 'NHS improvement Plan: the workforce contribution, 2004' emphasises a culture of values and personalised care, enabled by the empowerment of patients and staff operating on a network basis (internally and externally) and developing long term relationships as a key competitive strength. This is further supported by the approach of the Nordic School of Marketing as developed above.

The research of Chimhanzi (2004) investigating marketing and HR implementation issues pointed out relevant factors such as inadequate training (e.g. Alexander, 1985) and low motivation (e.g. Eisenstat, 1993). Such issues are often caused by a lack of synergy between both departments, whereby HR develops training, remuneration and appraisal schemes in isolation of marketing that will design ambitious goals and objectives. Ideally, properly integrating the marketing and HR departments should lead to proper alignment of workforce capabilities with customer focused marketing strategies (Gratton, 1994; Piercy, 1997). Chimhanzi (2004) further emphasizes the need to achieve proper coordination between both departments by working together on job descriptions, the screening of potential candidates and in designing appropriate training programmes.

### ***3.4.3.3.2 Marketing and human resources implementation factors in the NHS***

Within the healthcare context, the implementation of marketing strategies through HR has taken a rather dramatic perspective. According to West et al. (2002), there is generally a strong association between HR practices and patient mortality. Even though the quality significance of the whole meal experience has been recognised in the literature by the NHS Estates, its implementation appears to suffer from various factors that do not allow the NHS to implement a food service approach in accordance with so called 'soft' aspects of food leading to patient satisfaction (Dubé et al., 1994). In terms of the application of 'customer-centric' processes in the NHS, major impediments are cultural issues (Carr, 1992; Bolton, 2002), departmentalisation (Askham et al., 2002), lack of involvement from the patients, lack of co-operation amongst all staff groups (Melchior et al., 2003) and a failure by all stakeholders to recognise the patient as the real 'customer'. Another barrier to implementation identified in the context of hotel style room service implementation in US hospitals and identified by Sheehan-Smith (2006), put the responsibility on the nurses' shoulders as this staff groups tends to slow down the implementation process of hotel-style services.

Apart from the issue of not recognising the patient as a customer, all impediments proper to the NHS are also found in the general literature on marketing implementation dyads as developed above. However, the literature does not provide any cases whereby these impediments are contextualised to private food and service management firms. This is a gap the author aims to bridge with this study. Hwang et al. (1999) emphasized the need for more research into the communication between nursing staff, ward staff and the catering department and the effects of this communication on the food intake of the patients. The scope of such research will, in this study, be extended to encompass the whole patient meal service experience instead of focusing solely on food intake.

#### **Examples of implementation problems related to patient-oriented food services**

- According to Wood (1998) and Kowanko et al. (1999), many nurses have difficulty in raising priority of food above other nursing duties. Meal requirements often 'interfere' with the domestic medical routine which puts a lot of pressure on the nursing staff, and they have found it difficult to balance both roles, resulting in the meals taking second place (Edwards and Nash, 1999).
- Referring to Toraman et al. (2002), Hartwell (2004) has highlighted communication problems between nurses and ward hostesses, together with the need to conduct further research on this issue.

### **3.4.3.3      *Education of food service personnel within the NHS***

At present, there is no legal obligation for staff involved in catering activities to follow specific courses or be aware of nutrition and dietary implications of the food that they serve (Hartwell, 2004). An initiative, Catering for Health, introduced by the Food Standard Agency is a strategy to encourage chefs, lecturers and their students to be aware of the importance of food in health-related issues. As outlined by Hartwell (2004), the Council of Europe resolutions (2003) recommend to differentiate the training of hospital food service and hotel management by emphasising and preparing staff to cater for the infirm. According to May and Smith (2003), training structures and programmes within the NHS Trusts, were pragmatic and aligned to the ward housekeeper role. The training programmes include basic food hygiene, cleaning procedures and standards and other ward based skills required for the housekeeper role. Training away from the ward introduced the housekeeper to other services they may encounter in hotel services and the wider Trust including estates, dieticians, chaplaincy, security and infection control. Currently, Trusts develop training schemes for housekeepers like the National Vocational Qualification (NVQ), in consultation with hospital managers and professional associations.

### **3.4.3.4      *Aggregating marketing impediments across sectors of activity***

Some organisational features causing the implementation gap of marketing strategies are outside the direct control of the marketing function, but these still need to be influenced by marketing principles. This is particularly true in the context of the NHS, whereby various stakeholders are involved in 'patient oriented' service strategies that are instilled in a top down approach across the whole organisation by the NHS Estates. Major impediments to the implementation of patient oriented services in hospitals are, as identified above in the literature: culture, departmentalisation (Askham et al., 2002), lack of patient involvement, lack of cooperation among all staff groups (Melchior et al., 2003) and finally the fact that the patient is not yet recognised as a 'customer'. A need for multidisciplinary teams for successful implementation of hotel style room service was further identified by Sheehan-Smith (2006). Table 3.11 provides an overview of the most recent marketing impediments encountered in the general literature, the marketing/HR impediments and finally the 'patient-centric' implementation dyads within the NHS.

**Table 3.11 Overview of marketing implementation dyads across sector of activity**

Observed barriers in UK manufacturing and service sectors (2002)	Marketing/HR implementation dyads Human-related factors	Customer-centric service delivery implementation dyads within the NHS
<p><b>Operational:</b> staff: lack of and turnover lack of enthusiasm amongst non-marketers poor involvement of functions and teams</p> <p><b>Communications</b> inadequate communications inadequate information</p> <p><b>Managerial</b> individual manager's empire building lack of understanding of customers senior managers lacking business skills management's failure to see the whole picture</p> <p><b>Cultural</b> top-down approach to planning resistance to change monopoly market position and forces time to conduct planning activities</p>	<p>inadequate training poor integration marketing/HR function</p> <p>lack of functional synergy and communication between marketing and HR</p> <p>conflict lack of senior management support</p> <p>low motivation</p>	<p>lack of patient involvement departmentalisation lack of co-operation among staff groups, need for a multidisciplinary approach</p> <p>lack of communication between staff groups</p> <p>patient not recognised as a customer culture</p>

From Table 3.11, it appears that common marketing implementation dyads across all categories can be summarised as cultural, operational and communication factors. It is surprising not to see the managerial component in the implementation dyads within the NHS. All categories emphasise the lack of co-operation and communication across departments (departmentalisation), as well as a lack of involvement from staff or from customers/patients (symptomatic of a traditional top down approach). The lack of literature on the marketing/HR dyad is quite surprising, as the integration of the HR and marketing functions is seen to represent the alignment of workforce capabilities with customer focused marketing strategies (Gratton, 1994; Piercy, 1997).

### ***3.4.4 Potential solutions to marketing impediments in the NHS***

#### ***3.4.4.1 Importance of and determinants leading to employee and patient satisfaction***

##### ***3.4.4.1.1 The importance of job satisfaction in satisfying patients***

Potential solutions to marketing impediments often imply increasing employee satisfaction, which leads to improved service levels. The literature clearly states that food service staff appear to be undervalued, paid a low wage (Pratten, 2003) and perceive their job as being for the 'less intelligent' within the health care industry (Donelan, 2000). Positive attitudes expressed by staff can influence intake and significantly add or detract from a patient's mealtime experience (Engell et al., 1996). Other people can control an individual's behaviour in different ways; by their presence, by attention paid to the individual and his activities, through model effects and through persuasive action or communication (Rozin and Tuorila, 1993). All these authors emphasise the importance of employee consideration and job satisfaction.

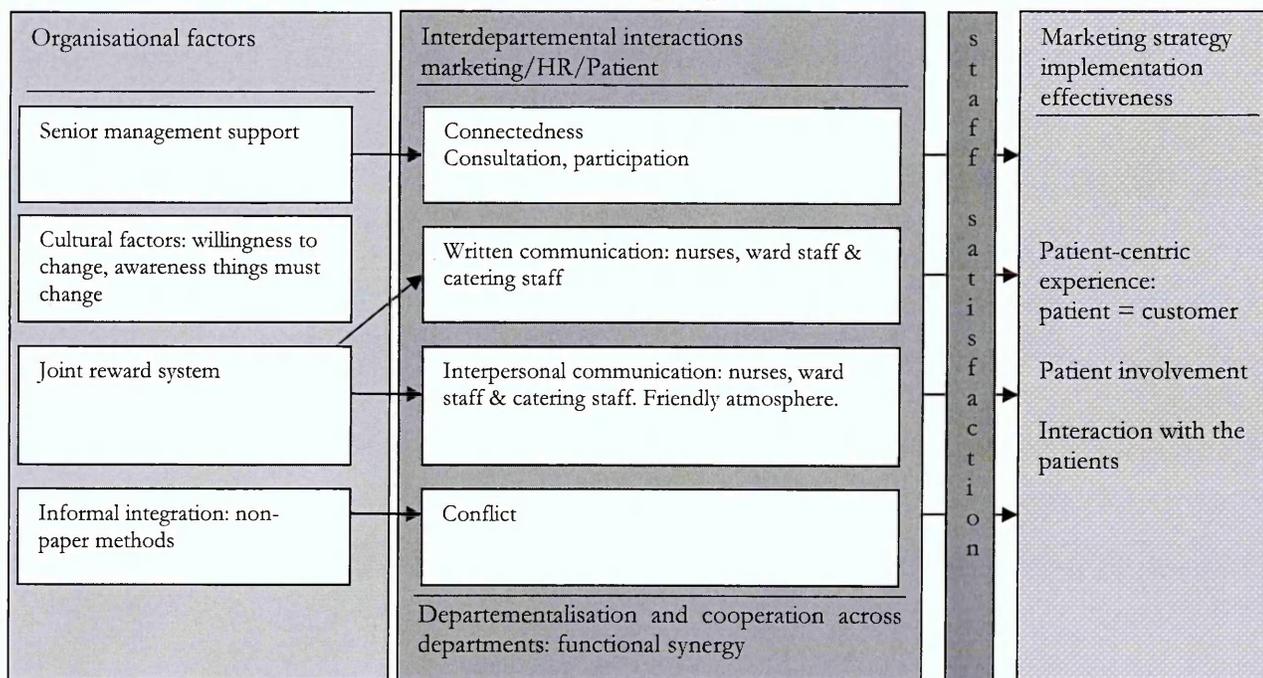
##### ***3.4.4.1.2 Other tools enabling employee job satisfaction and leading to patient satisfaction***

Smith (1999) observed that no association was found between financial incentives and job satisfaction or staff motivation. A possible correlation was found between staff centred programmes and staff satisfaction and motivation, as far as the participants were aware of the programmes available to them. The most effective method for communicating these staff centred schemes appeared to be through non paper methods such as staff meetings, job chats, staff appraisals and team meetings. Managers ranked financial rewards and incentives as of much greater importance to their staff than the staff did themselves. Job characteristics such as number of days annual leave, overtime opportunities, pension schemes and good bonus schemes were rated by the managers to be of much greater importance to their staff than to the staff themselves. The participating ancillary staff rated job security and friendly atmosphere to be most important to them. It has become widely recognised that problem solution is enhanced through effective internal communications in organisations (Kohli and Jaworski, 1990).

### 3.4.4.2 Marketing implementation through HR in the NHS: conceptual framework

Chimhanzi (2004) was the first author to develop a conceptual model of marketing implementation through human resources, based on available empirical work examining marketing's interactions with other functions. However, Chimhanzi's model (2004) was tested within organisations that have distinct HR and marketing departments, which is not the case within the NHS. Adapting the model to a healthcare environment is a route this study aims to follow. Having looked at the importance of employee satisfaction and the competencies of staff groups in delivering patient oriented food services, we can now go back to the implementation of NHS marketing plans. The conceptual framework developed by Chimhanzi (2004) and depicted in Figure 3.11, illustrates the relationships between organisational characteristics, interdepartmental (marketing/HR) interactions and marketing strategy implementation effectiveness. Working on Chimhanzi's (2004) model will help to achieve the main goal of this research, which is to develop a comprehensive conceptual framework of patient-centric food service processes based on the implementation of relationship marketing. This model will identify the necessary determinants to measure the effective relationship between a firm's customer-centric marketing approach and what is actually implemented in the field.

**Figure 3.11 Marketing/HR interactions and marketing implementation**



Source: expanded from Chimhanzi, 2004

Chimhanzi (2004) proposed that implementation effectiveness is positively influenced by the two aspects of interdepartmental dynamics (connectedness and communication frequency) and negatively influenced by conflict. These interdepartmental dynamics are in turn predicated on a set of organisational factors; namely senior management support, culture, joint reward system and informal integration. Adapted to the context of the NHS and interdepartmental relations between nursing and catering staff, culture has been added to the model as an organisational factor.

Staff satisfaction has also been added as an intermediary between interdepartmental interactions and marketing implementation. The model in Figure 3.11 is further developed below, integrating components from the literature related to the NHS in order to contextualise it to this particular setting. Adapting the model to a healthcare environment and testing it out would be an interesting approach to analyse marketing/HR implementation dyads within NHS hospitals that do work with private food and service management firms, filling a lack of research available on marketing planning in networks of relationships in this particular context.

#### ***3.4.4.2. Interdepartmental interactions***

##### **Connection and communication**

Chimhanzi (2004) has focused on interdepartmental interactions, referring to the work of Morgan (1995) who distinguishes between the concepts of connectedness and communication by expressing that connectedness may be seen as “the degree of communication co-operation between departments, and communication as the frequency of information flows through defined, appropriate media”. Communication and connectedness are considered to represent different dimensions of the level, process and context of communication co-ordination and information sharing between sub-units (Morgan, 1995, p. 213). In the operationalisation of the connectedness construct, Jaworski and Kohli (1993) identified its core aspects as the motivation of each party to communicate, the accessibility of staff in each area, and a ‘common language’ that allows for communication effectiveness. Chimhanzi further outlines that connectedness tends to lower dysfunctional conflict, according to the research of Barclay (1991) and Anderson and Narus (1990). Deshpande and Zaltman (1982) established that connectedness facilitates interaction and exchange of information. In the present study, there is no marketing department as such in each hospital, and the HR administration and operations are conducted by the private food service provider under supervision of the contracting Trust. There are no direct interdepartmental interactions between marketing and HR within acute NHS Hospitals.

However, we might wonder if organisational factors and interdepartmental interactions as developed by Chimhanzi (2004) are in application between catering and NHS staff. The desired output would be an enhanced patient centred service, in accordance with strategies as developed by the NHS Estates. May and Smith (2003), also stressed the importance of communication between the clinical and non-clinical ward based staff regarding new additions to the ward. The author stressed the significance of the ward housekeeper role as an 'information gateway' between patients and doctors as highly valuable.

### **Conflict**

Conflict has been defined by Menon et al. (1996) as a 'dysfunctional, task based tension between departments, which manifests in the form of 'turf battles' and 'destructive self-serving efforts' which are both counter to collaboration (Morgan and Pierce, 1998). In her conclusions, Chimhanzi (2004) observed that the two aspects of marketing/HR interactions that were found to directly impact on implementation effectiveness are conflict, negatively, and interpersonal communication, positively. In turn, a number of organisational characteristics were identified as impacting on these two variables. Joint reward systems were seen to alleviate conflict levels, while senior management support, joint reward systems and informal integration all had a strong and positive impact on interpersonal communication. Looking at the influence of eventual conflicts between private catering and NHS staff is a relevant matter to this study.

#### ***3.4.4.2 Organisational factors: antecedents***

##### **Senior management support**

Whether it be in the general literature on marketing impediments, or in the literature on relationship marketing, senior management support appears crucial in enabling the implementation of patient oriented strategies. Management must design job evaluations, compensation programmes and reward systems on a basis that facilitates and rewards customer-oriented services.

##### **Informal integration and joint reward systems**

Informal integration has a strong and positive impact on interpersonal communication. Based on this observation, Chimhanzi (2004) invited managers to encourage departmental members to integrate socially, through common social events (Shapiro, 1988). Developing the informal networks described above is difficult to manage through formal processes, but managers have a role to play in providing opportunities for staff members to socialise (Griffin and Hauser, 1996). Chimhanzi (2004) also

concludes that there may be advantages in implementing reward systems based on joint efforts across departments. Looking at the degree of connectedness and communication between NHS staff and catering staff from the private food service company, is of paramount importance in the perspective of patient orientation. This will be further investigated in this study.

#### ***3.4.4.3 Internal marketing to overcome implementation impediments***

Internal marketing offers an interesting and rather structured alternative to improve the implementation of marketing plans through HR. Some authors argue internal marketing can help in developing a customer focused organisation and helps ensure coherent relationship marketing (George 1990, Lings 1999). However, when envisaging the use of internal marketing in the context of the NHS, we might wonder how this discipline can be implemented, considering the variety of stakeholders with different priorities and core competencies, which are involved in creating valuable food experiences for patients. The core requirements of effective internal marketing are: information sharing, orientation sessions, multi-functional team interaction, formalised internal marketing communication campaigns, debrief and feedback sessions, incentivised staff motivation and finally empowerment of front-lines staff. All these hands-on tools seem to fill a gap that is recurrent in the literature on marketing impediments as developed above.

## 3.5 Conceptual model

### 3.5.1 *Development and application of the conceptual model*

Food service operations form a multi-disciplinary activity. This includes the management of a range of issues such as the food service management firm, hospital administration, nutritional staff and finally medical staff. In the present research, these components were initially described as the suprasystem; designed to operate within the subsystem (as designed by Government and Society throughout the NHS Plan) in an integrated manner. Finally, it was decided to use a representation of this complex network based on the model of Martin (2001), whereby dynamic relationships link three environments together as illustrated in Figure 3.12. The components of this conceptual model are developed further below.

#### 3.5.1.1 *The internal environment (purple)*

Looking at the model clockwise, the internal environment includes four different professional stakeholders involved in the delivery of food services to patients: the food service management firm, nutritional staff, medical staff and the hospital administration. These four stakeholders interact with one another, the patients and their relatives. All players can largely be controlled by the management of the hospital, in compliance with NHS guidelines. The roles and suggested relationships between stakeholders have been explored in detail in chapter 2 (Figures 2.1 and 2.2), but a brief overview is developed here.

The food service management firm is in charge of all tasks inherent to the food-related administration, production, purchasing & storage and non-patient services. The nutritional staff (dietitians and nutritionists) are involved in the diagnoses and dietary treatment of disease in patients having special dietary needs. They provide guidelines to the medical staff about patients' specific nutritional requirements when applicable. Depending on specific operational policies developed by the Trust, this information is then communicated by the medical staff to the catering staff who actually serve the food to patients. The medical staff are composed by ward and department heads, sisters, nurses and medics. Finally, the hospital administration has (together with the medical staff) overall responsibility for the

food process in acute NHS Hospitals. The hospital administration will ensure food-related policies developed on national level or by the Trust are implemented throughout the hospital.

### *3.5.1.2 The near environment (blue)*

The near environment is composed by two main components. First we have all stakeholders in direct contact with the hospital: patients, service users, relatives and friends. These stakeholders contribute directly to the patient meal experience, which determinants are outlined at the centre of the conceptual model in Figure 3.12. Secondly, there is the political environment issuing guidelines related to healthcare (e.g. NHS Plan or the BHF project) as well as other related pressure groups (e.g. HCA). These stakeholders are called 'Government and Society' in the conceptual model, and an overview of the players involved is provided in chapter two, under paragraph 2.6 'Current developments: towards a customer-oriented focus in healthcare'. These players cannot be controlled by the hospitals or Trust, but can be influenced by them.

Within the near environment, factors leading to patient satisfaction and increased nutritional intake are listed within four distinct categories. These are listed according to key components identified in the literature: psycho-social determinants, environmental and situational variables, food quality and menu and finally consumption of the meal itself. These components have been developed in detail in chapter three (literature review), and are integrated in the conceptual model (Figure 3.12). As the focus of this study is to develop an in-depth understanding of psycho-social determinants leading to satisfaction and increased nutritional intake, key elements from this first category are briefly explained here.

The psycho-social determinants leading to patient satisfaction and increased intake imply a better understanding of the patients' value systems towards food, issues of trust and involvement, and cultural and spiritual influences. As patients' value systems towards food have not been studied before, the model used in this study (Figure 3.6) from Winter Falk et al. (1996) and Furst et al., (1996) illustrates an approach to food choices, but does not focus on a healthcare setting. This model shows that events and experiences over the life course are viewed as shaping current food choices. This is through the influences of an individual's ideals, personal factors, resources, social relationships and food context. According to the model, most relevant values people place in food choice decisions are health (physical well being), taste (sensory perceptions), cost (monetary considerations), convenience (time and effort),

and managing relationships (interpersonal interactions). This study aims to broaden our understanding of how patients negotiate values in personal food systems and how they solve value conflicts.

Environmental and situational variables (issues of timing, place of consumption, service components, reliability, ambiance, sound and light) are of importance when considering patient satisfaction and the perception of service quality. In consumer research, the study of the atmosphere surrounding the consumer-related place is well established (Stroebele and De Castro, 2004). However, it is not the aim of this study to focus on ambient influences on food intake and food choice in order to understand and modify eating behaviour.

The quality of the food and overall menu is a key element leading to patient satisfaction and increased nutritional intake. The food received on the ward must be in accordance with the order placed, have acceptable sensory attributes and overall quality, must be sufficient in quantity, nutritional value and choice and must have an appropriate temperature. Issues of presentation are of significant importance too. Various food production methods also lead to different satisfaction levels. At this stage, there is no unanimous agreement among caterers as to whether bulk or plated systems are better. More recently, a new combined steam-microwave system developed as in 2003 offers good potential to increase patients' satisfaction. However, this lacks proper empirical research to bring definite conclusions forward. Repeat presentation of the food leads to consumers disliking the products, and this issue of menu fatigue is frequently addressed by menu rotation, the introduction of celebrity dishes or the development of the flexi-menu project (BHF, 2004). Overall there is a clear relationship between variety, menu size and patient satisfaction (Stanga et al., 2003). It is not the aim of this study to investigate tangible aspects related to the food served, but patients' comments focusing on such aspects will be explored if relevant.

When considering the consumption of the meals, patients must be given sufficient time and assistance if required. The protected meal times must be respected and monitoring must be completed when the food is not consumed. Ideally the food offered should be customised according to the patients needs and wants and carried out with a positive attitude from staff. Allison (2003) stressed the importance of such a positive staff attitude in relation to malnutrition. Allison (2003) stated that a major cause of undernutrition in institutions is not the failure to provide food, but to deliver it in a manner appropriate to the particular customer. Supporting this observation, Bélanger and Dubé (1996) found that patients perceive and benefit from the emotional support that they receive from staff, and transfer this 'added

value' to their satisfaction judgements. Delivering such services implies a certain level of empowerment to accept responsibility for the service encounter and interpret and deliver the customer service required (Lashley, 2000). However, unfortunately, hospital food is prepared by people who have no direct relationship with those who are served (de Raeve, 1994). This study aims to analyse whether the NHS enables interaction between the staff groups who are involved in the food process, and whether this is in line with the patients' value systems as developed above. As outlined in the 'near environment' of the conceptual model, determinants of patient meal experiences provide a concise structure that will be used to better understand consumer food behaviour of this particular group. Within this environment patients are influenced by the various plans and strategies as outlined by 'government and society'. However, as outlined below, influences of the macro-environment impact upon strategic decision making of the former.

### ***3.5.1.3 The far environment (grey)***

Finally, the far environment includes factors that can neither be controlled nor influenced from within the NHS. This implies political, economical, social and technological factors (PEST). Elements from the far environment will influence the near environment, which in turn will provide guidelines to the managerial functioning of the internal environment.

### ***3.5.2 Implementation dyads and facilitators***

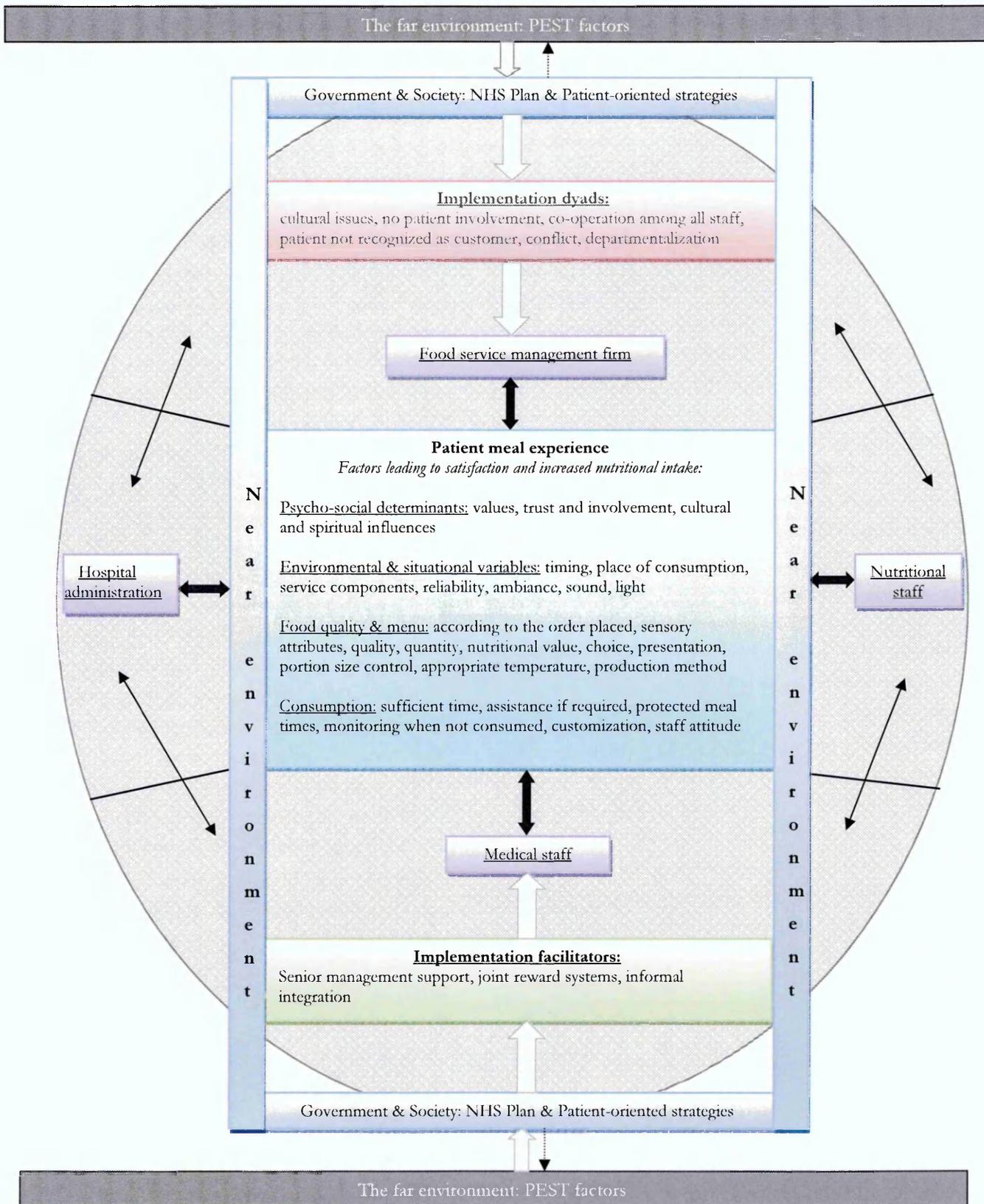
As outlined in figure 3.12, the implementation dyads and the implementation facilitators of patient oriented food services are elements that can, in theory, be largely controlled by the management. But one must be aware of the institutional nature of the NHS, whereby cultural and organisational issues are embedded and partly cautioned by official guidelines issued by the actors in the near environment (Government and Society).

The implementation dyads are the elements that cause the gap between patient oriented strategies as developed on governmental level and what is actually attained within the internal environment. In terms of the application of 'customer-centric' processes in the NHS, major impediments are cultural issues (Carr, 1992; Bolton, 2002), departmentalisation (Askham et al., 2002), lack of involvement from the patients, lack of co-operation amongst all staff groups (Melchior et al., 2003) and a failure by all

stakeholders to recognise the patient as the real 'customer'. As developed in chapter 3, the impediments proper to the NHS are also found in the general literature on marketing implementation dyads. However, the literature does not provide any cases where these impediments are contextualized to private food and service management firms. This is a gap the author aims to bridge in this study. Hwang et al. (1999) emphasised the need for more research into the communication between nursing staff, ward staff and the catering department, and the effects this communication has on the food intake of the patients. In this study, the scope of such research will be extended to encompass the whole patient meal service experience.

Naturally, implementation facilitators are components assumed to bridge the gap between the near and the internal environment. The conceptual model (Figure 3.12) combines the two stages of the present study. First the research will focus on the patient food experience. Second, this study will investigate how patients' requirements can be implemented by the various actors involved in the service process. The conceptual model (Figure 3.12) will enable the correct development of research tools in order to facilitate this research.

Figure 3.12 Conceptual model: patient food service experiences in the NHS



### 3.6 Conclusions and assumptions emerging from the literature review

Hospital food services have followed a major marketing trend in society, characterised by a shift from products towards services and the cautious development of relations not only between staff and patients, but also amongst staff members belonging to different staff categories. Consumerism in public policy and the healthcare sector in particular is a topical issue, sustained by various projects attempting to implement food service systems in healthcare whereby the patient is considered as the supreme customer instead of an ultra dependent patient. But although most companies or public institutions like the NHS confess to the marketing concept claiming they are customer-centric with customer needs and customer satisfaction as their prime goal, few seem to act that way. It is the aim of this study to analyse how a private food and service management firm has, in collaboration with NHS Hospitals across the UK, worked towards the implementation of (relationship) marketing strategies as developed by the NHS Estates. This study will analyse patient oriented services from the perspective of the network and relationship approach developed by the Nordic School of Marketing. This approach to relationship marketing emphasises that service marketing issues are intertwined with other business areas like human resources. In the literature, 'customer-centric' approaches based on service marketing and relationship marketing theories recognise that all individuals and all business processes should be focused on the customer in an ongoing value adding circle, with according changes in business processes and organisational culture reaching every part of an organisation. This approach, integrating the network and interaction concept, applies extremely well to chains of food production to consumption in hospitals, as these are complex and require the co-operation of all agencies involved. The NHS Estates have developed HR policies and strategies that are patient oriented and strongly rely on teamwork, cultural change and empowerment of front line staff and patients (Delivering the NHS improvement Plan: the workforce contribution, 2004). Even though the quality significance of the whole meal experience has been recognised in the literature, its implementation appears to suffer from various dyads that do not enable the NHS to implement its food service approach that should be in accordance with so called 'soft' factors that lead to patient satisfaction. Major impediments are identified as significant cultural issues, departmentalisation, lack of involvement from patients, lack of co-operation amongst all staff groups and a failure by all stakeholders to recognise the patient as the real 'customer'. The solution most frequently upheld to improve the implementation of marketing plans through HR lays in the use of internal marketing, considered to play a vital role in developing a

customer focused organisation and helping to ensure coherent relationship marketing (George 1990, Lings 1999). The literature review has been divided into two distinct phases. The first phase focuses on the literature about patients, while the second phase focuses on implementation impediments of patient oriented strategies across staff groups. The outcome of the literature of these two phases is briefly outlined below, as well as the ensuing propositions that will be investigated in this study.

### **A. The patient**

The food, the consumer and the situation have not yet been considered as an entirety when considering the specificities of an institutional environment. Little qualitative research has been conducted into the peripherals of food service operations in hospitals, focusing on the patient experience. The literature is quite rich in regards to food quality, but poor on psychological determinants, preferences and satisfaction of each patient group. This issue will need to be addressed if hospital food service is to fulfil both physiological and psychological requirements (Hartwell, 2004), key elements of 'patient-centric' meal experiences. The analysis of patients' internal processes has been completed from the perspective of the literature on relationship marketing as well as consumer food behaviour. Common elements between defining constructs of relationship marketing and psychological determinants related to food choice have been identified as trust, involvement and values. These determinants will serve as a guideline to conduct the research on patients in the acute NHS Hospitals under scrutiny. When focusing on patients, the research questions listed under 1.3 lead to a set of propositions that will be integrated in the interview schedule:

- Increasing the degree of involvement of patients in the food process leads to increased satisfaction. This assumption requires understanding the degree of involvement of patients in the food production and food service delivery process. Can we speak in marketing terms like 'value co-creation'?
- Developing relations between patients and staff members involved in the food process contributes to a better food experience. This raises the following questions, focusing on the customer's value generating process:
  - Are some patients more willing to accept a relational contact with a firm, whereas others may want to have a transactional contact?
  - Will patients in a relational mode be either in an active or passive relational mode?
  - Are patients who are more highly involved with food more sensitive to hedonic differences between similar samples?

- Understanding the patient's values and sharing these values with him will enhance the food service experience.
- Building up a relationship whereby trust is central is a key element in the development of positive food service experiences. This assumption implies developing an understanding of just who it is that patients do trust in regards to food services during their journey in hospital: nutritionists, doctors, nurses, non medical service personnel or their relatives?

### **B. The marketing - HR implementation dyads within a network of relationships**

The lack of literature on the marketing/HR dyad is quite surprising, as the integration of the HR and marketing functions is seen to represent the alignment of workforce capabilities within customer focused marketing strategies (Gratton, 1994; Piercy, 1997). A conceptual model developed by Chimhanzi (2004) and adapted to a healthcare environment by focusing on the interactions between catering and NHS staff is an interesting approach to analyse marketing/HR implementation dyads within the NHS. Companies in a network become dependent on one another's plans and therefore their resources and activities should ideally be co-planned. A potential solution to implementation of patient-centric strategies in the NHS comes from the literature on internal marketing within a network of relationships. But its implementation poses problems in the context of the NHS, knowing that lots of stakeholders with different priorities and core competencies are involved in creating valuable patient food experiences. This study aims to look at organisational factors that might improve interpersonal communication, ultimately leading to enhanced patient satisfaction. When focusing on the NHS and catering staff, the research questions listed under 1.3 lead to a set of propositions:

- Food and service management firms operating in acute NHS hospitals should be selective in their use of relational marketing and consider segmenting the market in a relational and a transactional market.
- The development of an interaction and network approach between medical and non medical staff is a prerequisite to enable a patient-centric food service experience.

# Chapter four: Research methodology

## 4.1 Introduction

Chapter one presented an overview of this thesis by defining the need for the present research. Chapter two discussed the context of food service operations in the NHS, with a special focus on private food and service management firms, working in a public context. Chapter three discussed the theoretical underpinnings, framework and justification for the present thesis. Using the constructs and variables emerging from the literature on (relationship) marketing, consumer food behaviour and human resources implementation dyads, it was possible to build research models (see figures 3.9 and 3.12). The purpose of this fourth chapter is to justify the research methodology and design used to complete this thesis.

As defined by Kerlinger (1986), the research design represents and articulates the researcher's plan. It also denotes the structure of investigation that will be followed when seeking answers to the research questions as stated above. Following the same logic, Yin (2003, p. 19) defines the research design as

*“The logic that links the data to be collected (and the conclusions to be drawn) to the initial questions of a study”.*

The research design in this study has been used to collect, analyse and work on the interpretation of the primary data. The questions addressing this study are of a contemporary nature. They focus on issues related to “how” to build a better understanding of the patients' food choices in a healthcare setting and the way the meal experience can be enhanced by involving front-line stakeholders involved in the food service process. Developing such an understanding requires the study must be conducted in a contextual setting - the hospital wards where patients experience the food service with various staff groups contributing to this experience. As a result of these two elements, the case study approach is the method of enquiry that best fits this research study. Yin's (2003) guidelines for conducting case studies include various critical components. Among these are a) the study's research questions, b) the research proposition, c) the units of analysis and d) the criteria for interpreting the findings. The research questions and units of analysis for the present research were introduced in chapter one and the research models were developed in chapter three. This chapter will emphasise the criteria for interpreting the findings.

## 4.2 Research design

The research method can not be determined arbitrarily, but needs to be guided by the research questions and the current state of knowledge reported in the literature (Morse, 1994; Janesick, 1994). Despite the growing importance of nutritional issues in the NHS, the literature covering so-called ‘soft’ service aspects is relatively limited and implies the use of more qualitative approaches. There appears to be no general development theory of food choices in acute NHS hospitals to serve as basis for interpretation. Qualitative approaches have widely been applied to managerial research in the NHS, but very little to consumer (patient) research within the same context. Developing a thorough understanding of the underlying reasons of these practices in the NHS is important, which will eventually pave the way for the use of quantitative approaches in future research. Developing this understanding was the aim of the present study, which was to develop an understanding of patients food choices in acute NHS hospitals where a private food and service management firm operates. The research will also focus on the processes required to enable the development of patient-centric service delivery. In order to achieve the aim above, the present chapter will focus on developing the tools required to fulfill the following research objectives:

- C. to identify the patients’ core psycho-social determinants leading to satisfactory food service experiences and investigate how these can be facilitated by the various stakeholders involved
- D. to examine how a major UK food and service management firm aligns its marketing strategy, human resources and competencies with patient-centric policies developed by the NHS Estates and serving as guidelines for the providing contractors (the NHS Trusts)

### 4.2.1 *Qualitative versus quantitative research on consumer service experiences*

The “Griffiths prescription” contained in the Griffiths Report (DHSS, 1983b) has been described by Hewison (2003) as the starting point for the introduction of managerialism in health care. The report was the first to advocate an explicitly ‘private sector’ model, paving the way to consumerism in public policy. This new model led to the development of a variety of qualitative research methods for research conducted in the NHS (Hewison, 2003). Extensive and relevant use has been made of the case study methodology in NHS management research (see Dopson and Waddington, 1996), providing interesting insights in complex social structures.

The aims, objectives as well as the assumptions in this study are definitely in the qualitative tradition of exploring the thoughts, beliefs and feelings of respondents (Strauss and Corbin, 1991), rather than trying to conduct measurement and establish causal relationships between phenomena. But the rather qualitative approach to management research used in the NHS is quite opposite to the approach developed to research consumer service experiences within the NHS. In this regard, Lehr and Strosberg (1996) stated that looking into patient satisfaction is only possible by obtaining feedback from the patients themselves, through the development of measurement scales. Most of these scales are straightforward satisfaction measures, placed in questionnaires completed by patients. The use of surveys in regards to public attitudes and values has expanded significantly over the past decade. A reservation regarding patient satisfaction surveys is the reluctance of many patients in the NHS to express critical comments, with typically at least 80% of respondents expressing satisfaction for any given question (Avis et al., 1995). In this regard, individual satisfaction scores issued from questionnaires are sometimes belied by the patients' qualitative descriptions of their experiences. The notion of the 'patient role' is significant in this regard, and the current trends towards consumerism and increased patient participation in their care might modify the manner patients reach an evaluation of their satisfaction.

Looking at consumer research from a marketing perspective, it is important to place the patient at the heart of all care business processes. We might question whether the traditional marketing approach to research (essentially based on quantitative research through questionnaires and quite similar to what is being done with NHS patients in this regard) is able to voice the thoughts, needs and wants of patients? This is further emphasised by Walsh (1994), who mentioned there is still a long way to go (and much to learn) in the use of qualitative techniques. The present research aims to bridge this gap. Another objective relates to the observation from Hwang et al. (1999) who noted that much of the previous research into hospital catering has concerned continuing care wards (Fenton et al., 1995; O'Hara et al., 1997), with the result that acute care has received little attention. This situation, according to Hwang et al. (1999) leads to propose two dangers:

*"Hospital managers have to cope with pressures, the nature of which they do not understand, and market is not understood" (Harrison, 1996, p. 202).*

Service quality in hospital care is difficult to define and rather intangible to measure (Hwang et al., 2003). Hwang et al. (2003) has highlighted deficiencies in understanding the quality of health care, with critical insights into so-called 'standardised approaches' to patient satisfaction survey research, a lack of

clarity and consistency in understanding the determinants of patient satisfaction, a lack of an accepted conceptual or theoretical model of the patient process, and a lack of consensus within the medical profession on the role that patient satisfaction should play in the assessment of quality of care (Aharony and Strasser, 1993, p. 50). Further research into hospital food service operations is thus deemed necessary, especially regarding patient residing in acute hospitals. More importantly, little research has been conducted on 'soft' factors related to food service operations in acute NHS hospitals, where private food and service management firms operate. Interestingly, the work of Donelan (2000) has focused on the relationship between dietitians and caterers from a grounded theory perspective. Qualitative in-depth interviews were used in order to account for the values, ideals and beliefs brought to practice by caterers and dietitians. The extensive existing body of knowledge on nutritional behaviour in healthcare does not allow for the use of grounded theory, but this study will rely on qualitative techniques enabling an in-depth understanding of patients and food service staff beliefs and values.

A key author that has influenced the research design in this study is Koster (2003), who outlined various fallacies frequently encountered in the sensory (food) science and inherent to the use of quantitative approaches. These fallacies are briefly summarised below. Firstly, consumer uniformity assumes that all subjects in an experiment are comparable and new scaling methods are advocated because they greatly reduce individual variability. The assumption that patients have expectations compatible with each other has further been questioned in the literature (Avis, 1992; Avis et al., 1995). The aim in the present study is to analyse further the variables currently used to determine food choice determinants leading to consumer satisfaction in a healthcare setting.

Secondly, consumer consistencies, based on the implicit idea that people do not change. However, changes in preference and choice do take place, which casts serious doubts on the predictive validity of consumer studies that rely on single measurement sessions (Koster, 2003). Thirdly, conscious choice is based on the implicit idea that people are 'reasonable' and make rational choices. The last factor developed by Koster (2003) relates to perceptual fallacy and forgetting memory. Almost all sensory and consumer research is based exclusively on perception and the role of memory in food choice is systematically forgotten. This study will look at the eventual role of memories and their influence on food service experiences. It is proposed that a more qualitative and interpretive approach will be used in the research. This will allow the development of a deeper understanding of consumers' food choices and their general attitude towards hospital food in acute NHS hospitals, hopefully leading to improvements in regards to food services that are fully grounded in patients' expressed values and aspirations.

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Looking at the dichotomy between qualitative versus quantitative research in the field of marketing, it is noticeable to see that paradigms of quantification and positivism directing marketing research have brought up questions for a couple of decades. As it is the case for consumer research in the NHS, marketing research has been mainly quantitative. However, consumer behaviour and research techniques are progressively moving towards more interpretive perspectives. This is consistent with the approach of the Nordic School of Marketing, who stated that asking the customer (particularly through structured questionnaires) only reveals a superficial layer of attitudes and behaviour, not the roots.

The present exploratory study is a necessary first step in understanding a complex phenomenon. The discussion in chapter three illustrates the literary void regarding 'soft' factors in terms of the way patients experience food service operations in acute NHS hospitals where food is produced and sometimes delivered by private food and service management firms. Consequently, the present research uses exploratory techniques associated with qualitative research, which is aimed at quality and depth of evidence, rather than coverage.

#### **4.2.2 *The coexistence of quantitative and qualitative methods***

There is a great debate regarding the scientific rigour, contributions and differences between so-called quantitative and qualitative research (Kerlinger, 1986; Denzin and Lincoln, 1994; Yin, 2003). As the researcher needs to establish themes, recurring patterns and categories from the data based on his experience and global understanding, the evaluation of qualitative data is considered to be more subjective than with quantitative data. The results from quantitative approaches are said to have greater validity, generalisability and replicability, leading to more significant theoretical contributions.

Going even further, various authors argue that scientific maturity in a specific field can only be achieved through empirical quantification (Guba and Lincoln, 1994). Guba and Lincoln (1994) stressed how quantitative methods are often synonymous of 'hard science', whilst qualitative methods pertain to 'soft sciences'. According to Yin (2003), qualitative research represents the weaker sibling. This stereotyping has led to a situation whereby qualitative research is often considered as an inferior manner of practicing science. In order to overcome resistance to acceptability of the qualitative approach used in this study, a number of empirical materials are used (interviews, focus groups, documents and to some extent observations) in an attempt to interpret phenomena in terms of the meanings people bring to them (Denzin and Lincoln, 1994, p. 2). Using multiple methods, empirical

materials and participants in a single study, the aim is to develop rigour, richness (though in-depth analysis and broad scope), and triangulation. According to Morse (1994), the resulting product provides a more holistic view and understanding of the phenomenon at hand.

But the amount of criticism towards quantitative techniques has grown over the past decades (Guba and Lincoln, 1994; Weick, 1989, 1995). Very specific quantitative techniques often miss other relevant variables or lines of inquiry, not discussing meanings from the context in which the observations were taken. But there is a growing realisation that both qualitative and quantitative research methods can coexist and complement each other throughout the research process. The foundation of this study leans on a rather quantitative approach when considering the research undertaken up till now, focusing predominantly on nutritional intake. But when looking at patient value systems within a 'holistic' perspective focusing on the entire patient food service experience, this quantitative foundations needs to be developed further with a more qualitative approach that is likely to enable an in-depth understanding of patients' processes. A case study approach seems to be most appropriate to conduct this research, as developed further below.

### **4.3 The case study methodology**

#### ***4.3.1 Theoretical framework of case study research***

From the start of this study, the aim was to develop field-based research that could provide both academic and 'implementable' output. Working in the field, in collaboration with private and public partners has much to offer the research community, by way of teachings from the trials and tribulations that are encountered every day by those in the field. As case studies do blend inductive and deductive thinking, this approach offers the potential of introducing novel concepts and paradigms, which are essential to the advancement of theory (Eisenhardt, 1989). The purpose of case study research is usually systemic and holistic, to give a full and rich account of a network of relationships between a host of events and factors. As a network view has also been reflected in a broadened approach to relationship marketing (Gummesson, 2003) within the Nordic School of Marketing and case studies have been used to eludate the complex nature of hospital food service (Hartwell et al., 2006), the author has opted for a

case study approach to conduct the data collection phase. The NHS doesn't exist in isolation as an organisation, as it is part of a large and complex network of patients, service users, suppliers, competitors and regulators. This is in line with Yin's (2003, p. 13) definition, whereby he defines a case study as:

*“An empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident.”*

Ideally, a complete case study should include all stakeholders involved in the food service process (medical staff, hospital managers, pharmaceutical staff, food service staff, dietitians, patients and their visitors as well as eventual guardians) in order to obtain a holistic view on factors leading to patient's satisfaction. However, because of time and financial constraints it was not possible to involve all these stakeholders in this study. The focus was on patients and their guardians, as well as front-line NHS staff and staff of the private food service management firm producing the food and sometimes delivering it to the patients. This approach is adequate to examine social phenomena, relationships and causal powers between the various NHS-stakeholders (also implying the patients) in order to understand the existing structures that determine their behavioural patterns. The use of qualitative tools and the important contextual variables impinging on the behaviour of patients and stakeholders are of interest throughout this study.

In terms of methods used, the author aims to analyse both unobservable structures and social/practical issues that stakeholder's experience. The case study method is a multi-methodological approach that provides various tools, enabling the author to establish theoretical inference with the elements that have emerged from the literature review. Furthermore, the case study methodology is suitable to fulfil the research objectives, because it is an empirical enquiry whereby:

- 'how' and 'why' questions will be asked to identify operational links, rather than mere frequencies of incidence. In this regard the author will conduct it through an intense and/or prolonged contact with the 'field' or life situations, gaining a holistic view of the context under study;

- as investigator, the author will have little or no control over the events. We can't and do not want to manipulate behaviour directly, precisely and systematically (Yin, 2003). The author will capture data, essentially on the perceptions of local actors from the 'inside' and essentially based on words.

The case study will allow an in-depth empirical investigation of the nature of and relationship between, customer-oriented service initiatives in the field and the intentions developed in the NHS Plan. In line with the critical realist position, no methodology will be considered as epistemically superior to any other (Johnson and Duberley, 2004).

#### **4.3.2      *The number of cases: choosing a multiple case study***

As this study involves multiple cases to study the phenomenon of food service experiences in acute NHS hospitals working with a private food and service management firm, it will provide more robust insights than a single-case study. Each case (hospital) under scrutiny in this research can be viewed and studied alone, following a within-case analysis. The author has then conducted a cross-case analysis, whereby comparisons and contrasts, which provide richer details and insights regarding the subject matter under investigation, are used (Eisenhardt, 1989; Stake, 1994). This cross-case comparison allows the author to observe common patterns and differences from one case to the next. The number of cases deemed necessary for this study could not be determined using sampling logic as is done in survey and experimental research (Eisenhardt, 1989; Yin, 2003). Five cases were chosen by the author because of the relevance to the research questions posed. Since all cases in this research come from a healthcare context where the same private food and service management firm is operating and all cases are subject to and are faced with (fairly) similar external issues and constraints, the cases are deemed sufficient and appropriate to compare and contrast findings and establish replication (Yin, 2003). After consultation with the food and service management firm collaborating with the study, the decision was made that the cases should be deliberately selected. All cases are exemplary by nature (because of the characteristics of the hospital under scrutiny or because of the food production method used), making a significant contribution to the study. Yin (2003) repeatedly stresses that multiple cases should be treated in the same manner as a scientist would treat multiple experiments, with the intent to follow replication logic. Regardless of the criteria used to select the cases, these must support literal (predict similar results) as well as theoretical (producing contrasting results under predictable circumstances) replication (Yin, 2003, p. 47).

With regard to the interviews, Perry (1998) suggests a PhD thesis requires about 35 to 50 interviews, with approximately three interviews at different levels (in this case the patients, front-line staff from the food and service management firm and NHS staff working in each hospital). Looking at replication between cases (whether this be literal or theoretical), a strong framework is of paramount importance. Proposition that clearly articulates the conditions or context where we find particular phenomenon provides a basis for literal replication. Whereas proposition that state when the phenomenon is likely not to occur or be found, provides a source of theoretical replication (Yin, 2003). Results in contradiction with the proposition require modifying these propositions or even the theory itself.

### **4.3.3      *Limitations of the case study method***

Yin (2003) described four shortcomings associated with the case study method: perceived lack of rigor, subjectivity, little basis for scientific generalisation and finally time-consuming efforts. Right from the start of this research, the author intended to overcome the 'limited lack of rigor' by developing well-documented research questions. This was in order to reduce the chance to shift the theoretical concerns of the study along the process. In terms of overcoming possible subjectivity along the data collection phase, the author has tried to detach himself from special interests of organised groups. This in order to gain, as much as it is possible, an objective understanding of the phenomenon under investigation. This is a major issue that the author had to deal with, especially as the facilitation of the study is by a private food and service management firm that seeks its own interests in the project. Triangulation (interviews, focus groups, secondary data and company documents), multiple participants within each case who come from different horizons, and multiple cases (for replication) addresses the subjectivity of the study. Combined, these methods build robustness and add to the study's overall credibility (Kerlinger, 1986; Yin, 2003). Finally, maintaining short site visits allowed the author to maintain a fresh, objective perspective without getting involved as part of the setting of the daily business operations (Morse, 1994). In terms of generalisation of the findings, it must be said that, in the words of Stake (1994, p. 245),

*"The purpose of case study is not to represent the world, but to represent the case."*

Yin (2003) stated that multiple-case studies could provide sources of replication. One must remember too, that the role of exploratory/descriptive case studies is not generalisations but rather

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understandability, and any generalising that takes place is in reference to the theoretical propositions, not to a population (Stake, 1994; Yin, 2003). The conclusions of this type of research are only suggestive. Replication will be achieved in this research, if according to Yin (2003), the findings of two or more cases converge and support the same theory. The author admits that gathering of the data and necessary authorisations from the NHS Research Ethics Committee as well as from the Trusts' R&D Departments has slowed down the pace of the research considerably. In addition to the amount of legal paperwork required to gain access to the various sites, depending on the different Trusts and each of them having specific R&D regulations, it proved difficult and often impossible to complete all interviews with patients in one single site visit. The same also applied to the scheduling of separate focus group sessions with NHS and catering staff across hospitals.

#### 4.3.4 *The research process*

According to Yin's (2003) guidelines, the author has conducted the research following a predefined set of procedures using a fixed research plan and executed these procedures in a systematic manner. These procedures are shown in Table 4.1.

**Table 4.1 The research process**

Step	Step of the process	Action from the author	Date
1	Define research topics and question of interest	Open discussion with tutors Sheffield Hallam University (SHU)	June 04
2	Conduct preliminary literature review and create initial research questions	Submitted to tutors SHU	July - Aug 04
3	Application for approval of research programme to the SHU Graduate Studies Team	Submission and approval of the RF1 document within SHU by the student supervisory team	Sept 04
4	Complete detailed literature review: NHS, marketing, HR/mkt, implementation problems, food choices Formalise research questions Define constructs, variables and measures Develop a research model Define and document research design and methodological choice Develop data collection instruments, guides and table shells. Nvivo software for data analysis	Completion of the literature review and RF2 transfer paper (application for confirmation of PhD registration) Training NVivo2 within SHU	Oct 04 Nov 05
5	Determine the units of analysis	Discussions with a major private food and service management firm to gain access to the 5 hospitals	Dec - Jan 05

Step	Step of the process	Action from the author	Date
6	Conduct independent review by panel of experts (all activities up to date and exploratory research)  Academic qualification in research methods	Presentation and oral defence of the research (RF2 paper) to an independent panel within SHU Approval of application for confirmation of PhD registration by the Research degrees Sub-Committee within SHU Present research project to HCA (Hospital Catering Association) management Intention of a MA. in social sciences research methods within Sheffield Hallam University	Dec 05 Feb 06 Dec 05 Oct 05
7	Select cases and gain entry into the field through: <ul style="list-style-type: none"> <li>▫ Ethical review COREC (Central Office Research Ethics Committee)</li> <li>▫ Ethical review SHU</li> <li>▫ R&amp;D approval from each Trust</li> <li>▫ Obtention honorary contracts from each Trust</li> <li>▫ Access to ward level from each hospital under investigation</li> <li>▫ Standard disclosure certificate to gain access to NHS facilities and personnel</li> </ul>	Application for ethical review to the Nottingham Research Ethics Committee Application to R&D departments of each Trust and obtain of all honorary contracts required, issues by three NHS Trusts Contact ward managers, obtain written approval to access the wards and patients Application and obtain standard disclosure Submission for ethical review SHU	Jan 06 July 06 April – June 06 May 2006 Jan 06
8	Cooperation from the private food and service management firm in each of the 5 hospitals under scrutiny	Signing of 5 cooperation agreements between SHU and the catering managers working in each hospital for the private food and service management company	May 06
9	Conduct independent review by the external assessor	Submission and defence of the research to the Nottingham Research Ethics Committee Obtained a favourable ethical opinion from COREC	Feb 2006 30 June 06
10	Conduct first (pilot) case	Hospital C, paediatric ward: patient interview	Aug 06
11	Report initial findings to the director of studies and supervisors	Formal discussions within SHU, with director of studies and supervisor	Oct 06
12	Make modifications to the research design	Added one hospital (hospital D) to the number of cases, on request of the hospital management	Oct 06
13	Execute further case studies	Data collection phase 1 and 2 + documentary information	Oct 06 – July 07
14	Write individual case study reports	Within case analysis of all hospitals, using NVivo2 software	Aug 07 – Oct 07
15	Invite key informant review (with the food and service management firm)	Regular meetings with Board members of the food and service management firm	Continued
16	Conduct single and cross-case analysis	Report to Director of Studies	Oct 07 –
17	Fine-tune theory and adapt theoretical propositions	Meeting with Board members private comp	August 08
18	Determine policy implications	Review latest DoH documents and publications	Sept 08 – Nov 08
19	Prepare case study report	Report to first and second supervisor, layout and prints	
20	Submit and present the final report	Submission to the Graduate Office within SHU	Dec 08 – March 09

Sources: adapted from Eisenhardt (1989, p. 533), Morse (1994) and Yin (2003, p. 50)

### *4.3.5 Analytical process and pilot study*

The case study will be primarily deductive, used to confront existing theory (as developed in chapter three) with reality and test validity. This will lead to a mode of analytical generalisation in the analysis phase, as various anterior theoretical models are used as a template in the research. The author will work within a framework of interactive research, going from pre-understanding (using the literature review and all models developed above), to understanding, to a new level of pre-understanding, and so on. This is in order to strike a balance between the deductive and the inductive; to become more inductive and open to reality and practice, and less deductive and committed to approved theory or research techniques. In this regard, Perry (1998) also pointed out that the position of realism is one of relative emphasis, whereby the case study research includes some deduction based on prior theory. The first real test lies in the assumptions established for the patients, based on the literature on food choice and relationship marketing. If the patients also consider trust, involvement and personal values as key elements for a patient-oriented service, in line with the literature of relationship marketing and service marketing, it is possible to go further on this basis alone.

However, if other factors arise and are generalisable, then there would be a much more inductive approach to further build and develop the concepts and propositions. Miles and Huberman (1994) also advise for early steps in the analysis, as it allows interweaving data collection and analysis from the start. Following suggestions from Janesick (1994) and Yin (2003), a small scale pilot study also was used as a participating case. However, conducting a pilot study by collecting and analysing data from various sources (patient interviews, catering and NHS staff focus groups, documents) from one hospital was hindered by the chronology used in the research design. The research was chronologically divided in two phases, as developed in section 4.4.

## 4.4 Data gathering

### 4.4.1 *Phases of the research and sources of information*

The research design comprises of two phases. The initial phase focuses on patients, with semi-structured interviews conducted on several wards across the five hospitals collaborating with the research. The second phase investigates how (private) catering and NHS staff interact to fulfil the needs and wants of patients as identified in phase one. Separate focus groups have been conducted with staff groups in each hospital under investigation. Finally, documentary information within is obtained in order to complement the primary data sources.

#### 4.4.1.1 *Phase 1: patient interviews*

In phase 1, the research focused on the patient's perception of the hospital food experience. The aim was to determine whether common elements between the defining constructs of relationship marketing and the psycho-social determinants related to food choices, do apply in a hospital setting in regards to food services. The research questions relating to patients are:

- 1) how do patients in acute NHS hospitals experience food services delivered by a private food and service management firm?
- 2) can patient profiles be developed, relating to specific patterns of food acceptability, choice and satisfaction?
- 3) can common defining constructs of relationship marketing and consumer food behaviour possibly serve as a foundation to underpin the development of patient-centric approaches to food services in acute NHS hospitals?
- 4) is a personalized food service experience focusing on the development of relationships between patients and medical or non-medical staff likely to achieve increased satisfaction levels, eventually leading to a shift of attitude towards hospital food services?

In order to answer these research questions, semi-structured interviews were conducted with 35 patients across five hospitals. Only 31 semi-structured interviews were useful to the research, as four interviews could not be used because of low quality of the tape recording or...the author pushing on the wrong recording button! The semi-structured interviews allowed some structure and guidance

(through predefined questions) to keep the researcher focused. They also enabled flexibility to pursue divergent evidence or other interesting and related issues, not previously considered in the research design. These interviews were essentially conducted as conversations with the patients. Interviews were supplemented by the collection of secondary data, including customer satisfaction surveys, and were conducted face-to face and one-to-one (apart from the interviews conducted on the paediatric ward in hospital C where the presence of a parent or guardian was an obligation imposed by the Research Ethics Committee). Interviews lasted between 30 minutes and one hour. The recording and developing took place in accordance with the pyramid model as defined by Wengraf (2001) using qualitative research interviewing.

The semi-structured interview included open-ended questions about current and past food and eating practices, changes in dietary behaviour, and beliefs and attitudes towards food. Direct questions about values were not asked to interviewees, but the author was looking for description and explanations of their eating behaviour that might include references to underlying motivations. A summary of the interview questions is in Table 4.2. For a complete listing of the interview questions as used in the study and the development from central research questions up to interview questions (according to Wengraf, 2001), see Appendix A. The interview schedule used during the data collection phase with patients is to be found as Appendix B.

**Table 4.2 Summary interview questions**

Topic	Theme of interviews
Interview participant	Information regarding age, job, income, length of stay on the ward, frequency of stays in hospital, food preferences, basic demographic information, education, religion, vegetarianism, food allergies
General info about the hospital (not asked to patient)	Name, type of ward, staff group delivering food to patients, food system in use in the hospital
Involvement	<p><b>Involvement, communication and interaction</b></p> <ul style="list-style-type: none"> <li>▫ Discussions about food with different staff groups on the ward</li> <li>▫ Time spent on the ward and type of relationships developed with different staff groups</li> <li>▫ Flexibility and cooperation of various staff groups in meeting patient' demands</li> </ul> <p><b>Involvement and satisfaction</b></p> <ul style="list-style-type: none"> <li>▫ Food behaviour at home, looking at the degree of patient involvement with food</li> <li>▫ Importance of hospital food to the patient</li> <li>▫ Interest in receiving information about the food when admitted on the ward</li> </ul>
Values	<p><b>Relation between food choice, food intake and satisfaction</b></p> <ul style="list-style-type: none"> <li>▫ Type of food picked from the hospital menu and underlying reasons</li> <li>▫ Eventual preference to have food brought in from outside the ward by friends/relatives</li> <li>▫ Comments on the food experience</li> </ul> <p><b>Life course events and food choices</b></p> <ul style="list-style-type: none"> <li>▫ Eventual changes in what is usually considered as ideal food (influence of hospital stay on food choices)</li> <li>▫ Discussions about hospital food with friends and relatives, their influence on the patients food consumer behaviour</li> <li>▫ Preferred location of consumption when admitted in hospital</li> </ul> <p><b>Categorisation of food</b></p> <ul style="list-style-type: none"> <li>▫ Influence of staff, friends and other patients on actual food choices</li> <li>▫ Food behaviour once dismissed from the ward</li> <li>▫ Expectation towards hospital food</li> <li>▫ Food choice strategies</li> <li>▫ Eventual purchases of food in hospital restaurant or shops</li> </ul> <p><b>Patient values</b></p> <ul style="list-style-type: none"> <li>▫ Importance of one single contact person in charge of food issues</li> </ul>
Trust	<p><b>Trust and satisfaction</b></p> <ul style="list-style-type: none"> <li>▫ Contacts (and eventual trust) with various staff groups involved in the food service process</li> <li>▫ Length of stay and contacts with the different staff groups involved in the food process</li> <li>▫ Eventual promises made by staff in regards to food issues</li> </ul>
Food	Texture, presentation, quantities, diversity, temperature, issues with catering food, convenience, patient suggestions, worries about the production method, availability of the food, comments on the meal experience, freshness, comments on the food and service management company, comments on the steam system

The interviews had flexibility, adaptability to individual situations, interactions (which allows to clarify points and probing discussion) and the ability to obtain a wealth of information (Kerlinger, 1986). The richness provided by each interview for this research is well worth the investment in time that this technique requires. However, some inherent weaknesses of interviews, as developed by Yin (2003), include response bias, inaccuracies due to poor recall, reflexivity (i.e. the interviewee says what he or she thinks the researcher wants to hear) and bias due to the questions used and how they are constructed. The author also faced significant problems in obtaining the documents required from the private food and service management firm. Nevertheless, by using multiple sources of evidence, the author has considerably reduced these limitations by establishing triangulation (covering key themes from the perspective of patients, NHS staff and catering staff). This study also took precautions by consulting experts in the field to review interview questions, by using the first interviews as a pilot test and by signing confidentiality agreements with various respondents in order to gain access to documents and proprietary information.

#### ***4.4.1.2 Phase 2: separate focus groups with NHS and catering staff***

This phase focused on two research lines of enquiry.

1. the way the determinants of consumer-oriented food service experiences identified in phase 1 of the research are perceived and eventually implemented by front-line NHS and catering staff working in each hospital;
2. the marketing/HR implementation problems as identified in the literature, relating to issues of cost, departmentalisation, lack of patient involvement, lack of cooperation among staff members and culture.

These factors served as the basic template for the research conducted in phase 2, and relate to research question 5 that is written below for convenience of the reader:

5. do private food and service management staff and NHS staff interact in a way that enable the needs and wants of the patients to be fulfilled?

The focus groups conducted, were with staff members working on the wards where patients were interviewed along with staff from other wards. Structural relations were explored through separate focus groups conducted with catering and front-line NHS staff. The same focus group schedule was used for both catering and NHS front-line staff involved in the food service process and was much more unstructured than the one used for the patient interviews. The idea was to stimulate an open

discussion with both front-line staff groups, by proposing six key themes and adding elements integrated from the patient interviews in the ongoing discussion. Even though the use of such qualitative approach raises the issue of subjectivity from the researcher in preparing, collecting and analysing the data, the use of different focus groups hoped to demonstrate convergent results leading to greater confidence in the findings (May and Askham, 2005). Participants to the focus groups from the private food and service management firm were recruited by the firm within each hospital, following contacts between the author and the hospital manager (from the private food and service management firm) within each hospital. Focus groups represent a cost-effective way of gathering data, different from group interviews as the researcher's role is to facilitate discussion amongst a group of participants sharing some common interest (May et al., 2006). This approach is different than simply asking questions at a group similar to what would be done with an individual structured or semi-structured interview. As such, a focus group approach appeared to be the most appropriate data collection method given the need to facilitate discussion and gather in-depth information of participants' views. The themes are outlined in Table 4.3 below, and a complete listing of the focus group schedules used in this study is to be found in Appendix C (NHS staff) and Appendix D (staff from the private food and service management firm).

**Table 4.3 Themes of the focus group sessions with the NHS and catering staff**

Theme	
A	Please discuss: <i>"There is a consensus that the BHF (Better Hospital Food) targets have been achieved. Now the programme must move towards nutritional outcomes and improvements in food delivery to enhance the patient meal experience. We must move more towards a guest-host relationship with our patients, to give an extra comfort factor that will improve outcomes".</i> Graham Walker (England representative of the BHF, 2004)
B	What does a good 'patient meal experience' mean to you?
C	Are patients currently regarded as customers?
D	Do you consider the patient is sufficiently involved in the food service process?
E	Who should be in charge of the food within the hospital? <ul style="list-style-type: none"> <li>▫ for delivery on the ward</li> <li>▫ for delivery to the patients</li> </ul>
F	How would you describe your cooperation with (name of the food and service management firm)?

#### 4.4.1.3 Documentary information

Finally, various documents were collected in this study. But little use was made of these because not all documents could be collected in every hospital: patients menus, order forms, flow charts from the food and service management firm employees and the outcome of food satisfaction surveys whenever possible (secondary data that will be treated as a primary data source). The collection of these rather quantitative elements was considered as a way of combining both quantitative and qualitative data, as preferred by various authors in the literature and often referred to as triangulation (Miles and Huberman, 1994; Yin, 2003). Put within the critical realist approach holding that there is an external reality (Tsoukas, 1989); the complexity of that reality and the limitations of a researcher's mental capacity makes triangulation of data essential to refine fallible observations of that reality. Table 4.4 provides an overview of the data requested by the author across hospitals involved in this study.

**Table 4.4 Documentation collection guide for secondary sources of information**

Category/Area	Document	Hosp A	Hosp B	Hosp C	Hosp D	Hosp E
Strategic	Business Plan					
	Company mission statement					
	Critical success factors					
Financial	Annual report					
	Budgetary policies and guidelines					
Operational	Technology analysis/evaluation criteria					
	Training matrix catering					
	Policies and procedures staff awareness					
	Customer comment card					
	'Be a star' nomination					
Administrative	Organisational charts					
	Job descriptions front-line staff					
	Copy of a job chat report					
	Company (hospital) policies					
	Meeting agendas and minutes to meetings: notes from departmental managers meetings, staff quarterly meeting					
	Documents related to customer care					
	Patient satisfaction interviews: survey copy and key figures					
	Catering service level specification					
	Catering services level agreement					
	Press releases					
Internet	Company web page					
Secondary sources	Articles in the trade press and news media					

#### 4.4.2 *Gaining access to the field and ethical considerations*

All research carried out in a U.K. healthcare environment must satisfy set ethical standards. Some of these ethical principles do inform participants of the nature of the research, as well as the possible risks and benefits and not exposing them to unacceptable risk (World Medical Association, 2000; Miser, 2005). The ethics of research have developed over the last fifty years. The Declaration of Helsinki is the universally accepted code of conduct for researchers worldwide (Miser, 2005). In the U.K., a centralised ethics committee called COREC (Central Office for Research Ethics Committees) approves all research projects. Initially, some Local Research Ethics Committees were set up in the UK in 1966 (Ferguson, 2001) before expanding as from 1967 following a proposal from the Royal College of Physicians that each hospital should have one. As only the individual can give consent to participate in a research project, this may produce difficulties in cases of unconscious patients and children. This last group has been integrated in the present research (paediatric ward, hospital C), and required going through rather stringent ethical review procedures.

COREC, operating on behalf of the Department of Health in England co-ordinates local and multi-centre Research Ethics Committees (LRECs and MRECs). The National Research Ethics Service (NRES) were established on 1st April 2007 to replace the former Central Office of Research Ethics Committees (COREC). But within this study, the author still dealt with COREC as ethical approval was granted in 2006. The Research Ethics Committee meeting held on 27 February 2006 and attended by the author, resulted in the issuing of a provisional favourable ethical opinion. COREC issued a final clearance in May 2006. Formal R&D approval from the three Trusts involved in the research process were consequently obtained. Then contact was made with ward managers or hospital managers in order to gain access to the wards. To be included in the research, the ward had to be of critical importance for the hospitals and the food and service management firm (in terms of volume and strategic role). Contacts were first made over the phone, after which a letter of introduction containing an overview and summary of the research and its objectives was sent by post to the person designated as the primary contact within each hospital (usually the ward manager). A copy of this letter is added to this study as Appendix J. Upon arrival on the wards and in regard to the selection of patients, consultation with the ward managers determined which patients would be suitable under these criteria: co-operative and capable of answering questions. Patients with mental or physical problems or with intravenous feeding were not included. After submission of an information sheet describing the aims and objectives

of the research, a consent form was then submitted to the patients (Appendix L). On most wards, a nurse introduced the author to potential participants.

The selection of the focus group participants with NHS staff was carried out by the ward managers, and these persons facilitated a suitable appointment to conduct the focus group session. Ethical approval was further obtained from the Ethics Committee of the Faculty of Organisation and Management within Sheffield Hallam University in June 2006, together with the COREC approval. Furthermore, an investigator Site File was submitted to and accepted by the Sheffield Health and Social Research Consortium in July 2007. The contents of the Site File serve to demonstrate the compliance of the author to the requirements of the Research Governance Framework for Health and Social Care and to standards of Good Clinical Practice. Guidance is based closely on that provided by Sheffield Teaching Hospitals NHS Trust.

## **4.5 Theory production and development: phases of data analysis**

### **4.5.1 *Data analysis patient interviews***

#### **4.5.1.1 *Within case analysis***

The data analysis stage consists of three processes: data reduction, data display and conclusion drawing and verification (Miles and Huberman, 1994). After the stage of data reduction and the development of themes and categories using the NVivo(2) software, key answers have been summarised hospital by hospital and explained in a continuous text. Many quotes have been used to support the findings. Raw narrative have indeed been included throughout the discussion in order to ensure authenticity (Hartwell et al., 2006). Using a multiple-case study approach, the author intends to use a fully developed within-case analysis for all patient interviews. This is an important process, due to the amount of data collected from each separate case, which could otherwise overwhelm the researcher (Eisenhardt, 1989). In addition, detailed reports from patient interviews conducted on each ward were completed progressively. With this approach, the research aims to identify patterns for each individual case, and then compare these to the other cases during the cross-case analysis.

When there was a significant difference in the answers from the patients residing on two different wards in one same hospital, the data was analysed separately. This was only required for the analysis of

hospital C, where the paediatric ward showed patterns distinct from what emerged from the surgical ward. The author has merged deductive (structured framework of the interview) and inductive (emerging themes) analysis by developing themes, patterns and categories from the data, by locating key phrases or statements that speak to the phenomenon in question (Janesick, 1994). In accordance with Yin (2003, p. 116), the author intends to use pattern matching and explanation building as key data analysis techniques. Pattern matching involves the mapping of observed patterns with predicted or theoretical patterns. Internal validity is enhanced by making matches.

### **Pilot case**

The first two interviews with patients (hospital A) were used as pilot cases in this study. At the end of the interviews, patients were asked about the questions posed. No significant changes were made to the interview schedule.

For the very first within-case analysis (hospital A), the author has briefly listed relevant comments and quotes from patients, which relate to the various subject categories outlined in Table 4.2. Key information was then placed in a nested table to provide a clear, comparative overview of the output (see Table 4.5). Table 4.5 provides an example of how question responses were recorded and summarised for each patient interviewed in hospital A (with seven patients interviewed in that particular hospital). It is important to specify the initial manner of coding was derived from the structure outlined in the interview schedule for patients (Appendix A) and developed according to the model of Wengraf (2001). This model enabled the author to direct the interview questions and organise the coding pattern. Initially the author wanted to use automated coding, as the interview schedule was rather well structured. But as from the very first interview conducted in hospital A, this way of coding proved not to be applicable as patients answered in a very 'unstructured' manner, forcing the author to constantly navigate between questions, and be open and flexible in order not to omit valuable information provided by the interviewees. The coding pattern for patients finally developed (Table 4.5) has 4 main categories (involvement, value, trust and characteristics of hospital food) and 40 sub-categories. But although the initial coding pattern had the same 4 main categories, there were 85 sub-categories which were 'reduced' (categories were actually merged, renamed or brought from free nodes into tree nodes) during the initial phase of the data analysis. A list of this initial coding pattern is added to this study as Appendix K.

Finally, a grand summary (within case analysis) of hospital A developed into a continuous text, using many quotes from patients. Compiling these within-case analyses was a lengthy process that is not

entirely illustrated in this study. However, chapter 5 provides summaries of each within-case analysis per hospital.

**Table 4.5 Question responses and summary statements for patients**

	Patient 1	Patient 2	Patient 3	Patient 4	Patient 5	Patient 6	Patient 7
1. Involvement							
1.1 Involvement: communication and interaction							
1.1.1 Importance of hospital food							
1.1.2 Info received & interest in receiving information							
1.2 Involvement and satisfaction							
1.2.1 Discussions catering staff							
1.2.2 Discussions NHS staff							
1.2.3 Food requests & complaints							
2. Values							
2.1 Values: intake & satisfaction							
2.2 Values: life course & food choices							
2.2.1 Monetary issues							
2.2.2 'Ideal' food changes							
2.2.3 Friends & relatives							
2.2.4 Location of consumption							
2.2.5 Conversation							
2.3 Categorisation of food							
2.3.1 Influence of staff on food choices							
2.3.2 Food patterns back home							
2.3.3 Expectations							
2.3.4 Food choice strategies							
2.3.5 Hospital shop purchases							
2.4 Conversations: single contact person							
3. Trust							
3.1 Contacts							
3.2 Length of stay & contacts with staff							
3.3 Food promises made							
4. Characteristics hospital food							
4.1 Texture							
4.2 Presentation							
4.3 Quantities							
4.4 Diversity							
4.5 Names given to food							
4.6 Temperature							
4.7 Catering food							
4.8 Convenience							
4.9 Repetitiveness							
4.10 Patient suggestions							
4.11 Worries about production method							
4.12 Availability of food items							
4.13 Comments food experience							
4.14 Freshness food							
4.15 Patient's ideal picture							
4.16 Comments on the food and service management firm							

For subsequent data analysis of patient interviews, the author has used the output of the NVivo software to work directly on a within-case analysis from each ward.

#### **4.5.1.2 *Between-case or cross-case analysis***

The goal of cross-case analysis is to expand the inquiry and to force the researcher to delve deeper into the case. Cross-case analysis develops a more complete and robust understanding of the phenomenon in question. This analysis extends the search for patterns to each of the cases involved. Eisenhardt (1989) suggests three useful techniques when conducting cross-case analysis. These include the development of categories or dimensions, paired cases and the separation of data-by-data source. From the within-case analysis and between case analysis, various themes, patterns, concepts, relationships and overall impressions will emerge (Eisenhardt, 1989). By using this approach, the validity and reliability of the study strengthened.

In this study, the author has used two techniques to conduct the cross-case analysis. First, categories helped to identify within-group similarities and between-group differences. The categories used for the within-case analysis (Table 4.5) have also been used for the between-case analysis. Lists of emerging themes and characteristics of each hospital were then developed and compared, as illustrated in Table 4.6. The structures of these lists based on the interview schedule are outlined in Table 4.3 and further developed in Table 4.5. Secondly, data obtained was separated by data source, in order to attempt to triangulate the findings with other sources of evidence. The final process in the data analysis stage involves conclusion drawing and verification. The techniques used for conclusion drawing and verification are varied, but often involve comparison/contrast analysis, pattern matching, thematic analysis, and the creation of categories or dimensions. Comparisons within and between hospitals provided a means of triangulation and validation. Apart from the thematic analysis based on the nested tables, key elements from the cross-case analysis of patient interviews were systematically summarised at the end of each theme discussed. Brief examples of the nested tables and summaries of the cross-case analyses are to be found in Appendix G (patients), H (NHS staff) and I (catering staff).

**Table 4.6 Thematic analysis of the concept 'involvement' across hospitals**

	Hospital A	Hospital B	Hospital C	Hospital D	Hospital E
Involvement of the patients with food					
High degree of involvement					
Communication and interaction					
Importance of hospital food					
Information received & interest in receiving information					
Involvement and satisfaction					
Involving patients in food issues					
Discussions with catering staff					
Discussions with NHS staff					
Food requests and complaints					

**4.5.2 Data analysis of staff focus group sessions (catering and NHS staff)**

As with the patient interviews, focus group discussions were transcribed and analysed using thematic content analysis based on coding with the NVivo software. Because of the unstructured nature of the focus groups sessions conducted in this research, the process of analysis started with an ‘open’ coding approach of the transcripts to produce an extensive list of codes to break up the data collected. Codes were then merged, renamed or even deleted when not relevant in order to obtain categories and themes of each hospital that were then compared based on the themes developed in Table 4.4. To analyse the transcripts from the staff focus group sessions, the author used the output of the NVivo software directly working on a within-case analysis from each hospital. Apart from the thematic analysis based on the nested tables, key elements from the cross-case analysis of both NHS and catering staff focus group sessions were systematically summarised at the end of each theme discussed. These key dimensions emerging from both catering and NHS staff are ‘patients as a customer’, ‘food issues’, ‘comments on the NHS or catering staff’, ‘major issues between staff groups’, ‘comments on the food and service management firm’ and ‘operational issues’. Table 4.7 illustrates the emerging themes and characteristics of each hospital, which were then developed and compared.

**Table 4.7 Cross-case analysis of catering and NHS staff feedback across hospitals**

	Hospital A	Hospital B	Hospital C	Hospital D	Hospital E
<b>Patient as customer</b>					
Issues of patient involvement					
Patient involvement is sufficient					
Patient involvement is not sufficient					
Importance of interactions					
Interaction NHS staff & patients					
Interaction nursing staff & catering staff					
Interaction catering staff & patients					
<b>Comments and issues with the food</b>					
Key issue: food or service?					
Service is the issue					
Food is the issue					
Specific age groups					
Children					
Elderly patients					
Food production method					
Availability of chosen food					
Portion sizes					
Separate room					
Menu fatigue					
Choice available					
Room for improvement					
Food had improved					
<b>NHS staff</b>					
Major issues between staff groups					
Comments on the catering firm					
Operational issues					
Complaints					
Food served by					
Serving order					
Protected meal times					

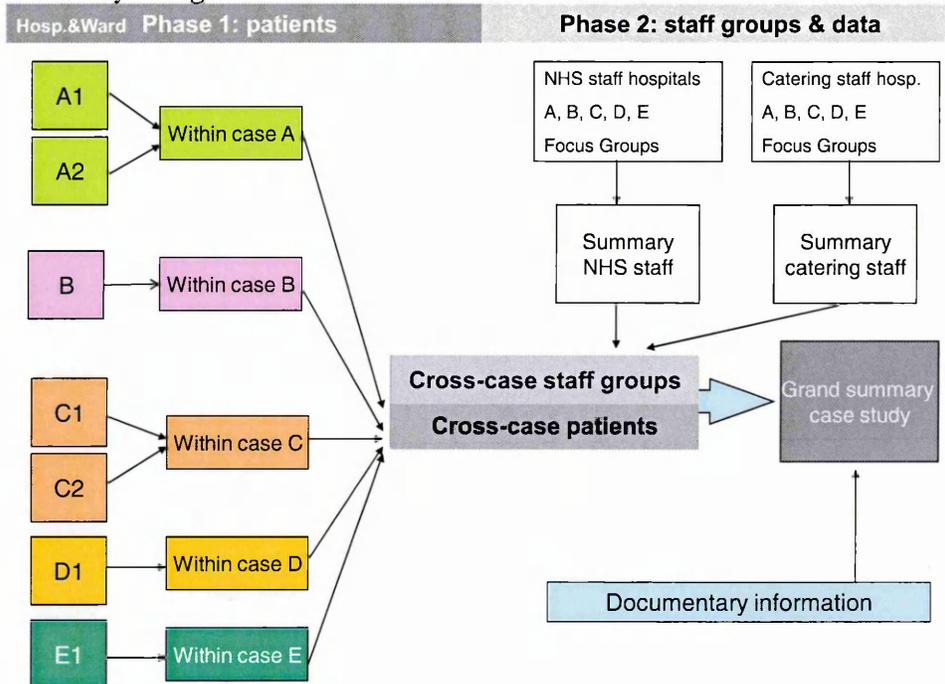
### 4.5.3 *Methods of analysis*

When conducting qualitative research, the researcher uses inductive analysis in order to develop themes, patterns and categories from the data. There seems to be a consensus that the analysis of qualitative empirical data requires constant comparisons and the use of multivariate techniques to bring structure to the data. There is also a general agreement that definition of the data analysis strategies start well before the data collection process begins. Data analysis occurs until a point of data saturation reached (Eisenhardt, 1989), giving greater depth to the study (Edwards and Hartwell, 2006).

When applied to qualitative methods, the term data adequacy refers to the amount of data collected, not the number of subjects used as in a quantitative paradigm (Morse, 1994). In an ideal sense and according to Morse (1994), attainment of adequacy occurs when enough collection of data compiled to explain or account for any variation and when saturation has occurred. The author believes data adequacy was reached through interviewing more than 30 patients, conducting 10 focus group sessions with NHS and catering staff across the five hospitals and through the collection of company documents and secondary data. However, and according to Morse (1994), it is clear that conducting the analysis independently by two or more researchers would have maximized the rigour of this study.

Table analysis was used along with the analysis of the within and cross-cases between patients and staff groups. Examples of how matrices used in this study to conduct constant comparisons among the data collected, found in Table 4.4, Table 4.5, Table 4.6 and Table 4.7. The logic depicting the flow and operationalisation of the analysis is illustrated in Figure 4.1. This figure and the discussion in this chapter illustrate the building process associated with the research design and the data analysis of the present study. Following this approach allows the validity and reliability of the present study to strengthen.

**Figure 4.1 Data analysis logic**



#### 4.5.4 Narrative

Yin (2003) suggests the use of narrative is a helpful technique for data analysis. Using this approach, the researcher asks a series of open-ended questions and then answers them based on the evidence and sources of information available. In each case study, Yin (2003, p. 74) recommends the following five levels of inquiry and ensuing analysis:

Level 1: questions asked of the specific interviewees

Level 2: questions asked of the individual case

Level 3: questions asked of the findings across multiple cases

Level 4: questions asked of an entire study

Level 5: normative questions about policy recommendations and conclusions

The outline of the narrative, which guided the author during the data analysis process, is inserted in Table 4.8

**Table 4.8 Five levels of enquiry and analysis**

Description	Operationalised questions	Chapter
1 Question asked of the specific interviewees.	<ol style="list-style-type: none"> <li>1. What are the key points/findings from this interview (patients) or focus group (staff groups)?</li> <li>2. Are there any recurring themes or patterns that became apparent during, or after the interview or focus group?</li> <li>3. What statements made during the interview or focus group are of particular interest to the researcher in this study?</li> <li>4. What, if anything, comes to the researcher as a surprise and why?</li> <li>5. Does the interview suggest any divergent or discrepant facts or information based on other interviews/focus groups or evidence collected up to this point? If so, what are they, and how can we explain them?</li> <li>6. Is the researcher satisfied that the information collected is complete? Are there any outstanding or follow-up items? If so, what are they?</li> <li>7. What can we learn from the interview and focus group that should be considered and incorporated in subsequent interviews and focus groups?</li> </ol>	Data analysis using NVivo. CD Rom with interviews and transcripts added to this study.
2 Questions asked of the individual case	<ol style="list-style-type: none"> <li>1. What is significant about this case and why?</li> <li>2. What are the key findings from this case and the main contributions it makes to the study?</li> <li>3. What categories or dimensions can be created?</li> <li>4. What common themes and patterns emerge from this case?</li> <li>5. Are the findings from multiple sources of evidence and interviews consistent with one another?</li> <li>6. What divergent data exists? What is the explanation for this?</li> <li>7. What areas require further probing?</li> <li>8. Does this case provide support for the a priori research model? If so, how, and if not, why?</li> </ol>	<u>Chapter: 5</u>
3 Questions asked of the findings across multiple cases completed in 3 phases: 1. patients 2. NHS staff 3. catering staff	<ol style="list-style-type: none"> <li>1. Which case(s) stands out as exemplar? Why?</li> <li>2. What similarities and differences exist between each case?</li> <li>3. How can these similarities and differences be explained?</li> <li>4. What themes and patterns emerge?</li> <li>5. Do the cases illustrate that replication has occurred? If so, how and where? If not, why?</li> <li>6. What divergent data exists? What explanations exist to account for these discrepancies?</li> <li>7. Do these cases provide support for a priori research models? If so, how? If not, why?</li> </ol>	<u>Chapters:</u> 6: patients 7: NHS staff 8: catering staff
4 Questions asked of an entire study	<ol style="list-style-type: none"> <li>1. What are the key findings of this study?</li> <li>2. Do these findings make sense (i.e. are they rational)?</li> <li>3. How do these findings compare to the extant literature?</li> <li>4. How do these findings compare to the a priori research models?</li> </ol> <p>The research questions are answered in chapter 9.</p>	<u>Chapter: 9</u>
5 Normative questions about policy recommendations and conclusions	<ol style="list-style-type: none"> <li>1. What conclusions are drawn from this study's finding? What is the significance of these conclusions? The research objectives are addressed in chapter 10.</li> <li>2. What practical implications does this study reveal? Based on these findings, what policy recommendations can be made to practicing food and service management firms?</li> <li>3. What changes, if any, are required to the a priori research models?</li> <li>4. Can tentative theory be developed? If so, what is it?</li> <li>5. Can new theoretical propositions and/or testable hypothesis be developed? If so, what are they?</li> <li>6. What are the primary contributions of this study?</li> <li>7. To what degree can these findings and conclusions be generalised?</li> <li>8. What are the limitations and shortcomings of this study?</li> <li>9. What opportunities exist for future research?</li> </ol>	<u>Chapters:</u> 9 and 10

## Test for design quality

The author has used four tests to assess the overall design quality of the research: construct validity, internal validity, external validity and reliability (Kerlinger, 1986; Yin, 2003). Definitions of these four aspects of design quality and their treatment in this research are to be found in Table 4.9 and the narrative that follows.

**Table 4.9 Four tests for design quality**

<b>Design criterion</b>	<b>Definition</b>	<b>Treatment in this study</b>
<b>Construct validity</b>	Establishes correct operational measures for concepts under study	Literature review Research models (summary literature review): RF2 document approved by SHU sub-committee Multiple sources of evidence (e.g, interviews and focus groups, company documents, archival data and secondary sources) Review of draft report by key people from the industry: private food and service management firm board members, Hospital Catering Association members, industry experts within SHU Pattern matching across the 5 hospitals under scrutiny
<b>Internal validity</b>	Establishes a causal relationship, whereby certain conditions are shown to lead to other conditions, as distinguished from spurious relationships	Not applicable in exploratory and descriptive case studies, as it only applies to explanatory or causal cases. However, as this study build upon extensive empirical research on factors leading to nutritional intake and satisfaction, causal relationships are identified
<b>External validity (Generalisability)</b>	Establishes the domain to which a study's findings can be adapted or generalised	Replication logic using multiple cases
<b>Reliability</b>	Demonstrates that the operations of a study (i.e. the data collection procedures) can be repeated and will yield the same results or findings	Triangulation Multiple sources of evidence (e.g. interviews, company documents, archival data and secondary sources) Multiple interviews within each case Multiple cases (5) Interdisciplinary grounding and focus (essentially in regards to the literature review combining marketing, NHS, food choices and mkt./HR implementation dyads) Review by key people from the industry Case study database and detailed field notes Database containing summaries of all articles used Use of a case study protocol Use of the first (partial) case as a pilot case to pre-test research design and data collection instruments / guides

*Source: adapted from Yin (2003, p.34).*

In terms of construct validity, the author has worked towards a high degree of congruence between the measurable and the instruments and variables used to measure them. The literature review further develops the key operational levels as summarized in Table 4.5 and Table 4.7. In terms of triangulation, the author used data triangulation and interdisciplinary triangulation. This last form of triangulation achieved during the literature review was done so, by drawing upon the works of various disciplines (marketing, consumer food behaviour and finally human resources).

In terms of obtaining external validity, and according to Yin (2003), the author aims to establish analytical generalisation (instead of statistical generalisation). This implies that all generalisations to a wider population other than the original five case studies should be treated as suggestive only, rather than definitive. It is these suggestions that can then form the basis of new propositions or hypothesis for more advanced, quantitative investigation and empirical testing.

## 4.6 Epistemological foundations

In terms of the phenomenological paradigm, the research will be conducted within the critical theorist' approach, as well as within the 'scientific revolution' conducted by the Nordic School of Marketing. Being committed to the existence of an external reality that is distinct from our psychological, cognitive processes and discursive practices, the undertaking of the research will be in accordance with the realist ontology developed by conventionalists like Burrell and Morgan (1979). Realists are united by a rejection of the view that the world is created by the minds of human observers (Johnson and Duberley, 2004), but consider that our perception of the world will be influenced by our social and personal background. As such, this approach is helpful in understanding what is salient in the patients' mind when considering various food-related situations. Agreeing with a realist viewpoint on metaphysical commitment towards unobservable entities, the author believes in the existence of a common referent between the various theories, which have been developed about marketing and relationship marketing in particular. This approach is developed in the various marketing paradigms outlined by the Nordic School of Marketing. Going in depth about the foundations of relationship marketing and linking these with psychosocial factors of consumer behaviour in regards to food service experiences in a hospital setting, the author will investigate underlying regular events, whereby generative mechanisms and causal powers between empirical patterns will be looked for. Another argument towards the realism approach

lies in the observation that realism has been found the preferred paradigm for case study research (Perry, 1998). The research aims to act on the physical relationships that exist in the natural and social world and learn how to manipulate them. The NHS involves so many stakeholders handling different agendas, that this way of proceeding seems the most appropriate to work and influence unobservable variables in the various processes and amongst the various staff categories implied. The word holistic is essential here. It goes far beyond the positivist empirical realism that overlooks 'existing', but unmanifested mechanisms causing behaviours and actions in the external reality.

#### **4.7 Practical aspects and considerations about the use of NVivo**

The carrying out of numerous in-depth interviews implied developing a system to index the material collected. All transcripts were standardized for format. The first letter of the author's name (M) was placed above each question, and the letter P (patient) above each answer. The audio recordings were transferred onto a PC, along with the labelling of files with the time, date, place and code of the interviewee. The analysis of the data was formed by the NVivo (second version) software program for treatment of qualitative data. In order to do so, all transcripts were imported in rich text format into NVivo and coded. Only the author and his supervisor were authorised to access the data collected, which was subsequently held on the authors' personal computer. Learning the functionalities of the NVivo software proved to be time consuming for the author, but rather useful when considering the vast amount of data collected for this study. Key functionalities included the creation of nodes, coding data, conducting advanced searches, creating reports and entering numerous attributes (gender, age, subject to allergies, annual gross revenue, eating characteristics, time spent on the ward, level of education, food production method, staff group serving the food, religion, ward type, hospital, etc.). Finally, the author soon learned that the NVivo software facilitates the sorting of information, but doesn't do the interpretation bit...which proved to be the most complex part!

## 4.8 Summary

This chapter presents the research design, methodology and data collection and analysis tools used in the present research. Given the current state of knowledge developed from the literature review and use of the case studies methodology as an emerging alternative to quantitative approaches about consumer experiences in the NHS, this approach is considered to be the most appropriate to explore the patients' viewpoints on food services in acute NHS hospitals. The test for design quality describes the procedures undertaken to ensure the integrity, reliability and validity of the present research; while minimising bias, subjectivity and errors associated with the case study technique. The resulting output of the research should create a foundation of knowledge for which future empirical studies can be based to test theory and hypothesis.

## Chapter five: Reporting and presentation of the research findings

### 5.1 Introduction and overall outline of the data analysis (chapters 5 to 8)

In agreement with the food and service management firm that has provided access to its facilities and employees for the data collection phase, the author has opted to work with five different hospitals where the firm is operating. Each one of the hospitals will serve as a separate case study. This chapter, as well as chapters 6, 7 and 8 provides an in-depth insight into five NHS acute hospitals based on the methodology presented in chapter four. Chapter five will introduce the various hospitals' characteristics and provide a brief within-case analysis of each. This approach is needed to understand the particularities of each hospitals' functioning and forms a basic requirement to further work on cross-case approaches in the ensuing chapters. Chapter five will provide a brief overview of the within-case analysis based on the patient interviews, broadly based on the structure developed in Table 4.5. Because of the significant work and length of the within-case analyses, no worked-out example of the way the analysis has been conducted and completed for each hospital has been included in this study. But the documents are at disposal of the reader on request. The focus of the research lies on the cross-case analysis (chapters 6, 7 and 8) as it is the author aim to compare and contrast the research findings in order to eventually unveil relevant patterns and relationships amongst the numerous variables looked at in this study. Detailed data of individual cases is incorporated in the cross-case analysis in this regard. Once the within-case analysis completed in chapter 5, the author will conduct the cross-case analysis of patient-oriented food services from three perspectives. First, the analysis presented in chapter 6 focuses on the 31 patients interviews, gathered across the five hospitals. The analysis will then move onto the focus group sessions conducted with front-line NHS staff involved in the food service process (chapter 7), before finally looking at the catering staff working for the food service management firm active in these five hospitals (chapter 8). Apart from working on the transcripts gathered from the patient interviews or focus group sessions with both staff groups, chapters 5 to 8 will integrate secondary information provided by each hospital and gathered along the data collection phase. The secondary information, consisting of food related information and agreements between each NHS Trust and the food and service management company, is used to supplement the respondents' responses to the interviews and focus group sessions. A summary of the available secondary data sources of information used in this study can be found in table 5.2.

Due to concerns for privacy and safeguarding of strategic information, the food and service management firm restricted access to some of the requested documents. Chapters 5 to 8 form the foundation of the discussion in chapter 9 whereby the outcome of the patient interviews, as well as the focus group sessions conducted with both NHS and catering staff, will be integrated and linked back to the literature.

In chapters 5 to 9, the author will often refer to the research material, mainly by relevant interview quotes. This idea is to let the respondents tell their own story, but without losing the structure which came from the theory under study. The language used in the analysis is simple and close to the one used by the respondents, in order to avoid forcing the reader to navigate from the academic theoretical language to the basic research material. These skills are required from the reader in chapter 9, where the cross-case analysis will integrate the outcome of all data sources and confront it with theory before drawing conclusions. In order to reach a satisfactory level of reliability the inclusion of interview quotes is essential as it results in quite extensive cross-case descriptions. Interview quotes added separately are in italics throughout the text. The adding of comments in the quotes is there to explain something to the reader.

## **5.2 Overview of key characteristics from the five hospitals serving as cases studies**

Each hospital has been assigned a letter (A to E), and each patient a specific number (from patient 1 up to 31). These references will be used throughout the data analysis and discussion chapters. Patient profiles have been added separately for each hospital in chapter 5. A complete list of the patient profiles has been added in Appendix F. Table 5.1 below provides information about the way the author has applied coding for the patients.

**Table 5.1 Information about patient coding**

Hospital	Ward	Patients
Hospital A	Surgery	1 to 5
	General	6 and 7
Hospital B	Surgery	8 to 12
Hospital C	Medical	13 to 18
	Pediatrics	19 to 22
Hospital D	General	23 to 27
Hospital E	Medical	28 to 31

Tables 5.2 and 5.3 provide an overview of the information collected across hospitals, based on the model developed in the methodology chapter (Table 4.4).

**Table 5.2 Information collection guide for secondary sources of information**

Category/Area	Information	Hosp A	Hosp B	Hosp C	Hosp D	Hosp E
Contract PFI	Start date	May 01	Dec. 04	April 99	April 03	April 03
	Expiration date	Confidential information, but provided to the author				
	Budget allocated per day for each patient	£ 4.26	£ 4.26	£ 4.24	£3.97	£3.97
Operational	Daily number of meals, 7 days a week	1070	X	1700	1110	990
	Total beds in hospital	1200	100	976	555	495
	Staff serving the food: NHS or catering?	NHS	Catering	NHS	Catering	NHS/C
	Food production method	steam	steam	cook chill	steam	plated
	Average non-plate wastage	2.5%	NA	NA	NA	NA
	Wastage	NA	NA	8.34%	3.5%	9%
HR Policies	Catering Staff working on site	600	41	167	27	29
	Staff members per ward	2.5	1	1	4	3
Services	Catering to patients	✓	✓	✓	✓	✓
	Catering to restaurant and functions	✓	✓	✓	✓	✓
	Vending	✓	✓	✓	✓	✓
	Domestic included theatres	✓	✓		✓	✓
	Portering included distribution	✓	✓		✓	✓
	External cleaning	✓			✓	✓
	Post	✓			✓	✓
	Stores management	✓		✓	✓	✓
Medical stores distribution	✓			✓	✓	

**Table 5.3 Documentation collection guide for secondary sources of information**

Category/Area	Document	Hosp A	Hosp B	Hosp C	Hosp D	Hosp E
Operational	Technology analysis/evaluation criteria					
	Training matrix catering	✓	✓			✓
	Policies and procedures staff awareness	✓				✓
	Customer comment card	✓				
	'Be a star' nomination	✓	✓			
Administrative	Organisational charts	✓			✓	
	Job descriptions front-line staff	✓			✓	
	Copy of a job chat report	✓	✓		✓	
	Company (hospital) policies				✓	
	Meeting agendas and minutes to meetings: notes from departmental managers meetings, staff quarterly meeting	✓	✓			
	Documents related to customer care					✓
	Patient satisfaction interviews: survey copy and key figures					✓
	Catering service level specification	✓	✓	✓	✓	✓
	Catering services level agreement		✓			✓
	Press releases	<b>Common to all Trusts</b>				
Internet	Company web page	<b>Common to all hospitals</b>				
Secondary sources	Articles in the trade press and news media	✓	✓	✓	✓	✓

### 5.3 Hospital A

Hospital A offers an on site canteen as well as various shops. In 2006, the private food and service management firm introduced the steam food process method in hospital A. The dishes are processed at ward level by catering staff, before being brought to patients by NHS staff. The latter staff group assist the nurses for non medical tasks on the wards. The food and service management firm has a dedicated ward housekeeper who serves as a liaison between the NHS staff and the (private) catering staff.

#### 5.3.1 Description of the sample: patients

In hospital A, seven patients were interviewed on two separate wards. In practice, it was the ward manager who introduced the author to the patients corresponding to the criteria outlined above. The sample of seven included 4 males and 3 females, aged between 17 and 89 years old. One patient was a middle-aged female (35 years) earning between £35,000 and £45,000 a year, whilst all other interviewees had a limited income ranging from £10,000 to £15,000 a year. Only the middle-aged female described herself as an 'experiencer' trying out new recipes, whilst all the other patients could be

considered as having rather ‘traditional’ food habits, i.e. (quite low involvement to food in terms of home cooking or interest in discovering new methods of preparation).

**Table 5.4 Overview of patient profiles hospital A**

P	Age group & gender	Length of Stay	Food type	Frequency hospital stays
1	46 to 60, Male	14 days	traditional	Couple of stays
2	17 to 30, Male	5 days	traditional	First time
3	31 to 45, Female	12 days	experienter	First time
4	17 to 30, Male	6 days	traditional but healthy	First time
5	61 to 75, Female	15 months	traditional	Extensive
6	76+, Female	6 days	traditional	Extensive
7	61 to 75, Male	5 days	traditional	Frequent

### **5.3.2 Within-case analysis**

#### **Involvement**

All patients unanimously agree hospital food is important for recovery, as it may speed up that particular process. Not a single patient received information about the food served and only two of them showed interest in doing so. There is no clear link between the patients’ profiles and their interest in receiving information about the food served. At best, the patients refer to the discussions with catering staff as ‘small talk’. Generally there is no real communication between patients and catering staff in hospital A. The patients explain their relationship with NHS staff is much closer, as they see this staff group much more often. Overall, patients do not want their relationship with the catering staff to change or to discuss issues more in depth with this staff group. Patient 5 stresses communication with catering staff is sometimes difficult because of language issues and would like to interact with the catering company’s managers more often. The patient thinks these managers do not dare to come on the ward because they are afraid of complaints. Patient 5 spent 15 months in hospital and is critical about the food and the food service. The fact that she stayed that long in hospital led to menu fatigue and a feeling of frustration, as the patient feels her complaints were not taken into account. The issue of language was further stressed by the NHS staff working with catering staff. Patient 2, 3, 4 and 5 do (or intend to) address catering staff directly if there is an issue with the food served on the ward. If the catering staff are too busy, patient 2 will contact the NHS staff as she thinks they are ‘committed to help’. The underlying reason is that (as stated by patients 3 and 5) these patients know NHS staff are not empowered to change anything regarding the food provision on the ward.

## Values

When in hospital, patients 1, 2, 4 and 5 look at very basic characteristics of food to make satisfaction judgements. Service aspects do not appear to be relevant in determining patient satisfaction, as basic qualitative characteristics of the food are sometimes deemed unsatisfactory. Patient 5 is the only one who (also) looks at service aspects to make satisfaction judgements. This is essentially due to her long stay on the ward and her professional background as a cook. All patients clearly express their willingness to go back to their usual eating habits once discharged from the wards. There are no examples of nutritional learning experience taking place in the hospital. Almost all patients talk about the food with their relatives, who tend to bring in fruit, sweets and sometimes home made or convenience food. It is essentially complementing rather than substituting the food received on the ward. The situation is different for the long stay patient 5, who asks her family expressly to bring in full home made meals. Except for patient 5, all patients prefer to eat in bed or besides their bed. Patient 2 also considers eating on the ward is an opportunity for him to talk with other patients. The approach of the long stay patient (5) is, once again, different from what the other patients experience. Overall, patients tend to talk about the food with each other. These discussions are more descriptive than directive, but most of the interviewees take suggestions into account when deciding which dishes to choose from the menu. Suggestions from other patients are definitely a key factor leading to specific food choices in this hospital. All patients have very negative expectations towards hospital food when arriving. They are all positively surprised by the quality of the meals offered within this particular hospital. Patient 5 clearly mentions the fact she asks relatives to bring in food is not due to the quality of the food, it is rather because of the limited variety of dishes on offer. Ironically, the patient also mentions it is the dietician who suggested to her to have relatives bring in fresh fruit and vegetables. Patient 7 expresses the need to 'feel safe' by systematically choosing the same dishes considered as 'what is not too bad'. Patients 2, 3 and 5 choose 'whatever they like', while patient 4 is just looking for 'decent food'. Patient 2 summarises pretty well the overall feeling:

*"Em, no I wouldn't say that's first on my list of priorities (health issues). I just look at what I like the sound of. Just want to know it tastes nice."*

Very few patients purchase food in the hospital shops, relying more on their relatives to bring in complementary food, than on the food available in the hospital shops or restaurant. Some patients do consider the shops and restaurant to be too expensive. This might be due to the low to average income

of the patients interviewed. Overall, the issue of high catering staff rotation in hospital A appears to be a key factor preventing the development of conversations with patients.

### **Trust**

Patients do not speak about real 'trust' with the catering staff or with the NHS staff serving the food, but allude to the frequency with which they interact with these staff groups. No promises were made to patients in regard to the food they receive on both wards.

### **Characteristics of hospital food**

Variety appears to be a key element leading to patient satisfaction. Patient 7 clearly states the menu offers an extended choice, but regrets he does not receive the full menu anymore. Instead, the catering staff sometimes only show a reduced (hand written) menu offering a very limited choice. Patient 3 calls the food 'dried to the bone,' while the other patients are more positive. Overall, patient 3 appears to be the most critical. The fact she is very focused and experimental with food in her day to day life partly explains this. Patient 5 considers the steam system 'is much better' than the traditional cook-chill method she considers as 'pretty naff'. Patient 5 had the opportunity to experience both systems during the 15 month stay within the hospital. The patients do understand and accept the difficulty of producing masses of very fresh and high quality food. This increases their acceptance of the food received on the ward. In terms of service, the patient (5) does not think there is likely to be any improvement in the near future. This appears to be due to the type of staff employed by the private food service management firm. Another issue stressed by patient 5 relates to the lack of vegetables on the menu. Only patient 4 expresses worries about the use of the microwave system. The patient heard the use of a microwave leads to a significant loss of vitamins.

## **5.4 Hospital B**

In 2006, the private food and service management firm introduced the steam food process method on the premises of this hospital. Catering staff process the dishes on ward level, before bringing them to the patients. The company has a dedicated ward housekeeper who serves as a liaison between the NHS staff and the catering staff.

### 5.4.1 Description of the sample: patients

Within hospital B, five patients were interviewed on one single surgical ward. Patients on this particular ward are treated for knee and hip replacement surgery. The average length of stay on the ward is about 4 to 5 days. The sample of five includes 2 males and 3 females, aged between 61 and 85 years old. All interviewees had an income ranging between £15,000 and £30,000 a year. Both age and income were higher than in hospital A. The average age was around 70, while the average annual income was £22,000. Only patient 10 described herself as an ‘experiencer’ trying out new recipes, while all other patients could be considered as having rather ‘traditional’ food habits. All patients have been hospitalised in different hospitals over the past few years, and are able to compare service levels between different hospitals.

**Table 5.5 Overview of patient profiles hospital B**

P	Age group & gender	Length of stay	Food type	Frequency hospital stays
8	61 to 75, Male	4 days	traditional	Frequent
9	76+, Female	2 days	traditional	One or two stays
10	61 to 75, Female	2 days	experiencer	Extensive
11	76+, Female	5 days	traditional but healthy	Two stays in same hosp.
12	61 to 75, Male	5 months	traditional	Frequent

### 5.4.2 Within-case analysis

#### Involvement

None of the patients received information about the food, and they did not want any. Their main focus lies on key characteristics like cleanliness (patient 11), taste (patient 12) or service. Patient 8 summarises the patient’s mainstream view on receiving information about the food:

*“I don’t feel that’s really important (to receive information about the food). Once, you em, once you do get into the meals in here, it then all those worries disappear, because it is so nicely set out and prepared. It’s, you know, just not bothered basically”.*

Only patients 8 and 9 commented on their conversations with catering staff. Patient 8 considers the catering staff are very busy and does not want to interfere in their daily tasks. Even if he would have the opportunity, patient 8 would not want to interact more with catering staff. The situation is different

with NHS staff, with whom the patient interacts much more. Patient 8 often mentions words like 'tasks' or 'job designation' proper to the catering staff. Apparently, he does not consider it is the catering staffs' duty to interact with patients. Overall the patients do prefer to communicate much more with NHS staff than they do with catering staff, even in regards to food issues. All patients interviewed in hospital B gave much more credit to the NHS staff, even in regards to food only issues. In terms of food requests and complaints, all patients interviewed appear to be very satisfied with both the food and service offered. A quote from patient 9 summarises this general feeling:

*"Oh! They are wonderful, wonderful staff (both catering and NHS staff)".*

## Values

Patients 10, 11 and 12 briefly describe their food habits when at home, and how they try to transfer these in the hospital environment. Patient 11 is used to eating big portions at home, but does not feel hungry in hospital. Because of this, she regrets so much food is wasted. Patient 12 is happy as he is able to follow his usual eating patterns in hospital. Unlike with some aspects of care (inability of doctors to operate on him in the future because of financial constraints/closure of the hospital), patient 8 is satisfied with the food provision as he considers it is well prepared and well presented. Patient 10 considers food provision in NHS hospitals has improved a lot over the past few years, but there is still a long way to go. Patient 11 regrets there is no more fruit on offer, and does not want to pay for it when the catering staff come around with the 'paying' trolley in the afternoon. Patient 11 suggests replacing desert with fruits, as it would not be much more of a cost to the catering firm. Having worked for more than twenty five years within the NHS, she also considers too much money is wasted. Patients 8, 10 and 12 commented on whether their 'ideal' food changed because of their stay in hospital. Patient 8 considers that he will try to stick to these 'smaller' portions once he is home again. Patient 10 and 12 clearly state they will go back to their usual food habits when dismissed from the ward. None of the patients would like to have full meals brought in, as they consider the food offered in this hospital as sufficient. Friends and relatives tend to bring in fruit and sweets, or very specific drinks that are not on offer in the hospital. None of the patients interviewed would like to consume their meal together in a separate dining room. There were various reasons for this. Patient 8 prefers to eat alone at his own pace, as quoted below:

*"I think, em, myself I prefer the solitary thing. I just take my own time, and er, just do my own thing if I want to just stop for a few seconds and push it away, which I did today, actually".*

Patient 10 ate in a common room in another hospital, and found it quite unpleasant. Patient 11 does not feel like he gets along with anybody very well, while patient 12 considers eating in another room would imply extra work for staff. Patients do influence each others food choices by giving advice or describing their experiences eating some items of the menu. Apart from patient 9, no patient had a nutritionist visiting on the ward. Overall, the expectation from the 5 patients interviewed towards hospital food is not negative. This is mainly due to the patients receiving positive feedback about the food in this specific hospital before their stay on the ward. Positive word of mouth appears to be a powerful tool modifying the patient's (generally negative) expectations towards hospital food. Patient 8 quotes:

*"In terms of food, I have been told by somebody, em, that - it was the man that brought me here, the transport, em they have a transport system which brings patients in - and he said to me that he knew from this experience from people coming in and out, em, he knew that the food was good".*

Three out of the five patients interviewed choose food items by simply going for what they feel like. None of the patients felt the need to purchase any food item in the hospital restaurant, as the food offered on the ward is considered sufficient.

### **Trust**

Even though patient 9 thinks the catering staff get to know her over time, communication remains superficial. Patient 9 does not think the catering staff remembers or takes into account her food preferences (because they have too many patients to serve on the ward), even during a longer journey in hospital. The key thing is that patient 9 is satisfied with the 'decent' food served, the choice, and this type of rather impersonal food service. The quote below is relevant in this regard:

*"Well, I mean, you know, when people treat you decently you remember. So, eh, that's why I didn't mind coming back here again".*

Patient 10 was hospitalised several times in another hospital where the catering staff got to know her over time. Length of stay, frequency of stay and staff rotation appears to be quite significant factors in regards to the development of relations between catering staff and patients. No promises were made to the patients in regards to the food served in this particular hospital.

### **Characteristics of hospital food**

Patient 11 regrets the condition of the patient is not taken into account when determining the portion size. Her quote below illustrates this:

*“Well, first of all, I think that the portions are too large, far too large. So much is wasted, because especially when, I mean I had an epidural this time, and those two ladies (unclear) after that, you feel terribly sick. Even though you’ve only had an epidural, and food, you’ve got to eat and yet it makes you feel terrible; and the portions are so large!”*

Patient 10 considers diversity is a key element leading to satisfaction, as she does not want to choose the same ‘good’ dish every day. The patient recently stayed in another hospital with less choice on the menu, and felt pretty negative when choosing items from the menu. She regrets there are no more vegetarian options listed. Temperature of the food is not an issue for the patients, who consider it as ideal the way it currently is. Patient 8 and 9 consider improvements are probably required in other hospitals, but not in this one. No patient commented on the steam system as a food production method. Availability and choice of the dishes is no issue for the patients of this hospital. The patients are satisfied with the choice and the availability of all dishes.

## **5.5 Hospital C**

Within hospital C, food is cook-chilled. The catering staff produce the food in the kitchen area and bring the food on the wards using a trolley. The food is then served by catering staff and brought to patients by NHS staff (nurse assistants). Within hospital C, a total of 10 patients were interviewed on two separate wards. Six patients were interviewed on a surgical ward and 4 on a paediatrics ward (oncology). Because of the very distinct profiles from the patients staying on these wards, they have

been analysed and described separately. The author will start with the patients interviewed on the surgical ward.

### 5.5.1 *Description of the sample: surgery ward, hospital C*

The sample of six includes 4 males and 2 females, aged between 17 and 75 years old. All interviewees have an income ranging between £15,000 and £45,000+ a year. Patients 13 and 14 can be described as real ‘food experiencers’, while all other patients could be considered as having rather ‘traditional’ food habits.

**Table 5.6 Overview of patient profiles hospital C, surgery ward**

P	Age group & gender	Length of Stay	Food type	Frequency hospital stays
13	17 to 30, Male	6 days	Experiencer	First time
14	61 to 75, Female	126 days	Experiencer	First time
15	61 to 75, Female	8 days	Traditional	Frequent
16	31 to 45, Male	8 days	Traditional	First time
17	46 to 60, Male	35 days	Traditional	One or two stays
18	46 to 60, Male	35 days, 1 week break, 7 days	Traditional	Extensive

### 5.5.2 *Within-case analysis surgery ward*

#### **Involvement**

Even though patients 13, 14, 15 and 18 view the hospital food critically, they all consider proper food should help them recover faster. Patient 13 regrets the food is not up to standards, while patient 14 regrets the nutritional value of the food is often lost because the food served in hospital is not fresh. Patient 14 quotes:

*“Yes I do. I think it is very important and the nutrient from it has to be there and this is where sometimes I think it has been let down by other nutritional value that you get in vegetables and salad. The fresh ingredient you don't get. It's plentiful I can't say it's not plentiful. But it's not...”*

Patient 15 considers there is a significant food problem in hospital, due to the huge workload catering staff have on their shoulders. Patient 15 would rather have her family and relatives bring in all the food, referring to Greece where this is common practice. Not a single patient received information about the

way the food was produced in the hospital, nor about the availability of alternative menus (Hallal or Indian). Overall the patients do not want information about food production methods or nutritional characteristics. The patients are much more concerned with the fact they were not told various menus are at their disposal on the ward (patients 14, 15, 16, 17 and 18). Patient 14 illustrates this, quoting as follows:

*‘No, they didn't (tell me about alternative menus). That wasn't explained to me, so I didn't know anything about these other menus. Fortunately, I haven't been in hospital before. Well, not for many, many years. So no, they didn't show me the menu. As far as I was concerned, even in the side room it wasn't visible. I couldn't see it and I couldn't get it. Whereas, if they gave these out to look through, then you would be able to choose’.*

Patient 18 also explains how he told fellow patients about the other menus on offer in the hospital, and regrets no staff members give clear guidance upon admittance on the ward. The patient also considers this should be done as soon as the patient is able to eat again after undergoing surgery or any other treatment. Patient 13, 14 and 18 consider talking with the catering staff as rather useless, because the catering staff are not in a position to improve the quality of the food or the opportunity is simply not given to give feedback on the food received. Patients 13, 14 and 18 all refer to a lack of empowerment, even though they are from different age groups and their length of stay ranges from 6 up to 126 days. Patient 15 would only talk to the catering staff if a major issue occurs, because she feels sorry the NHS staff have to take on the food service in addition to the numerous tasks they already have to complete. Patient 14 and 18 also have very little communication with the NHS staff, and regret they have no more opportunities to talk to this staff group about the food. Overall, there appears to be very little communication about the food between the patients and the catering staff plating the meals and the NHS staff serving the food. The patients clearly do suffer because of this, as they take a fatalistic approach (‘nothing can be improved anyway’). The patients do not like to complain because they consider none of the catering nor NHS Staff will be able to improve the poor quality of the food (patients 13 and 15), or because they do not want to put additional pressure on the NHS staff who they consider to be too busy and qualified to serve the food (patient 15 and 16). Patient 13 suggests it is up to the NHS (as an institution) to change the way food is produced and delivered.

## **Values**

The patients who frequently have full meals brought in (patients 13, 14 and 18) do not care about the financial cost attached. The other patients have small items of food brought in by friends and relatives, but these things are complementing the basic menu instead of replacing it. The stay in hospital did not lead to any change of what patients consider as their ideal food. Patient 13, 14 and 18 have full meals brought in on a regular bases. The fact that patients 13 and 14 can be considered as real food 'experiencers' partly explains their need of having 'home food' brought in or food bought in the hospital's restaurant. There is no link between the age groups and whether food is brought in or not by relatives. All patients think eating in or close to their bed is not an issue. Overall, food appears to be a topical issue on the ward. Lots of caustic jokes are made, but feedback also helps patients to determine food choices. It is somewhat surprising to see patient 17 is the only one who really enjoys hospital food, being very little involved himself with food (he never cooks, and eats lots of convenience food). Apart from patient 13 who expected hospital food to be healthy and nutritious, all other patients had very negative expectations. It clearly appears that the expectations of patients towards hospital food are influenced by the patients' friends and relatives, as well as their previous experiences during stays in NHS hospitals. Being hospitalised for a long period of time, the patients tend to develop fixed food choice patterns (patient 14 and 18). Unless the patients receive consistent home made food from friends and relatives on a regular basis (patient 13 and 14), they generally feel like having a look at the hospital restaurant and compare the food with what is being served on the ward.

## **Trust**

Patients 13, 14 and 16 did comment on this issue. The patients mention they feel more comfortable having the same person serving the food, as they feel this person knows them better (as well as their preferences) over time. But there is no trust as such between patients and catering or NHS staff. Patients 13, 15, 16 and 18 did not receive any food related promises upon arrival on the ward. The other patients interviewed did not even comment on this issue.

## **Characteristics of hospital food**

The patients interviewed are very critical about the texture of the meals served on the ward. The food is often described as soggy, dry, globular and similar to leather or cardboard. Patient 17 is satisfied with what is served, unlike all his fellow patients. Overall, patients are satisfied with the presentation of the food. Patients are satisfied with the quantities served, but dissatisfied with the quality of the food itself. Patient 14 resumes this view with the following quote:

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*“The quantity is enough, but not the quality. It isn't as good as it could be”.*

The comments of patient 13 are rather self explanatory:

*“Yeah, and I just look at it and think McDonalds looks better than that and I don't eat that. I don't know, it just looks like a school dinner and I don't like that sort of thing”.*

Apart from one single patient who considers there is too much choice (patient 15) and patient 17 who is happy with the choice available, all patients consider this is a key element leading to satisfaction. Patient 14, once she discovered the existence of all the menus on offer, started trying out almost every single dish. The fact that the patient stayed on the ward for an extended period of time (128 days) partly explains this need to try new recipes. Patients 15, 16 and 17 consider the food (often the main meal) is sometimes not warm enough. Patients 15 and 18 consider regular surveys would help avoiding huge food waste. Patient 15 thinks such surveys might provide the management with the necessary feedback to implement changes the catering staff are not able to conduct. Patient 16 mentions that sometimes the food ordered is not available on the trolley anymore, as it has been picked by other patients served first and the last patient is left with leftovers. Patient 17 regrets he was not made aware of all the menus on offer, and had to find out by himself after three weeks spent on the ward. Patient 18 considers hospital food is simply horrible, with little prospects of improving the situation as all the food is mass produced. Patient 18 quotes:

*“The situation can't be improved, because they are all set meals and thrown out by the thousand: just slopped in and no thought. It's all pre-produced food, isn't it?”*

Finally, three patients (13, 14 and 17) complain about the freshness of the food in hospital C.

### 5.5.3 Description of the sample: paediatric ward, hospital C

The sample of four includes 3 males and 1 female, aged between 3 and 16 years old. In most interviews, the parents intervened and added their own comments on the food. Only patient 22 (3 years old) was unable to participate in the interview, and the child's mother answered all interview questions. The average income of the parents was around £20,000 a year. Patient 20 can be described as a real 'food experienter', while patient 22's parents are real food experiencers. Patient's 21 mother is a professional cook, but her child has rather traditional food preferences. Only patient 19 can be considered as having traditional food habits, as well for the mother as for the child.

Table 5.7 Overview of patient profiles hospital C, paediatric ward

P	Age group & gender	Length of stay	Food type	Frequency hospital stays
19	6 to 16, Male	1 days	Traditional	Extensive
20	6 to 16, Female	2 days	Parents & child experiencers	Frequent
21	6 to 16, Male	1 days	Traditional, mother is a cook	Frequent
22	3 years, Female	2 days	Parents experiencers, NA child	Frequent

### 5.5.4 Within-case analysis paediatric ward

#### Involvement

The parents of patients 20, 21 and 22 commented on the importance of food on the ward. The parents of these three patients unanimously agree hospital food is very important in terms of their child's recovery. Patient 19's mother is disappointed about the quality of the food, but did not comment specifically on the issue. Patient 22's mother stressed the importance of food in hospital increases with the length of stay. Patient 20 considers food in hospital is important for recovery, and regrets the overall quality of the food on the ward is not satisfactory. Patient 20's mother quotes:

*"I think, as well, like when you're in hospital, you are ill. So, your food is more important, because you need, you know, you need your vegetables more to get, you know, the protein from them and things like that. And if it's not fresh, then it's something that's got nothing left in it. So, you know, there's no point, is there?"*

Patient 20's son goes even further, mentioning that instead of the food served on the ward, he:

*"Might as well just eat junk food. Might as well have a McDonalds everyday".*

Three out of the four patients interviewed received basic information about the various menus available. Being very involved with food herself, the mother of patient 21 even considers a visit to the kitchen is important. The issue of involving children/patients in the food process seems to be paramount on this paediatric ward. Patient 21's mother suggests providing the children with tasters would be an alternative whereby the kids are more involved with food. The patient's mother suggests developing more interaction between the staff producing the food and the children consuming it, quoting:

*"I think it would be better if - that the people that did it got to know the kids on a regular basis. We have been here from March and I haven't met the same catering person twice. The kids don't get the meals, they just shout, "Dinners!" and the parents go and fetch it. They don't even get to look at what it is. Half the kids in here can't read, so they don't know what they are getting. I do believe that they need tasters on the side or just come round and show pictures and get the kids more involved in the preparation of the dinners, because it is just a basic standard menu that revolves every six weeks".*

Patient 20's mother has addressed both catering and nursing staff about food issues, but considers it as useless as nothing is done about it. According to this patient's mother, the problem lies in the fact that she cannot get hold of the person actually producing the food, quoting:

*"Em, I've done both (addressed both catering and nursing staff). I've done both. I haven't done it for a while, because there is no point. Nothing is ever done about it. (Unclear) You know, it's like you speak to the nurses about it. In the past I have. And em, they don't really say much. And then, you know, you speak to the people that serve the food, and you know, I think sometimes it's hard because you can't get to the person who actually deals with the food. It's just there, and they're the middle person, if you know what I mean".*

Like patient 21, patient 22's mother also regrets she is never in touch with the catering staff producing or serving the food on the ward. Patient 21's mother regrets no direct contact with the staff producing the food is possible. She would like to have a phone on the ward, directly linked to the kitchen. Patient 21's mother does not want to bother the nursing staff as she considers they would be better dedicating their duties to medical activities. Three out of the four patients interviewed feel sorry the nursing staff have to deal with the food and the problems resulting from the poor quality of what is on offer (mothers of patients 19, 20 and 22). These parents consider it is not the nurses' role to worry about

food related issues, as they have enough on their hands helping out children by fulfilling medical duties. Overall, the patients feel much more comfortable talking and complaining to the nursing staff than with the catering staff, as they interact much more with the former. But the patients do realise that neither the nursing staff (nor the catering staff bringing up the food) are empowered to improve the food itself. The patients are rather fatalistic because of this, and patient 22's mother even goes to say she has given up on food in this hospital already. Patient 19's mother does not know who to complain to, and feels confused when considering all the staff involved in the food process. She would prefer to have one single contact person who is in charge of the whole food process, properly empowered to take corrective action wherever required.

## Values

Patients 19, 20 and 22 are dissatisfied with the food served on the ward and what is on sale in the hospital restaurant. They consider the food in the restaurant or hospital shop to be too expensive, and the vouchers given to parents whose child stays more than 3 days on the ward offers little comfort. Patients 19 and 20 consider the NHS does not invest enough in the food provision. Patients 19 and 21 mentioned their food preferences and habits are unchanged, and they intend going back to their usual eating habits once dismissed from the ward. The same can be concluded from the other patient's aversion towards the food received on the ward. All patients do rely on friends and relatives for their daily food consumption. The mothers of patients 21 and 22 even mention their child will not even eat anything else. Patient 22 describes in detail the emotional rollercoaster she went through when her child's sickness was discovered, and how the first weeks in hospital had a dramatic effect on the family's food behaviour. When in hospital for more than four days, patient 20 has friends and relatives bringing in food for at least one meal a day. Without considering the cost issue attached, patient 20 would prefer to have friends and relatives bring in all the food. Patient 21's parents also bring in home made food every day, mentioning her child will not eat anything apart from that. In line with patient 21, patient 22's mother quotes:

*"I have to say that I bring in a lot of food for Lilly because if you rely on hospital food then she wouldn't eat full stop. So, we have a big bag of food. There is stuff in the fridge and we have cool bags. You do! You bring stuff in everyday, because if she is not tempted by what you ordered the day before then you need back up. I would say at least 75% [of the food is provided by friends and relatives]"*.

Patients 19 and 21's parents both consider eating with their children is essential, as it comes closest to eating as a family unit. The patients' parents do not consider eating with other children or parents is something to wish for. Their need to stay with their child at all times is paramount. Patient 21's mother mentions the children can eat in the playroom located on the ward, but prefers to eat close to the bed using trays, as she considers it comes closest to eating as a family. She would prefer having a table and chairs at her disposal to eat with her child, but realises there is not enough room on the ward. Apart from patient 19, who did not comment on this issue, all patients do confirm they talk a lot about the food with fellow patients and parents. They are all appalled by the poor quality of the food and tend to laugh about it or share their experiences. All patients on the ward do receive advice from a nutritionist. Because of a significant weight loss, patients 19 and 21 were told to eat anything they want. Patient 20 cannot apply the nutritionist's guidelines because of the limited food choice on offer. All parents clearly mention their child will go back to their usual food habits once dismissed from the ward. Apart from patient 22's mother who did not specifically comment on this issue, all patients expressed how negative their expectations were towards hospital food in general. The mother of patient 20 expected the situation to be better on a paediatric ward, but was forced to notice this was not the case. The food choice strategies developed by the patients and parents show various common elements. As all patients and parents are dissatisfied with the food served on the ward, they compensate this by bringing in food from outside. During short stays (less than 3 days) the parents tend to buy food in the hospital restaurant, while for more extended periods on the ward they rely on friends and relatives to bring in home made food (patients 19, 20 and 22). Being real food experiencers, the parents of patient 20 even tend to avoid the hospital restaurant completely. Most patients tend to prefer to choose from the Book Menu (versus listed menus), as they consider it offers better quality and they enjoy the flexibility of this system (whereby food is delivered on request). All patients and parents go through a 'trial and error' approach whereby they quickly learn what they like and dislike (patients 19, 20 and 22). Once the children eat a specific dish, they tend to stick to this (patients 19 and 20). Patient 22 experienced much better food service in another hospital. Not only was the quality of the food much better, but the interaction with the staff was much smoother too. This also applies for patient 22's mother: good quality food is a prerequisite for the development of smooth interactions with the catering staff.

## Trust

Patient 19 has spent several stays on the ward, and knows the NHS staff really well. Patient 20's mother feels sorry there is such a high staff rotation amongst the catering staff. There is no mention of any form of trust between patients or parents and the NHS or catering staff.

## Characteristics of hospital food

Patient 19 describes the texture of the food as being 'mush', over cooked, watery and pretty vile. Patient 19's mother quotes:

*"It sounds good [when reading out the menu], but looks little and tastes very watery and horrible".*

Patient 20 also used to be impressed by the description of the dishes on the menu sheets, but describes the roast potatoes as 'hard' and the mashed potato as 'lumpy'. Patient 21 complains about the smell of the food that is far from appetising. The patient's mother describes the texture of the food as 'bland' and 'soggy', with little taste. Patient 22 also describes the food served on the ward as being 'bland', and complains about the chips, like patient 20. Patient 19 and 21 are very critical about the presentation of the food. In terms of quantities, patient 19 would prefer to have various portions sizes on offer. All patients or parents do complain about the limited choice on offer on the ward. Patient 19 finds the food is not kept warm long enough, and his mother describes the food as 'luke warm'. In line with patients 19 and 21, patient 22's mother mentions sometimes the meal is really hot, but a lot of the time it is warm. According to her, this is due to the way the food is delivered to the patients. Patient 22's mother mentions she is better off going and getting the food from the trolley herself, because otherwise it is not hot enough. Patients 10, 20 and 21 clearly state the Blue Menu Books offer much more convenience than the traditional listed menus that must be ordered 24 hours in advance. Key advantages of the so called Blue Menu Books are choice, freshness and ability to order it at (almost) any point in time.

## 5.6 Hospital D

Back in 2006, the private food and service management firm introduced the steam food process method on the premises of hospital D. Catering staff process the dishes on ward level, before bringing them to the patients. The firm has a dedicated ward housekeeper who serves as a liaison between the NHS staff and the catering staff.

### 5.6.1 *Description of the sample*

Within hospital D, five patients were interviewed on one single surgical ward. The average length of stay on the ward is about 4 to 5 days. The sample of five includes 5 females, aged between 17 and 75 years old. All interviewees had an income ranging between £15,000 and £25,000 a year, except for patient 26 who is a student still living with her parents (categorised as 'not applicable' in terms of income). The average age was around 45, while the average annual income was £18,000. In terms of food habits, all patients can be described as 'traditional'. Interestingly, patient 27 is also a nurse usually working in this particular hospital.

**Table 5.8 Overview of patient profiles hospital D**

<b>P</b>	<b>Age group &amp; gender</b>	<b>Length of stay</b>	<b>Food type</b>	<b>Frequency hospital stays</b>
23	46 to 60, Female	29 days	traditional	First time
24	61 to 75, Female	10 days	traditional	One or two stays
25	61 to 75, Female	7 days	traditional	Few stays, same hospital
26	17 to 30, Female	11 days	traditional	One or two stays
27	31 to 45, Female	3 months	traditional	First time

### 5.6.2 *Within-case analysis*

#### **Involvement**

All 5 patients interviewed tend to have traditional food habits and a low degree of involvement with food. None of the patients received information about the origin or production methods of the food. With exception of patient 24, the patients do not want to receive this type of information upon admittance on the ward. Patient 26 mentions the (private) catering employees are always different, and are not really concerned about the food they serve. The contacts with the catering staff are described as

'friendly' and 'small talk'. Being a nurse working in this particular hospital, patient 27 explains she's happy the catering staff have taken over food related duties from the nursing staff. Patient 27 quotes:

*"Yeah, I think it's all right [the relationship between catering staff and patients]. It's just like the changeover of staff, I think that's their domain they have the time to do - deal with the food and tell the patients anything they want to know about it more than we [nursing staff] do".*

According to patient 27, the catering staff get to know her better over time but can not remember her food preferences because there is so much choice on the menu. Her rather superficial but polite and courteous relationship with the catering staff does not need to be changed, as she is satisfied with the very basic service that is currently implemented. Patient 23 states she has got the same attitude towards catering and nursing staff, trying not to differentiate any staff group. But when it comes down to specific issues relating to food choices, then the patient prefers to ask the nursing staff for more professional guidance. The patient does not know to what extent the catering staff's guidance is reliable, and prefers to play safe by asking the nursing staff which come across as more reliable (due to their degree). Patient 25 considers the catering staff are really good in terms of service, even though she does not talk a lot with them. Conversations do not go any further than 'chit-chat', and the patient does not think anything more than that is wishful or achievable. The language or (foreign) culture of the catering staff appears to be an issue here. Two patients (25 and 26) also tend to interact more with the nursing staff than with the catering staff. Patient 26 mentions this is due to more frequent interactions with the nursing staff, while patient 26 considers the catering staff are simply not bothered to do anything else but supply the food. Overall, the patients on the ward are satisfied with the food experience and the catering staff.

## **Values**

All patients do consider the NHS invests sufficient money in food provision and note the improvements achieved. All patients clearly mention they intend to go back to their traditional food habits once dismissed from the ward. No learning experience has taken place, and in some cases the food served on the ward is even quite similar to what the patients tend to prepare at home (patient 25 and 26). All patients receive fresh fruit, small snacks and drinks from their friends and relatives, even though they consider the food served in hospital is sufficient and satisfactory. Food related discussions with relatives are not a topical issue, unless there is some specific concern about eating patterns (patient 23) or previous experiences (patient 24). Patients 26, 27 and 23 did comment on their ideal location to

have lunch and diner. Even though patient 26 would like to go to the restaurant if her medical condition would allow her to do so, the patients tend to prefer eating in their bed, or close to their bed. The medical condition of the patients appears to be a determining factor not allowing them to move to another room to have their lunch or dinner. Unless the patients do not consume enough food and tend to loose weight, they are not referred to a nutritionist. For patient 23, her stay on the ward has been a learning experience in terms of food behaviour. She (a woman with a pretty busy working life) has learned to take time out to eat proper meals instead of eating small bits here and there between meetings. Patient 23 quotes:

*“Hmm. So it's been, it's been good for me to learn, erm, instead of eating on the hop (grabbing a sandwich, packet of crisps between your thighs and a sandwich on the, on the passenger seat you know, eating as you going along and a drink, erm,) all the time like I do when I'm, when I'm working, but I've not been at work for four months now. Erm, and it's a whole new experience for me [to have structured meals every day in hospital]. Erm, but here it's, erm, yes I'm very, very impressed”.*

All patients had negative expectations towards hospital food before being admitted on the ward, but were surprised by the quality and the choice of the meals on offer. The negative expectations were due to previous hospital stays (patients 23 and 24), from word of mouth from other patients in other hospitals (patient 26) or from the general public perception towards hospital food (patient 25). One patient's (patient 26) food choices are guided by the fact she does not think preparations coming from a microwave can form a proper meal. This forces the patient to eat sandwiches and salads only. Patient 27 also regrets the cooking method does not allow proper preparation of meals that are supposed to be crispy, and this influences her food choices. The patients in this hospital do not require food to be brought in by family and friends, as they are all satisfied with the food and choice on offer (apart from patient 26). However, all patients enjoy receiving fresh fruit and small snacks from relatives, complementing the food they receive on the ward.

## **Trust**

All patients explain the contact they have with the catering staff is limited to gentle 'chit chat'. Most of the patients do not want any more contact than that with the catering staff (patients 23, 25, 26 and 27). Patients 25, 26 and 27 clearly state the catering staff duties should not go any further than the sole duties of serving and taking back the food, while patients 25 and 26 even mention the catering staff are simply not bothered nor concerned with the food they serve. Having one single contact person in

terms of food service is not a requirement for patients 23 and 24. Length of stay does not really influence the way catering staff interact with patients or deliver the food to them. None of the patients think the catering staff remember their food preferences, with patient 23 being the exception here. It is relevant to note patient 23 has been on the ward for almost one month, while all other patients did not exceed a stay of 11 days maximum. But the other patients who tend to stay a bit longer on the ward do mention the catering Staff call them by name (patients 23 and 25) and tend to serve drinks the way they like it (patient 25). This is highly appreciated by the patients. No promises were made in regards to food to any of the patients interviewed.

### **Characteristics of hospital food**

Two patients are critical about the texture of the food. Patient 26 considers nothing that is micro waved can be anywhere near decent food, while patient 27 regrets nothing crispy can be delivered because of the food production method. All other patients are satisfied with the texture and taste of the food served.

Patient 26 quotes:

*“The texture really [is the key problem with the food], because it is not like a proper meal. It is just shoved in a microwave and brought back out. So I always have the sandwiches or salads and soup”.*

Except for patient 26, all patients are satisfied with the presentation of the food. Patient 25 and 27 are satisfied with the size of the portions served. The other patients mentioned they found quantities too large, especially for the initial phase on the ward after undergoing surgery. These patients suggest offering smaller portions to patients who have just undergone surgery. All patients mention the menu offers a wide selection, and are satisfied in terms of possible food choices. Most patients are satisfied with the temperature, except patient 27 who considers the food is sometimes too cold. Patient 23 considers it is convenient to have the food pre-plated, as it allows maintaining the temperature at an appropriate level. The patient considers the catering staff have currently got it right, and quotes:

*"To be able to say what they want. So, I think that the menu is set out, that's what it contains. It's the same when you go to a restaurant. That's what is in it, you know. So, yeah! No, I think it's, erm, no I think they got it right".*

Patient 26 mentions the gap between what is listed on the menu and what is actually delivered to her. She quotes:

*"Yeah! It is a posh, fancy menu, but it's not what comes out, really. Like, I had the Spaghetti Bolognese. It wasn't spaghetti it just normal pasta. A dollop of Bolognese and 5 pieces of sweet corn plonked on top with two slashes of pepper".*

Patient 26 considers the main problem lies in the overall quality of the food (taste and texture), and considers the service to be not being very personal but quite all right. Patient 27 prefers the steam system to the traditional plated service that was previously in use in the hospital. This is due to the quality, extensive choice and temperature of the food. Being a nurse too, patient 27 considers patients are actually regarded as customers in terms of food service. When asked if she considers patients are treated as customers, patient 27 quotes:

*"Yes, I think they are. They've got choice, its more on their terms rather than what is available. I think its fine: it's hot, it's fresh, and it's tasty; and you couldn't ask for anything better unless you got someone to come into the kitchen and do it fresh".*

Most patients interviewed do realise hospital food has many constraints attached to it in terms of production method, delivery to the patients and freshness of the ingredients. They tend to accept these constraints (except for patient 26). Patient 26 would like to discuss food issues with the catering management, and regrets she does not know who the top person is. The patient suggests bringing in an outside catering company to improve the quality of the food, but thinks money is a constraint (the money available being spent on medication rather than food). Patient 27, being a nurse too, appreciates catering duties have been taken away from the nursing staff. Patient 27 quotes:

*“I think it is pretty good. Although, it is a bit strange, because you used to do everything; but it is now nice that you have designated staff members who are there for their patients and can be there solely for your patients when it comes to feeding. [The patient is a nurse working in hospital, who just went through surgery. She comments on two alternative food delivery systems and the collaboration with the catering company]. As a nurse I think they've got loads of time to do that. Because as a nurse we had to do it to the best of our ability in the time that we had. However, if you ask them they [the catering staff] say they can't”.*

Patient 27 considers that professionally, the catering firm is very approachable. She mentions she has seen a massive improvement in terms of food standards, when compared to the previous food system in place in the hospital (plated food delivered on the ward by trolley).

## **5.7 Hospital E**

The food and service management firm operates a plated service on the premises of hospital E. Catering staff does process the dishes in the central kitchen, before it is brought to the wards by NHS staff using trolleys. The food is then handed over to the patients by NHS staff who are on the food and service management firm payroll.

### **5.7.1 Description of the sample**

Within hospital E, four patients were interviewed on one single medical ward (patients recovering from a stroke). The average length of stay on the ward is quite long, averaging about one month. The sample of four includes 1 female and 3 males, aged between 52 and 77 years old. All interviewees had an income ranging between £15,000 and £45,000 a year, with an average of £26,750. The average age was around 61.

**Table 5.9 Overview of patient profiles hospital E**

P	Age group & gender	Length of stay	Food type	Frequency hospital stays
28	76+, Female	42 days	traditional	First time
29	61 to 75, Male	42 days	traditional	First time
30	46 to 60, Male	90 days	traditional	Frequent
31	46 to 60, Male	42 days	traditional	First time

### 5.7.2 *Within-case analysis*

#### **Involvement**

All patients can be considered as ‘traditional’ food consumers, as they are not that involved with food and tend to favour very traditional patterns. Apart from patient 28 who had no specific comments on this topic, all other patients do consider hospital food has an important role to play in the recovery process. It seems the first solid meals are important for the patients, stimulating appetite (patient 29) and breaking the monotony on the ward (patient 31). None of the patients received any information about the food. Only patient 30 considers some more information about the food could be of interest. It is worth noting the patient is the only one who has frequently been hospitalised over the past few years. The other patients are happy as long as the food tastes nice (patient 29) or as long as the temperature is fine (patient 31). None of the patients have the opportunity to talk to the catering staff (kitchen staff in this particular case), and they regret this. More interaction with the catering staff would be appreciated by the patients, allowing them to voice their comments on the food. But when asked if the catering staff should serve the food, patient 30 mentions they are not skilled enough to do so (patient 30 was hospitalised in another hospital before, where the catering staff served the food to the patients). There appears to be little communication between the nursing staff serving the food and the patients. Patients 28 and 31 did not face any significant issue with food while hospitalised, and are rather satisfied with what is being served in this hospital. But both patients 29 and 30 mention they have often received food items they did not order, and think this is due to the lack of communication between the nursing and catering staff as mentioned above. Both patients would like to interact with catering staff directly, and stress that food issues should not be dealt with by the nursing staff who have many other duties to complete. Apart from the communication issue between staff groups, patient 30 also mentions no one is being proactive in meeting the patients’ needs or in solving issues related to food. Patient 29 also stresses his numerous complaints do not improve the situation. Patient 29 stresses the fact the staff serving the food are just part of a string (that fizzles out), whereby nobody actually takes ownership of a problem. The notion of empowerment is pointed out here. Patient 29 quotes:

*“Well, if there is a problem I would talk to, to the nurse, or whoever, whoever's serving it. Yeah! You can bet there won't be any pepper on my plate. I did, I have done [ask for pepper to the staff serving the food] on the, erm, odd occasion, but you see, they're one of a string of people, aren't they, really”.*

As an alternative, the patient now asks relatives to bring up bags of pepper from the hospital restaurant.

## Values

Patient 30 also realises the food in hospital is mass produced with a limited budget, quoting:

*“Erm, and I don't expect, because it is mass catering, I wouldn't expect much more because they've got this, a vast amount of food to get out in a, in a limited period to a very limited budget, I would imagine. I don't know what the budget is for, for food, but I wouldn't think it's very much”.*

Patient 30's wife visits her husband every day, consuming one daily meal in the hospital bistro. Having both lunch and dinner every day would turn out to be too expensive for her, so she only gets a sandwich and a bag of crisps for dinner. These food choices are related to the extensive length of stay of her husband on the ward, which is about 3 months. Patient 31 considers the NHS invests sufficient money in food provision, as he is quite satisfied with what is being delivered by this hospital. All patients stress their stay on the ward has not changed what they consider to be their ideal food patterns at home.

All patients have friends and relatives visiting and bringing in fruit, sweets or small snacks and drinks. None of the patients have requested friends and relatives to bring in full meals, and patient 30 is the only one who would consider this option. While patients 28 and 31 have no specific opinion on the location of consumption, patients 29 and 30 would prefer having one separate room at their disposal. This would allow them to change environment and interact with other patients. Patient 29 mentions this would be preferable for long stay patients, while patient 30 realises most of the patients on this recovery ward are unable to walk very far from their bed. Patients do not have real conversations about the food, but tend to give brief comments on what is served. These comments between patients do not appear to have a significant influence on their food choices. None of the patients met a nutritionist. They all mention their food choices are not influenced by staff members. Apart from patient 31 who did not have specific expectations towards hospital food before being admitted on the ward, all other patients had rather low expectations. These low expectations were essentially due to the fact that the food is mass produced. Patient 28 quotes:

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*‘No, it’s not too bad at all [the food]! You know, for mass produced stuff they do quite well, really. Well, it has to be [mass produced] in a place like this, doesn’t it?’*

Patients 28, 29 and 30 ate little during the first weeks of their stay on the ward, and food became more important for them over time. This was essentially due to their medical condition in the early days of their stay on the ward. Patient 28, who is quite elderly, does not want to be a nuisance to anybody on the ward. This attitude often surfaces when considering elderly patients. Patients 28 and 31 think two hot meals a day is far too much, even though this is due to different reasons (usual eating patterns for patient 28 and excessive caloric intake for patient 31). All patients purchase nibbles and fruit from the hospital shop, except for patient 28 who needs assistance to move around. The patients do not purchase more consistent items like sandwiches as they believe there is enough on the ward.

### **Trust**

All patients are on the ward for more than 40 days, and they seem to know the staff serving the food a bit better. But these relationships with the staff remain very superficial. It does not have any positive effect on the way the food is delivered to the patients. The staff merely seem to remember the patients’ food preferences, but cannot recall patients’ names. Patient 29 knows the staff serving the food rather well, but they still (after 42 days on the ward) cannot manage to get him his special request for some pepper delivered. This is the case even if it is the same person serving the food day in day out. Patient 29 quotes:

*‘Yeab [I get to know the staff a bit better]! But, sometimes you don’t get things, like erm, in my case there always seems to be a shortage of pepper. Yeab! They always, they always give you salt which is not supposed to be healthy for you, but never pepper. I always have to ask for pepper. Well, they know I like pepper, but erm, I always have to ask and they always have to make a special journey to go and get some pepper’.*

The key issue leading to patient 29’s satisfaction is the taste of the food served on the ward, as well as to the choice and different types of food available. Patient 31 also mentions the taste of the food is fine. Patient 30, on the other hand, is quite dissatisfied with the food in general. Patients 28 and 29 are rather satisfied with the presentation of the food. Patient 30 and 31 are not satisfied with the presentation of the food. Patient 30 mentions the food is simply slopped on a plate, quoting:

*"I think if they could present it a little bit better instead of just slopped on a plate. It's...could be better".*

Patients 29 and 30 do not have any issue with the food quantities served on the ward. But patients 28 and 31 consider they do not need three full meals a day. These patients consider the portion sizes are simply too large, even for lighter substitutes like sandwiches (patient 28). Quantities are too large for the ageing patient 28, who prefers smaller portions, while patient 31 thinks three full meals are not required in a hospital where you do not burn up the calories consumed. Patients 28, 29 and 31 are pretty satisfied with the diversity of the menu. Only patient 28 finds the food to be not consistently warm enough. Patient 30 experienced another food system (in hospital D) whereby he could order his meal about one hour in advance. He finds this system to be much more convenient than having to order 24 hours in advance.

*"I mean, that, that one you had at the city when they came up, they actually gave you, it was like a glossy menu [the patient refers to the steam menu]. And then you got it for lunchtime. You know, I mean you didn't have to do it like the day before, and when it came it was actually presented nice, weren't it? It looked like food you could [sit?] and enjoy".*

Patient 30 regrets no one from the catering staff ever makes a visit to the ward. The patient would like to interact with someone from catering in order to voice his comments, as he now feels catering is simply not interested in receiving feedback.

## Chapter six: Cross case analysis of patients

The following three chapters presented are a cross-case analysis between hospitals involved in this study. Chapter 6 will focus on the patients' feedback, while chapter 7 will focus on the outcome of the focus group sessions conducted with NHS staff involved in the food service process. Finally, chapter 8 will look at the catering staff feedback from the five hospitals involved in this study. The structure used for the cross-case analysis of the patients in chapter 6 is to be found in Table 4.5. Chapter 6 unfolds as a continuous text. Appendix G provides the reader with a brief example of how summaries and nested tables have been used in the cross-case analysis phase of this study, focusing on the issue of patient involvement with food.

### 6.1 Cross-case analysis patients

#### 6.1.1 *Involvement*

From the 31 interviewees, only four patients and two parents (with their child on the paediatric ward in hospital C) qualify as 'food experiencers' (referred to as patients 3, 10, 13, 14, and guardians 20 and 22). All other patients have very traditional food habits, as they do not have much involvement with food

##### 6.1.1.1 *Communication and interaction*

#### **Importance of hospital food**

All patients agree that hospital food is important for recovery, as it might speed up that particular process. Several patients, however, do mention the quality of the food on the ward is not good enough to support proper recovery. Food also appears to become more important over time for the patients, breaking the monotony of their stay in hospital. Most patients from hospital C consider the food served in that particular hospital is simply not good enough to achieve the objective of proper recovery (patients 13, 14, 15, 18, 20, 21, 22). It is important to note that hospital C is the only hospital in the sample that uses the cook-chill method. Like all patients across hospitals, the mother of patient 20

considers food as an important part of recovery. She is disappointed that the overall quality of the food on the ward, and quotes:

*‘I think, as well, like when you're in hospital, you are ill. So, your food is more important, because you need, you know, you need your vegetables more to get, you know, the protein from them and things like that. And if it's not fresh, then it's something that's got nothing left in it. So, you know, there's no point, is there?’*

### **Information received and interest in receiving information**

Not a single patient received information about the food served in terms of origin or production methods, and only a few showed an interest in doing so. Additional information does not appear to be a priority for most patients, especially when they are satisfied with the food offered. When patients are dissatisfied with the food (as it is the case in hospital C), they mention it would be helpful for them to receive information about the alternative menus on offer. Patient 8 summarises the overall patient's mainstream view on receiving information about the food when satisfied with the product:

*‘I don't feel that's really important (to receive information about the food). Once, you em, once you do get into the meals in here, then all those worries disappear, because it is so nicely set out and prepared. It's, you know, just not bothered basically.’*

Most patients consider receiving additional information about the food is not paramount, as they tend to focus on core aspects such as temperature (patient 29 and 31); taste (patient 12 and 31); cleanliness (patients 9 and 11); hygiene (patient 29) and proper service delivery (patient 9).

#### **6.1.1.2 Involvement and satisfaction**

The issue of involving patients (and children) in the food process is the overriding principle on the paediatric ward in hospital C. The mothers of patients 19 and 21 suggest involving the children much more in the food process by using tasters, or displaying the food on offer. The parent's idea is to give their child a chance to experience the food before ordering large portions of it. The mother of patient 21 quotes in respect of this:

*"I do believe that they need tasters on the side, or just come round and show pictures and get the kids more involved in the preparation of the dinners, because it is just a basic standard menu that revolves every six weeks. If the kids can't get out of bed themselves, bring a smaller tray to the bed so that they can see what is on offer, even if it is not going to get touched on the top with the lid sealed. So that they can see what is on offer, because come 12 o'clock they won't want it".*

Various patients across the other wards and hospitals also consider they are not involved enough in the food process, no one considers their comments. Regular surveys would help avoid huge food waste, providing catering management with the necessary feedback to implement changes to the food service. Various patients across the 3 hospitals (A,D,E) complain about the fact they never get the opportunity to talk to the catering management to voice their complaints. Various patients in hospitals C and E would prefer to interact directly with a catering manager, who has the ability to act on the situation, instead of going through NHS or catering staff that they consider is not empowered to do so.

#### **Discussion with catering staff and patient perceptions towards catering firm**

At best, the patients refer to the discussions with catering staff as 'small talk'. Generally and across hospitals, there is no real communication between patients and catering staff, as most patients consider this is not part of the catering staffs' job description. Patient 8 illustrates this approach, considering it is not the catering staff's duty to interact with patients. This implies therefore that the catering staff are there to present the menu, take the order, prepare and serve the food (in the hospitals where this is not done by the NHS staff), without any additional service components attached. The quote below of patient 8 illustrates this point:

*"Oh! Yes. Oh! Yes, yes, yes. And that is what their job designation is (serving the food). They are not, em, their job designation is not to engage with me if, em, if they don't want to, obviously. And again, I don't wish to disturb them from their job. They are getting paid for it, at the moment. I am not."*

The patients explain their relationship with NHS staff is much closer (than with catering staff), as they see this staff group much more often. Illustrating this point, patient 4 also mentions this is because he considers the nursing staff to be much more accessible than catering staff, as illustrated in the quote below:

*“Ah, okay! We don't see the kitchen people as often, no. You see them when they bring the food, but the nurses are always around here, so you just ask the nurse. It's much easier.”*

Overall, patients do not want their relationship with the catering staff to change or to discuss issues more in-depth with this staff group. This is essentially due to the fact they don't know the catering staff well enough and prefer to stick to the NHS staff who they interact much more with. Keeping a status quo seems appropriate to most patients. The age, gender or food habits of the patients do not directly influence their views on the relations with the catering staff.

### **Discussion with NHS staff**

Patients tend to have discussions with NHS staff much more easily than they do with catering staff, and this also applies to food issues. Patients tend to give much more credit to the nursing staff with regard to food issues. Patients simply feel it is easier to establish contacts with staff they see frequently. It is interesting to note however that in hospitals C and E, patients never have the opportunity to get in contact with the catering staff.

### **Food requests and complaints**

In terms of complaints and specific requests, patients from hospital A and D tend to address catering staff directly (patients 2, 3, 4, 5, 24, 25, 27). It is relevant to note that, in these two hospitals, that the catering staff brings the food to the patients. This offers more opportunities for the patients to interact with this staff group and voice specific complaints and requests. In addition, being a nurse working in the hospital, patient 27 considers it is the catering staff's duty to handle food-related issues. Patient 27 quotes:

*That's their job (of the catering staff), because they have taken it off the nurses now who used to give out the food and now the catering staff, that's their duty. We, as the nurses on the ward, we now have nothing whatsoever to do with the food and delivering it to the patients.*

## 6.1.2 Values

### 6.1.2.1 Intake and satisfaction

The majority of the patients only look at very basic characteristics of food to make satisfaction judgements. The focus is certainly not on service components. Patient 1 summarises this approach pretty well, as quoted below:

*I mean, they do have quite a large range on the menu. Em, you know from salads like quiche, and meat, and so and so on, fish. I mean the basic protein should be there, which is what's important, so I don't see how they could improve, really.*

Service aspects do not appear to be relevant in determining patient satisfaction, except for long-stay patients or patients that are considered as food 'experiencers' in their day-to day life outside hospital.

### 6.1.2.2 Life course events and food choices

Patients 10, 11 and 12 briefly describe their food habits when at home and how they try to transfer these to the hospital environment. Patient 10 just started eating again after surgery, as she used to eat at home, a sandwich at lunchtime and a hot meal in the evening. Patient 11 is used to eating big portions at home, but doesn't feel hungry in hospital. She is not happy that so much food is wasted. Patient 12 is content, as he is able to follow his usual eating patterns in hospital.

## Monetary issues

### Food served on the ward

Many patients across the hospitals expressly stated they were satisfied with the investments the NHS does in terms of food provision (patients 6, 8, 9, 31 and all hospital D patients). In terms of satisfaction with food provision, hospitals B and D stand out. Both hospitals use the steam system, but hospital C also uses it. When evaluating whether enough resources is put into food in hospitals, the patients tend to look at basic, tangible characteristics of the food. This is due to their low level of expectations, where they initially do not even consider service aspects as being developed. Illustrating this, patient 9

considers that having a couple of good three-course meals every day is a good deal and that it does not require improving, see quote below.

*Yes! Yes! Certainly! We get three meals! It's three meals: you get breakfast, lunch and dinner, and a cup of tea in between times, twice a day.*

Interviewer: So, you think it's a good deal?

*It is good, yes! Especially being the NHS: I mean you can always, I suppose, you can always improve. But, I don't think they need to here.*

It is interesting to note patients with very different profiles (different age or social background) expressed their satisfaction with food for very different reasons. For the young and price sensitive patient 2 (a young student) it is about having two full meals a day without paying for it. The 'cost' of the food served appears to be significant for him, as he's unable to pay for and prepare two full meals a day at home. Patient 6 (aged 76+) thinks it's good food being served, quoting:

*Well they must do (invest a lot of money)! Because this must cost an awful lot: they give you. It is not second hand food if you get what I mean. It is good food so they must spend quite a lot on it.*

However, (patients 5, 13, 19, 20 and 22) consider the NHS invests insufficient money in food provision. The patients dissatisfied are from wards in hospital C.

### **Hospital restaurants and shops**

Numerous patients interviewed consider the food sold in the restaurant of the hospital is too expensive (patients 13, 19, 20, 22, 24 and 30) and not offering value for money.

### **General observations related to cost issues**

It is relevant to note that only long-stay patients and the so-called food 'experiencers' look beyond tangible characteristics of food to build up their satisfaction judgements. The patients who frequently have full meals brought in (patients 13, 14 and 18 from hospital C) do not care about the financial cost attached.

## **Ideal food changes due to hospitalisation**

All patients clearly express their willingness to go back to their usual eating habits once dismissed from the wards. There is not any sort of nutritional learning experience taking place in hospital, whereby patients learn to eat in a more healthy and balanced way, taking into account their overall health condition.

## **Friends and relatives**

### **Type of food brought in by friends and relatives and underlying reasons.**

Most patients do talk about the food with their relatives, who tend to bring in fruits, sweets and sometimes home-made or convenience food. But in the majority of the cases, it is limited to 'small food' that complements rather than substitutes the food received on the ward (hospitals A,B,D and E). When patients are satisfied with the food on offer, they do not envisage the need to have full meals brought in.

When asked if it would be an option to have friends and relatives bringing in whole meals, patient 30 quotes:

*I don't know (if I would like to have full meals brought in by relatives)! Depends! I think if they could present it a little bit better instead of just slopped on a plate, people perhaps wouldn't want to go out. I mean we've just been talking to somebody and they said their meal turned up the other day, absolutely disgusting, didn't taste very nice, and they come down to the little Bistro.*

The situation is different for long-stay patients (like patients 5, 23 and 4 who considers the event of an extended stay on the ward) and for the patients admitted in hospital C, as they tend to have fuller meals brought in (providing they have relatives who can manage and afford to do this regularly). In the case of hospital C, once again the food production method (cook-chill) plays a significant role. However, the cooking method is not the sole factor influencing the food consumption behaviour of the patients and their relatives. On the surgical ward within hospital C, patients 13, 14 and 18 have full meals brought in on regular basis. However, considering the fact that patients 13 and 14 are real food 'experiencers' partly explains their need of having 'home food' brought in or food bought in the hospital's restaurant.

## Discussions about food between patients and relatives

Food-related discussions with relatives are not at all a topical issue, unless there is some specific concern about eating patterns (patient 23) or previous experiences (patient 24). However, most patients do talk a little about the food with their relatives, generally on a rather light note.

## Location of consumption

Except for patient 5, 26, 29 and 30, the patients expressed their preference to eat in bed or besides their bed. Patients are not bothered about the place where they consume their meals during their journey on the ward. Sharing a common room for lunch or dinner is not an interesting option for many patients interviewed, as they consider having enough social contacts with the other patients on their ward already. On the paediatric ward within hospital C, patients 19 and 21's parents both consider eating with their children is essential, as it comes closest to eating as a family unit. The patients' parents do not believe eating with other children and their parents is something to wish for. Their need to stay with their child at all times is paramount.

## Conversation with other patients

Patients tend to talk about the food with each other, more than they do with their friends and relatives. These discussions are more descriptive than directive, but most of the interviewees consider suggestions when deciding which dishes to choose from the menu. Suggestions from other patients are definitely a key factor leading to specific food choices in hospital. Patient 2 illustrates this behaviour, quoting:

*Well, yeah! Because I've had certain foods that the other guy has eaten. It's only us two who are allowed to eat. Em, and he's had certain things that I've eaten; and we basically say what's good and not good, and em... Yeah, you listen to it, because if he's says, "Don't eat the chicken!" Then, I'm not going to order the chicken. But, em, everything he said has been fine.*

As patients tend to be less satisfied with the food offered in hospital C, food appears to be a topical issue on both wards of that hospital. The patients are very critical amongst each other when talking about the food. Many caustic jokes abound, but feedback also helps patients to determine food choices. It is surprising to see that some patients made other patients aware (or were made aware) of the existence of alternative menus on the ward (patients 14, 15, 16 and 17).

### 6.1.2.3 *Categorisation of food*

#### **Influence of staff on food choices**

Only seven out of the 31 patients interviewed received advice on food from ward staff or a nutritionist during their stay on the ward (patients 5, 9, 19, 20, 21, 22 and 23). All other patients point out that staff members do not influence their food choices. Patients are not referred to a nutritionist unless they do not consume enough food and tend to lose weight or are on a paediatric ward. Patient 2 and 22 were told by the NHS staff to 'make sure to eat', while patients 4, 19 and 21 were told by the doctor to eat 'whatever they want'. The long-stay patient 5, also received nutritional advice, as well as an informative leaflet. The dietician suggested patient 5 to have her family bring in fresh food, as she couldn't catch up with the food on offer in hospital!

#### **Food patterns when back home**

The vast majority of the patients mention they intend to go back to their usual eating habits once dismissed from the ward. The hospital doesn't provide the possibility to learn much in terms of (healthy) food behaviour. Patients 8, 9 and 23 somehow think that their stay on the ward is a learning experience (in terms of food behaviour), for different reasons. Patient 23 (a woman with a hectic working life) has learned to take time out to eat proper meals instead of eating bits and bobs between meetings. Patients 8 and 9 mention they will try to stick to the smaller portions served in hospital or follow the diet list given by the nutritionist. Patient 8 will stick to the smaller portions served in hospital in order to keep fit, even though his schedule at work might not allow him to do this.

#### **Expectations towards hospital food**

Most patients have very negative expectations towards hospital food before their admittance on the ward. The quality of the meals offered positively surprises most of the patients. A significant exception is the case of hospital C, within both the surgical and paediatric ward. Patient 1's feedback summarises the feeling of many patients interviewed as to their expectations, as quoted below:

*You can't expect too much in hospital. It is pretty much like school dinners. Yeah, most people say they are like school dinners. So, I'm quite happy with what they do here, really. Yeah, I'm not expecting much in luxuries.*

Negative expectations were due to previous hospital stays (patients 5, 6, 15, 17, 18, 23 and 24), from word-of mouth from other patients in other hospitals (patients 8, 9, 10, 11, 12, 14 and 26) or from the general public perception towards hospital food (patient 25).

### **Food choice strategies**

#### **Food and health**

Patients 1, 6, 17, 25, 26 and 28 tend to choose the healthier options listed on the menu. These patients are from three different hospitals and have very different profiles. Patients considered as 'experiencers' do not specifically choose more healthy options.

#### **Food quantities**

Patients 6, 9, 15, 27, 28 and 31 cannot eat two full meals a day and so choose a lighter option in the evenings. Except for patients 27 and 31 who are between 31 and 60 years old, the other patients are ageing.

#### **Length of stay and food strategies**

Food choice strategies of long stay patients like patients 5 and 30 are very specific. Both patients know the menu by heart and strongly rely on relatives to bring in dishes cooked at home. Patient 5 shows acute menu fatigue and switched to the menu's sandwiches in order to eat something different, even though her son brings in full meals as often as possible (every evening at a certain time). Patient 5 clearly mentions this is not due to the quality of the menu, but it's rather because of the limited variety of dishes on offer. Ironically, the patient also mentions it's the dietician who suggested to her to have relatives bring in fresh fruits and vegetables. Patient 5 quotes:

*In my own personal, to you know, my my, erm, iron levels were really low at one point and - oh! some other bits and piece. And, so I said to the dietician, came and talked to me, and said, "Well, what are you eating?" And I said, "Well, on hospital foods I'm not going to improve am I?" And she said, "No, you just have to get your family to bring you in meat freshly cooked and vegetables."*

During his first week on the ward, patient 30 ate three full meals a day, but switched to two full meals as he felt he was putting weight on.

### **'I eat what I feel like' determining food choices**

In terms of food choices, apart from the few patients who opt for 'healthy' food choices, all other patients choose according to what they feel like. It's really only about satisfying a need to eat. Patient 2, 3, 5, 8, 10, 16, 17, 23, 27, 29, 30, 31 and all patients from hospital C, expressed this viewpoint.

### **Availability of items listed on the menu**

In hospital A especially, what is on the menu determines the food choices of the patient. Even though the menu list is quite extensive, it appears not all dishes are available every day in that specific hospital. As quoted below and illustrating this point, the long-term patient 5 tends to ask what's available, before even telling the catering staff what she would like to eat:

*Erm, well I just pick it because you're hungry and want something to eat. But erm, they've got erm, here they've got a nice selection. They give you the board with the nice selection on, about a dozen different items, and you say, "Well, I'd like this one." That's off! "I'd like this one." That's off. "Yeab! This one?" That's off! So, now I don't even ask I just say, "What have you got?"*

### **Portions, safety and security determining food choices for children and ageing patients**

Patients 7, 14, 19, 20, 21 and 28 express the need to 'feel safe' by systematically choosing the same dish. Apart from the patients on the paediatric ward (20 and 21), the other four patients can be considered as ageing people who prefer sticking to set routines.

### **Expectations versus reality & food production method**

Patient 20's mother indicates her child is unsure of trying out new dishes listed on the menu, as a few bad experiences have put her off. The difference between what the description on the menu and the meal itself is huge, annihilating the little positive expectations patients might have towards hospital food.

This surfaces across all hospitals under investigation (especially where cook-chill or plated food is in use).

### **Food choices and length of stay: focus from food to services**

Upon admittance and during the first week on the ward, patients tend to focus on qualitative aspects of the food (instead of also looking at food service aspects). This is essentially due to their low level of expectations and what they consider to be 'shipped-in' food (food not freshly made from scratch on the premises). It is only when staying for longer periods (more than a week generally) that patients start to focus on service aspects. Patient 15 has only been on the ward for eight days, and does not feel the need to adapt to hospital food (as if it would be the case if she would stay much longer).

Commenting on another patient (14) on the ward, patient 15 quotes:

*She (the other patient who has spent one hundred and twenty six days on the ward) seems more satisfied than I am, but I think that is simply because she has been here a long time and you have to adapt. I'm sitting here thinking that I will soon be home and I'm not getting there you see.*

After a period of trial and error, patient 14 has developed some fixed patterns in terms of food choices. In the early days of her eighteen-week long stay on the ward, patient 14 didn't like the food at all. The nursing staff informed her about the celebrity chef menus available after a couple of weeks. Food choices and length of stay of patients on the paediatric ward are very specific, and shown below in the paragraph dedicated to this ward.

### **Food choices and food production method**

Patients are steered by certain food choices by the limitations of the production method itself. Patients 4, 24, 26 and 27's food choices believe that preparations coming from a microwave do not form a proper meal. This forces patient 26 to eat sandwiches and salads only; while patients 24 and 27 regret that, a microwave does not allow proper preparation of meals that are supposed to be crispy. Patient 4 heard the use of a microwave leads to a significant loss of vitamins, while patient 26 has been eating sandwiches all week and her parents bring in cold dishes for her such as sandwiches, grapes, tomatoes and strawberries.

### **Food brought in by relatives**

Some patients require full meals to be brought in by family and friends (patients 5, 13, 14, 18, 26 and all the patients on the paediatric ward), as they are rather unsatisfied with the food and choice on offer. Apart from long-stay patient 5 who shows acute menu fatigue, and patient 26, it is relevant to note the vast majority of patients hospitalised within hospital C ask relatives to bring in full meals. In an ideal world, patient 18 would prefer to have all his food brought in from the hospital restaurant, but realises his relatives can't do that because of practical implications (essentially related to their work and lack of time). All patients interviewed enjoy receiving fresh fruits and small snacks from relatives, complementing the food they receive on the ward. The patients who have food brought in all have their relatives worrying about them eating enough to overcome their illness. Patients who are very involved in food (the 'experiencers') tend to have full meals brought in, as long as their family and relatives can provide this.

### **Food choice guided by third parties**

#### **Advice from nutritionists and medical issues**

Patient 23 needs to build up, as she lost weight since her admittance on the ward, so she has three full meals a day. All patients in hospital C (ward C4) are very sensitive to the variety of the menus, and are saddened because they did not find out earlier on about the existence of alternative menus providing more choice. In this sense, third parties (staff or fellow patients) also guide the patients' food choices. The nursing staff informed patient 18 about alternative menus as the nursing staff worried about him only eating sandwiches. All patients on the paediatric ward received advice from a nutritionist, but were not always able to follow this because of the type of food served on the ward (lack of fresh food and vegetables).

#### **Influence from fellow patients**

Overall, patients tend to talk about the food with each other. It is noticeable that patients talk more about the food with fellow patients than they do with their friends and relatives. These discussions are more descriptive than directive, but most of the interviewees consider suggestions when deciding which dishes to choose from the menu. Patient 2 illustrates this behaviour well, quoting:

*Well, yeah! Because I've had certain foods that the other guy has eaten. It's only us two who are allowed to eat. Em, and he's had certain things that I've eaten; and we basically say what's good and not good, and em...Yeah, you listen to it, because if he's says, "Don't eat the chicken!" Then, I'm not going to order the chicken. But, em, everything he said has been fine.*

As patients tend to be less satisfied with the food offered in hospital C, food appears to be a topical issue on both wards. Although many caustic jokes abound, the feedback helps patients to determine food choices. It is surprising to see that some patients made other patients aware (or were made aware) of the existence of alternative menus on the ward (patients 14, 15, 16, 17 and 18). Patient 18 often talks with other patients about food, advising them to try alternative menus on offer.

### **Physical condition of the patients**

The physical condition of the patients and consequences on taste buds influences food choices (patient 14 prefers highly flavoured dishes because of her medical condition, whereby she dislikes traditional dishes as she considers them as tasteless). As developed above, some patients are on a soft diet or fed and follow the guidelines given by medical staff whenever possible.

### **Food behaviour of relatives visiting**

Patient 30's friends bring in drinks and his wife eats one meal a day in the hospital café. She can't afford to have two full dinners within the hospital every single day she comes to visit.

### **Trial and error**

A 'trial and error' approach is developed by patients 10, 14 and 18, along with all the patients admitted on the paediatric ward within hospital C. There is common linkage between the concept of trial and the food production method, with hospital C using the cook-chill method that receives negative feedback from the patients. Patient 18's food choice strategy with the alternative menus illustrates the common 'trial and error approach', as shown in the quote below:

*If I was to get a menu where I thought, I don't know whether to have that or that. I try that one, and then sometimes they follow over to the night one. So I would think Ill have that one at dinner and that one at night and see what one I like best. Then the next day I know, oh I like that one or I don't like it. You take your choice don't you, but at least you have more variety.*

## **Food choices on the paediatric ward: a specific case**

### **Food brought in**

As all patients and parents are dissatisfied with the food served on the ward, they compensate this by bringing in food from outside.

### **Use of the hospital restaurant and shops**

During short stays (less than three days) parents tend to buy food in the hospital restaurant, whilst for more extended periods on the ward they rely on friends and relatives to bring in home made food (patients 19, 20 and 22). Being real food experiencers, the parents of patient 20 even tend to avoid the hospital restaurant completely.

Patients 19 and 21 consider the hospital shop and restaurant are too expensive, but are in favour of the hospital voucher system. Patient 19 prefers the hospital restaurant much more, and often (almost daily) asks his mother to go and find some food items there. The patient describes the restaurant food as being much fresher and warm, offering a larger variety of food. Over time, the patient's family faces a cost issue, as the expense of the restaurant food becomes excessive.

### **Preference to choose from the book menu**

Most patients tend to choose from the Book Menu (versus listed menus), as they consider it offers better quality and they enjoy the flexibility of this system (whereby food is delivered on request). All patients and parents go through a 'trial and error' approach whereby they quickly learn what they like and dislike (patients 19, 20 and 22). Patient 22's mother prefers choosing from the alternative menus (Hallal), believing the food is better. Once the children eat a specific dish, they tend to stick to this (patients 19 and 20).

### **Choices guided by third parties**

All patients in hospital C receive advice from a nutritionist. Patients 19 and 21 eat whatever they like, as advised by the nutritionist as they had lost weight. Patients 20 and 22 took a more healthy approach as advised by a dietician, but were unable to apply this whilst in hospital because of the limited amount of fresh ingredients and vegetables served on the ward.

## Hospital restaurant and shop purchases

### Hospital restaurant

Unless the patients receive consistent homemade food from friends and relatives on a regular basis, they generally feel like having a look at the hospital restaurant (when their medical condition allows this) and compare this food with ward food. This is not (or less) the case in the hospitals where patient satisfaction is high (hospital B or D). Hospital B has no restaurant or shop on its premises. As stressed by a few of the patients (20 and 22), patient 30 also feels that the restaurant is very expensive and offers poor food quality. The patient prefers the hospital Bistro in hospital E.

### Hospital shop

Many patients and relatives buy some small food items (sweets, fruits or drinks) in the hospital shop, complementing rather than substituting the food received on the ward. Patients 26 and 30 buy some small food from the hospital shop as well as patients 29, 30 and 31.

#### *6.1.2.4 Developing relations with a single contact persons*

Patients 3, 4, 5 and 6 express the feeling that the catering staff get to know them better over time. These patients regret that they have to build up relations from scratch when a new employee comes on the ward. This quote from patient 5 illustrates the point:

*Erm, but quite frequently they move the hostesses round to different wards so therefore they don't get to know the patients. And it's only if you get to, they get to see you talk to somebody that you know like a hostess from a previous ward then of course they look after you.*

Apart from the patients above who enjoy developing contacts with the same (catering) staff members, patients 4, 14, 19, 20 and 29 would prefer having one same ward housekeeper to interact with on a daily basis. The frequency of interaction also forms a determining factor leading to patient satisfaction. Patient 30, referring to a stay in another hospital where ward housekeepers liaise directly with patients about food issues, believes this doesn't work out. In line with patient 14, patient 30 thinks the catering staff is not skilled enough to handle all food-related issues.

### **6.1.3 Trust**

#### **6.1.3.1 Contacts with people involved in the food service process**

Talking about any form of trust between patients and catering staff is certainly not applicable. At best, patients refer to gentle 'chit chat' when talking about the type of relationship they have with the catering staff. There is no clear link between the patients' profiles and their attitude towards the catering staff. Most patients don't want any more contacts with the catering staff (patients 23, 25, 26 and 27). These patients clearly state the catering staffs' duties shouldn't go any further than the sole duties of serving and taking back the food.

#### **6.1.3.2 Length of stay and contacts with staff**

Instead of trust, patients rather allude to the frequency with which they interact with catering staff. Length of stay, frequency of stay and staff rotation appears to be quite a significant factor in regards to the development of relations between catering staff and patients. None of the patients interviewed think the catering staff remember their food preferences (patients 9, 11, 24, 25, 26 and all patients from hospital E). Patient 23 is the exception here, probably because she has been on the ward for almost one month. Patient 5 is an interesting example of a very long stay patient who does not speak about trust either, but she feels understood when in contact with one same hostess for an extended period of time. Patient 5 feels understood in terms of preferences, attitudes and moods. Patient 5 is the only patient who considers the catering staff develops empathy towards the patients over time. However, she believes language issues hinder proper contact.

#### **6.1.3.3 Food promises made**

Of the patients interviewed, none had any promises made with respect to food issues.

## **6.1.4 Characteristics of hospital food**

### **6.1.4.1 Texture**

Patients satisfied with the texture of the food (patients 2, 4, 7, 23, 24, 25, 29, 31 and all patients in hospital B) appear to use the steam system across the hospitals. Patients dissatisfied with the food in general are predominantly from both wards in hospital C, with a few from hospital E (plated food). These patients describe the food as being soggy and globular (patient 21), mush, watery and overcooked (patient 19), lumpy (patient 20), bland (patients 21 and 22) and having a bad smell (patient 21). Patient 22's mother quotes:

*The food on the ward, honestly, it's not good, not good at all. You go to the trolley to get food that you have ordered the day before, or that morning. It isn't just bland. Say you ordered chips; we don't make that mistake any more. It's in a little plastic container that you peel the cling film off and the steam comes out, and you have a chip that drops. Do you know what I mean? That's not a chip!*

### **6.1.4.2 Presentation**

#### **Positive comments on the presentation**

Presentation is a key factor leading to satisfaction for patients 8, 9 and 10. There appears to be no direct relationship between the food production method and satisfaction related to presentation. Patients 7, 14, 15 and 17 believe the food presentation is 'as well as can be expected' when considering a hospital setting. Patients 2, 5, 6, 11, 23, 24, 25, 27, 28 and 29 are happy with this aspect of the food service.

#### **Negative comments on the presentation**

Patients 13, 19, 21, 26, 30 and 31 are not satisfied with the presentation of the food, stressing it is simply slopped on a plate.

### **6.1.4.3 Quantities**

Patient 6, 11, 28 and 31 explain that having three full meals a day is far too much. Ageing patients like patient 6 and 28 tend to prefer eating later and somewhat lighter in the evenings. These patients think the portion sizes are simply too large, even for the lighter substitutes like sandwiches (patient 28 considers sandwiches are too filling). Patient 31 is satisfied with the food, but thinks he doesn't need three full meals a day as he doesn't do any physical exercise. Considering food portions are too large can also be due to medical reasons (patients 23, 24 and 26). These patients suggest offering smaller portions to patients who have just undergone surgery. Patient 11 also thinks the medical condition of the patient is not taken into account when determining the portion size. Her quote below illustrates this:

*Well, first of all, I think that the portions are too large, far too large. So much is wasted, because especially when, I mean I had an epidural this time, and those two ladies (unclear) after that, you feel terribly sick. Even though you've only had an epidural, and food, you've got to eat and yet it makes you feel terrible; and the portions are so large!*

### **6.1.4.4 Diversity menu**

Variety appears to be a key element leading to patient satisfaction. Most patients are satisfied with the diversity of the food on offer, but are rather critical about the quality of the food. Freshness and quality are determinants (leading to satisfaction) often raised by patients. Even though choice is certainly important for patients, the quote below (patient 15) illustrates the dilemma of quantity versus quality:

*This might conflict anybody, but perhaps less choice would make better quality...*

### **6.1.4.5 Names given to the food**

Patient 3 considers the food is 'dried to the bone'. The fact she is very focused and experimental with food in her day-to-day life partly explains this. Patient 4 can't call it 'bad food', while patient 6 is surprised as 'normally hospital food is not always that good'. The descriptions of the food in hospital C are very harsh. The comments of patient 13 are rather self-explanatory:

*Yeab, and I just look at it and think McDonald's looks better than that and I don't eat that. I don't know, it just looks like a school dinner and I don't like that sort of thing.*

#### **6.1.4.6 Temperature of the food**

Ten out of the thirty-one patients interviewed are sometimes dissatisfied with the temperature of the food, considering the food is sometimes too cold (patients 15, 16, 17, 19, 21, 22, 23, 25, 27 and 28). Patient 15 thinks the main meals are not very warm, and complains about the breakfast always being cold.

#### **6.1.4.7 Catering food**

Many patients do realise the food is brought or 'shipped in' by a food and service management firm (patients 1, 4, 5, 7, 13, 18, 23, 28,29,30,31). Patients 4, 5, 18, 19, 28, 30 and 31 are aware it is difficult to produce large quantities of 'decent food' (patient 4) or produce it 'from scratch' (patient 5). Reflecting the general feeling about the food served on the wards, patient 4 quotes:

*Yeab, exactly! It's not like frozen food you know but it's still not like home made. Well saying that it's quite complicated if you're gonna prepare everything right here, right now.*

#### **6.1.4.8 Convenience**

The issue of ordering 'on the spot' and receiving fresh food is of paramount importance to patients; therefore ordering on the spot is good. Various patients (19, 20 and 21) in hospital C explain how they prefer to pick from alternative menus so that ordering on the same day instead of twenty-four hours in advance works better. Key advantages of the so-called Blue Menu Books are choice, freshness and ability to order it at (almost) any point in time.

#### 6.1.4.9 Patient suggestions

##### Relations with the catering staff

Patient 26 would like to know the names of the catering staff, as she does with the nursing staff.

##### Patients' ability to give feedback

Patient 30 is sad that no one from the catering staff ever comes on the ward within hospital E. The patient would like to interact with someone from catering in order to voice his opinions, as he now feels catering is simply not interested in receiving feedback. Patient 30 quotes:

*I know, I know you can't have patients in the kitchen for obvious reasons, but you never see any of 'em. Nobody ever comes round and says, "What's the food like? Are you happy with the food?" I think it might be an idea if they did [catering staff coming up on the ward to enquire about the patients' satisfaction]. I mean, I wouldn't want to be the one who did it because you're just gonna get a load of ear ache. But, I think it ought to be somebody. You know, even if they only came round...once every couple of weeks or something, at least there would be...it, it proves that they're showing an interest.*

Patient 30 extends this communication issue to the nursing staff too, quoting:

*Yeab! So, I'd imagine they, they, they do the best they can. But I think there ought to be more communication. [between] catering staff, nursing staff and patients.*

Patients 15 and 18 consider regular surveys would help avoiding huge food waste. Patient 15 thinks such surveys might provide the management with the necessary feedback to implement changes the catering staff is not able to conduct.

##### Time to choose from the menus

Patient 24 would like more time to choose items from the menu, as she feels a bit rushed the way it is done now.

### **Quality and freshness of the food**

Patient 26 considers the main issue with the food doesn't lie in service issues, but rather in key characteristics of the dishes served (quality, taste, texture and freshness of the food itself). Patient 3 suggests serving the food straight after production in order to avoid it drying out, whilst patients 4, 5, 10, 11, 16, 20 and 29 request a wider variety of fresh food: vegetables and fruits. The overall freshness of the food appears to be an issue across the five hospitals. Patient 4 quotes in his regard:

*The only thing I'm missing is food, as I said to you, I like fruits and they don't have a big variety of fruits. My friends bring to me fruits. They have (unclear)..., yeah. And they had more fruits there so for me it's fine... Yeah! The variety is good. If it was fresh it would be perfect. Yeah! If it was like home made foods, but I know this is very difficult 'cause, err....its very expensive.*

### **(Language) skills of the catering staff**

Patient 5 suggests recruiting more catering staff that are better skilled, especially in relation to their English language. In terms of service, the patient doesn't think there is likely to be any improvement in the near future. This appears to be due to the type of staff employed by the catering company (referred to by the patient as being multi ethnic and not fluent in English).

### **Opening hours of the restaurant and time of visits on the ward**

Patient 31 suggests changing the opening hours of the hospital restaurant during the weekend, matching them with the visiting hours of 2 to 4pm on Sundays. Patient 31 complains about Asian visitors who do not speak English and visit their relative outside the usual visiting hours. He is quite angry these visitors don't comply with the nursing staff's requests to respect visiting hours.

### **Hospital C: ability to choose from the various menus on offer**

Patient 18 believes (as do most of the patients on the surgical ward in hospital C) that the catering or nursing staff should take enough time to present all menus available to the patients and guide them through.

### **Specific suggestions for the paediatric ward**

Within this ward, the core focus of the patients lies in the improvement of the overall food quality, presentation and freshness of the products. The mothers of patients 19 and 21 suggest involving the children much more in the food process by using tasters, or displaying the food on offer.

### **Various**

Patient 11 suggests making herbal teas available, and reducing the time span between the last drink served in the evening and the first one served in the morning. Patient 25 thinks that the cutlery could be a bit better, as she receives big spoons for little trifles. Patients 1, 2, 6 and 7 do not have specific suggestions in respect to food. For patients 1, 2 and 6 this is due to the fact they are rather satisfied with the food. On the contrary, patient 7 considers not much can be improved as the staff simply does not have time to focus more on delivering proper food and service.

#### ***6.1.4.10 Worries production methods***

Patients 4 and 26 reject the idea of preparing food with a microwave. Patient 26 believes the food can't be cooked very well, because of the use of microwaves at ward level. Patient 11 says she prefers the oven, but doesn't mind the hospital using a microwave. Patients 27 and 24 regret some 'crispy' food simply can't be steamed. Where other food production methods are used, patients are rather worried about very practical matters like receiving cold food (patients 29 and 31), or having the wrong food delivered (patient 30). According to patient 30, this is due to a lack of communication, essentially, in the kitchen area. Patient 29 realises it takes time to transport the food up to the patients and understands this explains why it is not always warm enough.

#### ***6.1.4.11 Availability of food items***

Within hospital A, patients 3, 5, 6 and 7 do complain about the fact that all dishes listed on the menu are not always available. Patient 16 (hospital C, cook-chill method) mentions that sometimes the food ordered is not available on the trolley any more, as it has been picked by other patients served first. Therefore, the last patient always has to have the leftovers. Within hospital B, availability of the dishes is not an issue. The patients are satisfied with the choice and the availability of all dishes.

#### **6.1.4.12 Comments on the meal experience**

Patients 26, 28 and 31 found out that in hospital they don't have an appetite and they received far too much food. Patient 31 believes he receives too much food whilst being completely inactive. At the same time patient 31 is happy with the food served on the ward, as it is quite similar to what he is used to eating at home. In general, the patients' focus lies on the qualitative aspects of the food, instead of the service aspects. Apart from patient 17, most patients clearly expressed their satisfaction towards the food service in general (patients 4, 6, 8, 9, 10, 11, 12, 23, 24, 25, 28, 29 and 30). Almost all patient describing negative food experiences come from hospital C (patients 13, 16, 18 and all patients from the paediatric ward).

#### **6.1.4.13 Freshness of the food**

Patient 4, 5, 13, 14 and 17 complain about the freshness of the products and lack of fruits. Patient 13 does not like what he considers packed food, believing everything should be much fresher. No patient from hospital B commented on the freshness of the food, as this appeared not to be an issue.

#### **6.1.4.14 Comments on the catering company**

Staying within the hospital for more than fifteen months, patient 5 has experienced both catering systems (cook-chill and steam). Bearing in mind that the catering firm has grown too big and lost its focus on quality, this does not impress patient 5. The patient thinks the staff is rather rude and careless, and is very critical about the service of way identical food is served on the 'private' wards in the hospital. This viewpoint is illustrated by the quotes below:

*Yeah! Yeah! Not a smile, not a, "What d'ya want?" And you know, I mean, part of being given a lunch or a meal is the fact that somebody does it with a smile and they give it to you and... Yeah! And then you know you say, "Can I have a cup of tea?" Or, "Could I have some butter with my cheese and biscuits?" and, "No you can't!" Or "Yes you can!" And sort of bring it in and throw it on the tray.*

Like patient 29, patient 30 also thinks the responsibility lies with the kitchen staff. The patient is mildly unhappy with the food itself, but rather with all the small issues like wrong orders being delivered. Patient 22's mother regrets nobody from the catering staff reacts to her food related complaints. Over time, she has given up, merely getting used to the food being bad.

# Chapter seven: Cross-case analysis NHS staff

## 7.1 Introduction

Chapter 7 focuses on the outcome of the focus group sessions conducted with NHS staff involved in the food service process, based on the structure developed in Table 4.7. Chapter 7 unfolds as a continuous text, but Appendix H provides the reader with a brief example of how summaries and nested tables have been used in the cross-case analysis phase of this study, focusing on the issue of NHS staff comments and issues with the food.

## 7.2 The patient as a customer

Across hospitals, the NHS staff are rather conflicted when judging whether patients are treated as customers. In hospital C and E, the nursing staff consider the food not to be good enough to be customer-oriented, although in hospital E the kitchen staff believe they do all they can to satisfy individual requirements from patients. Nurses in hospital A and D consider they have some kind of (medical) ownership over their patients, believing they could never actually become real customers. Two hospitals (A and D) consider the new steam system has allowed working in a more customer-oriented manner.

### 7.2.1 *Issues of patient involvement*

#### **Patient involvement: sufficient involvement**

#### **Giving patients the opportunity to express their opinion about the food**

Nurses in hospital D consider patients are more involved now the 'new' steam system is in place, as they are able to choose their food on the same day (instead of 24 hours in advance).

Hospital D also participates in patient experience groups run by the Trust, where patients are given the chance to share their opinion on the food. One of the nurses in hospital D indicates it would be impossible to receive daily feedback from the patients.

### **Involving the catering staff towards the patients**

In hospital E, the nursing staff try to involve the catering management (as well as the kitchen staff) in the relationship with the patients. The underlying idea is to involve catering staff in dealing with patients complaints that the nursing staff can not do a great deal about (quality of the food predominantly). The nursing staff also try to involve patients more by giving them the opportunity to give feedback on the food. A nurse of hospital E quotes in this regard:

*P1 "They have got the opportunity to write on the back if there are any complaints and if we have had something they are not happy with we can actually get someone from the kitchen to come and see them and apologise in person".*

### **Patient involvement is insufficient**

In hospital C (surgical ward), the nursing staff consider patients should be more involved by giving them a chance to choose from 5 or 6 food alternatives on the spot, instead of having to order 24 hours in advance. The nursing staff of the paediatric ward in hospital C can not think of any specific manner of involving patients more in the food process. The nursing staff do not believe neither parents nor patients would be interested in receiving more information about the way the food is produced or where it comes from. This is because the acute medical condition of the children on this particular ward means they simply will not be interested in this type of information.

## **7.2.2 The importance of interactions**

Understanding the patients' preferences and achieving these implies regular interactions on three levels: between the NHS staff and the patients, between nursing and catering staff and finally between the catering staff and the patients. Achieving these interactions largely depends on the type of food production method in use and the staff group who serve the food. The nursing assistants of hospital C have described the importance of these interactions, as developed below.

### **Interaction between NHS staff and patients**

The nursing staff from hospital C consider that it is normal for the patients to complain to them first (instead of going to the catering staff), as they interact much more with patients. The nurses in hospital C explain how some patients tend to refuse the food they serve, and consider it their duty to get them to eat. A hospital C nurse quotes:

*“They sometimes say that I don't want that, so you have to coax them into it”.*

### **Interactions between nursing staff and catering staff**

The nursing staff on the paediatric ward in hospital C stress it is important for them to see the same catering staff working on their ward. Interacting with the same catering staff enables a smooth service, supposedly leading to patient satisfaction. A nurse of hospital C quotes:

*“Like Eileen, she's our (catering company name) she's excellent isn't she June? She is very good. But sometimes we have different (catering company name), but you think (the portion is so) small! But obviously you have got to take it out because it is a hot meal and you have to take it out. That makes a huge difference having a regular server that knows us and knows and the wards. Sometimes when we have different servers it is hell. That makes a huge difference having a relationship with the server. But the weekends aren't so great (as other servers take over)”.*

### **Interactions between catering staff and patients**

Even though nursing assistants serve the food in hospital C, patients (on the paediatric ward) tend to go to the trolley themselves and have a chat with the catering staff handing out the dishes to the nursing assistants, who then bring the food to the patients. But the nursing staff in hospital C regret that the catering staff do not interact more with patients, as quoted by an assistant nurse on the surgical ward:

*S “But they are not accessible are they? If your patient is stuck in bed and (catering firm) come on with a trolley and stand behind it, they don't have an opportunity. No they don't have any contact. I don't think that they distrust the (catering firm) team its just that they don't have a relationship with them”.*

The nursing staff propose that the catering staff should go round the wards with the menus in the morning, fill out the menus with the patients and bring round the meals that were requested. By doing so, the catering staff might develop more of a relationship with the patient and they might gain some feedback, rather than patients reporting straight to the nursing staff regarding catering issues. Disintermediation seems of paramount importance to the nursing staff in hospital C. The NHS staff would like to see the catering staff become more active on the ward, to empower themselves enough to solve problems. In the current situation, the NHS staff in hospital C feel that they are the ones that have to support and deal with all the food related problems (cold food and wrong orders delivered to patients) caused by the catering staff (both kitchen and service). The nursing staff consider that more interaction would help catering staff to build up a level of trust and relationship with the patients.

## 7.3 Comments and issues with the food

### 7.3.1 *Key issue: food or service?*

#### **Service is the issue, the food is fine**

The NHS staff in hospitals D and E believe that the key problem leading to patient dissatisfaction lies with service components instead of the food itself, but for very different reasons. This viewpoint is illustrated in the quote from hospital D below:

*S2 "I think most of the staff when you talk to them on the wards it's the meals themselves we haven't got a problem with it is the way that is delivered there has been a few hiccups in the system. But you can see the positives that when (the catering company) get the delivery right it will be good".*

These food service issues emphasised by NHS staff in the focus group sessions relate to the catering system in place in each hospital. In hospital D the food is delivered by the catering staff, whilst in hospital E patients do not interact with this staff group. Within hospital E, the nursing staff regret that catering do not interact more with patients, as it would give them the opportunity to learn about their likes and dislikes. The NHS staff within hospital E are quite satisfied with the food as they consider it is produced in house and that this is the best way to do it. But in general, their overall perception is one

of dissatisfaction, considering catering staff does not have any communication with the patients. The nursing staff in hospital E feel that the private food and service management firm do not take into account the issues they bring forward, and they are frustrated to keep saying it over and over again without noticing any change. The NHS staff simply dislike the catering firm in terms of service aspects, communication and relationships. Hospitals A and B are rather satisfied about the food.

### **Food is the issue**

Nursing staff on both wards of hospital C are very critical about the food itself (cook-chill method) and they also mention the lack of staffing. Decent food appears to be a pre-requisite for a customer focused orientation.

### **7.3.2 Specific age groups**

#### **Children**

##### **Healthy eating children**

The nurse assistants on the paediatric ward in hospital C have divergent opinions in regards to the variety and food choices proposed to the children. But, they all recognise children have specific food patterns that are related to their medical conditions and food habits at home.

##### **Parents bringing in food**

Within the paediatric ward in hospital C, the nursing staff know from experience that parents of long stay patients often bring in food, or purchase food from the hospital restaurant. The nursing assistants stress they receive very few complaints from parents, and it essentially comes down to a few individual cases. A nurse assistant quotes in this regard:

*S        “No, I've not really had any complaints about food. Like I say the odd child won't have anything off it at all and the parents have to bring in the food”.*

## Elderly patients

The nursing staff in hospital C (surgical ward) mention the portions given to elderly people are too large, leading to significant waste levels. The nursing staff find it difficult to get elderly people eating. The situation is opposite for younger patients, as quoted by a nurse of hospital C below:

*S        "Whereas the young even if it doesn't look appetising they are starving anyway and they'll eat it. They eat a lot. Yes they do, but they are not allowed to have a larger portion, they have just got to have like two roast potatoes".*

### 7.3.3      *Food production method*

#### Steamed food

##### Negative comments and fears towards 'steamed food'

Hospitals E and C are very apprehensive towards the future implementation of the steam system in their hospital, while hospitals A and B are rather disappointed about the gap between what was promised with the new system and what came out of it. However, the NHS staff of both hospitals A and B do not wish to go back to the old system that was in operation on their ward. Interestingly, a nurse from hospital B considers the steam system has been imposed on her ward because of financial restrictions related to food operations. A nurse assistant from hospital E fears the implementation of the steam system in her hospital for the same reason, stating that it is a measure imposed by the Trust (and the government) in order to cut food costs. NHS staff from this hospital consider the current system (plated food produced in the hospital kitchen) to be much better in terms of quality and the ability of the staff to cater for patients' specific needs. The nursing staff wonder where the new 'steamed' food will be produced, doubt its nutritional value and expect wastage levels to increase. NHS staff in hospital C also question the implementation of the steam system, fearing not to have enough space on the ward. Key questions the nurse assistants ask themselves are illustrated in the quote below:

*S        "There would be major problems with it. It sounds good in principle, but there is no room in the kitchen at the moment. Who would be responsible for the equipment? It would turn into a nightmare but you know you would have to store all this stuff".*

### **Positive comments on the steam system**

The nursing staff of hospital D are very satisfied with the new steam system implemented in their hospital, while hospitals A and B are satisfied and definitely want to keep this system operating. The underlying reasons are developed below. The nursing staff in hospital A feel that the patients complain less than they used to. The staff would like to keep the new system in place, but improve it by increasing the choices available. When asked what needs to be improved to the steam system, a nurse from hospital A quotes:

*S2 "More choice, because some people like less Africans and Caribbean's. You know that Africans would like to eat more English food. Most of the time they do overdose on curry".*

Comments on the steam system are also positive in hospital D, for various reasons: freshness, ability to choose on the day of consumption, reduced wastage, nice smell and the involvement of all staff categories to get their buy-in for the new system before it was implemented across the hospital.

### **Microwave is not an issue**

Within the hospitals using the steam system (hospitals A, B and D), the use of a microwave to prepare the food does not seem to be an issue to the NHS staff.

### **Food ordered the same day**

The NHS staff of hospitals A, C and D stress how important it is to choose food from the menu on the day of consumption instead of the traditional 24 hours in advance.

### **Canteen**

The nursing staff in hospital E are rather negative about the food on offer in the hospital canteen, as quoted below:

*P1 "The food in the staff canteen is horrible, it's disgusting. Absolutely disgusting the food in the canteen".*

*P2 "And at the weekends it's even worse, because I'm about the only one that uses the canteen. Well the food in the staff canteen is utterly disgusting".*

## Food made on site

Producing food on site and offering a customised choice ‘on the spot’ to patients is regarded as the best way of proceeding across the various hospitals. But the NHS staff are aware of the practical impediments of this method. Hospital E is happy to have the food still produced on site, considering this is the only viable solution eventually leading to patient satisfaction. Two nurses of hospital E quote:

P1 *“But the food, the majority of the food is well cooked”.*

P2 *“Yeah, I think so, definitely, because it's made fresh (on site)”.*

This view on producing food in house is shared by the nursing staff of the surgical ward in hospital C. A nurse quotes with reference to this:

S *“I think that for the duration that someone is in hospital that you don't need to bombard them with massive menus. It would be better to give them a couple of choices of well cooked tasty food. If you have someone in the kitchen down there and is experience in cooking then you could adapt to that. I don't see why that would cost so much more. It is the same as school dinners isn't it? They should have it cooked on the premises, by somebody who can adapt to different dietary needs”.*

## Comments other production methods

Plated food produced in the kitchen is favoured by hospital E, whilst the nurses from hospital D clearly state they do not want to go back to the traditional ‘cook-chill’ method.

## Comments cook chill

The cook-chill method used in hospital C is very unpopular amongst NHS staff. Key issues with this method are the texture, the obligation to order 24 hours in advance, quality and poor nutritional value.

### 7.3.4 Availability of chosen food

The nursing staff of hospital A (both wards) complain about the fact the food chosen by the patients from the menu is not always available on the ward shelves. Hot food cannot be provided on a 24 hour basis either, as the catering staff lock the fridges where the food is kept on ward level.

### **7.3.5**     *Portion sizes*

Hospital A is satisfied about the portion sizes and the flexibility of the catering staff to deliver double portions when required. The NHS staff of hospitals D and E did not comment on this issue. Hospital C is rather dissatisfied about the fact the catering staff do not show any flexibility in portioning the food for patients, while hospital B considers that the portion sizes have become too small. There is no clear link between food production method and issues related to portioning. The issue appears to lie with the willingness of the catering staff to show flexibility when it comes to portioning for patients.

### **7.3.6**     *Eat in a separate room*

The nurse assistants from the paediatric ward in hospital C would like the children to have their own dining room, sharing a communal experience. But a nurse assistant stresses this might complicate food provision as children tend to change their mind easily when influenced by others.

### **7.3.7**     *Menu fatigue*

The nurses from the paediatric ward in hospital C mention the long term patients on the ward are tired of the food served, and have their relatives bring in food for them. Within the surgical ward in this same hospital, the nursing staff also mention that long stay patients become aware of the menu rotation and become bored with the food on offer. The patients try to adapt to the menus by developing specific food choice strategies. Patients tend to switch to Hallal menus, and even the nursing staff considers these dishes to be much better (fresher and larger portion sizes).

## **7.4**     **NHS staff**

### **7.4.1**     *Opportunity for the NHS staff to try the food produced by the catering firm*

The NHS staff of hospital A were not allowed to try out the new steam system, whilst the staff in hospital D did have this opportunity. The latter enjoyed this, as it acted as a buy-in for the new system.

#### **7.4.2      *General knowledge food and BHF***

Only the nursing staff of hospital C had heard about the BHF guidelines.

#### **7.4.3      *Key suggestions NHS staff***

Key suggestions across various hospitals relate to more involvement of catering staff towards the patients. This implies better training of the catering staff in food related issues (hospitals D and A) in order to avoid situations where wrong food is served to patients with specific dietary requirements. More involvement (and even empowerment) also implies that the catering staff should listen more to the patients and to the NHS staff feedback, and write down the orders as well as hand out the food to patients (hospitals A, C and D). By doing this, catering staff would interact more with patients. Interaction is supposed to lead to trust between patients and catering staff (hospital A) and increase responsibility of the catering staff towards patients when food related problems occur. Hospitals C and E would like to see the quality of the food improved. Staff turnover seems to be an issue in hospitals A and D, especially during the weekend where better training and more responsible catering staff are required by the NHS staff.

#### **7.4.4      *NHS staff as trouble-shooters***

Within hospitals C, D and E the nursing staff describe themselves as real trouble shooters, often rectifying the omissions or mistakes from the catering staff. This is due to a lack of decent supervision and support of the catering staff on ward level (hospital D), or simply because the catering staff do not hand out the food to the patients (hospitals C and E).

The situation in hospital D is even worse now that the catering firm supplies provisional staff on the ward, which is in need of additional support (from the nursing staff) to deliver a proper service. Illustrating the issue of trouble shooting towards patients, a nurse from hospital D quotes:

S2 *“The supervision on the ward is not good, they don't come and supervise and help their hostesses. We have to do that, we have to check that all our patients are fed. We have to check that all the dirty dishes are collected up afterwards and that the water jugs are changed. We are the monitoring system really they're (catering supervisors) not here to, they don't supply the monitoring system as such. Which is poor when they know that the hostesses that they supply to us at the moment are not regular hostesses. Once you've got regular people then the monitoring can move away you can monitor at a distance, but when you have different people all the time then you should put more monitoring and support in for them”.*

S2 *“We are always troubleshooting aren't we?”*

S2 *“We are preventing negative feedback; we always do for everything, nurses. If the breakfast is late you are dashing around apologising to the patients and finding them an alternative. If the water jugs aren't done, then you are dashing around and filling them up. So as nurses we are troubleshooting and we want the best for our patients. Nobody from (the catering firm) comes up and walks around all the 28 patients and says I'm sorry that we are late. But we will have done it”.*

#### **7.4.5 Stress among NHS staff groups**

The working environment appears to be upmost stressful on both wards of hospital C, for both nursing and catering staff. This is partially due to chronic under staffing, the move of the paediatric ward to another location within the hospital, as well as to what the nursing staff perceives to be a generalised stressful ambiance within the NHS.

### **7.5 Major issues between staff groups**

#### **7.5.1 Cultural issues and departmentalisation**

Across hospitals, there is a clear difference of culture between the nursing and the catering staff. The nursing staff really feel as though they are part of the NHS global structure and institutional culture. The catering staff are regarded as real outsiders by the nursing staff and considered to be less educated

and having fewer privileges than the nursing staff do. It can be said that the nursing staff tend to look down on the catering staff. The fact that the nursing and catering staff respond to two different managerial structures contributes to the development of the two different working cultures evolving in the same environment. It is difficult to identify a common patient oriented culture in this situation.

Within hospital E, the nursing staff feel 'sealed off' from the catering staff. A similar situation occurs in hospital A, where the nursing staff are not allowed access to the fridges of the catering room on the ward in the evenings. The roles of both staff groups are well separated across hospitals, except on the paediatric ward in hospital C where the roles are sometimes blurred. Within hospital D, the rules are well defined: catering staff put the food close to the patient, while the nursing staff are responsible for the feeding and record the amount of food eaten. The nursing staff think that, eventually in the future, the catering staff might take over the feeding and recording. But, as illustrated in the second quote below, it is not possible to implement this at the current stage because of safety issues. The first quote below illustrates that the nursing staff from hospital D would like the catering staff to prepare the patients better before the meals:

*S1 "I noticed a few times that when the catering staff put the food on the trolley they don't prepare the patient, as maybe sit them up in the bed, they just put it on the trolley and perhaps push the trolley close to them, so you still have to make sure that if you are going to somebody probably more so in the side room that the patient is ready and able to eat and feed themselves. But if the trolley is across the other side of the room then that is a bit of an issue".*

*S2 "If you are delegating the feeding to non nursing staff then there is an issue. Whereas, if health care sisters feed then they know the patient and regarding sitting people up and if they need special utensils or whatever. So there is quite a big thing if you start delegating to non nursing staff so in some respects it is safer to keep it where it is".*

Within hospital E, the nursing staff complain about the kitchen staff, that never appear to take into account their feedback on the food.

## **7.5.2 Cooperation among staff groups**

The nursing staff within hospitals A and C are on speaking terms with the catering staff, which they consider to be generally helpful in satisfying patients requirements. Overall and across hospitals A, B, C and D, the collaboration is judged as being fine but subject to improvements. Developing a patient orientation implies the need to decrease the catering staff turnover (C and D) in order to build up set routines and better coordination between both staff groups by increasing written and oral communication (A, C and D). In hospital E the nursing staff consider it useless to give feedback to catering staff as no corrective actions are taken. Instead, the nursing staff prefer to talk directly to the catering management. Collaboration between both staff groups in hospital D is hampered by language issues and high level turnover of catering staff during the weekends.

## **7.6 Comments on the food and service management firm**

### **7.6.1 Language issues**

The nurses in hospitals A and D are critical about the poor language skills of the catering staff. The NHS staff in hospital E is aware of the language issues in hospital D, as both hospitals are located closely to each another. When asked if the nursing staff in hospital D faces language issues with the catering staff, a nurse quotes:

*S1 "Yes, we are learning Polish".*

### **7.6.2 Skills catering staff**

Apart from hospital E where the food is not delivered on the wards by catering staff and hospital B where the food is delivered by catering staff, the other hospitals (A, C, D) all emphasise that the catering staff should know more about the types of food that can be served to patients with specific dietary needs. The key issue for the NHS staff is patient safety and thus avoiding having wrong dishes served to some patients. Hospitals A and C further emphasise that the basic skills of the catering staff should be improved during the week end, as they often deal with students that lack experience of

working on a ward. The nursing staff of hospitals C and D also stress that the catering staff on their wards need to develop the skills enabling them to become more patient oriented.

### **7.6.3 Staff turnover**

Within hospitals C and D the high turnover of the catering staff forms a major issue. Whilst the nursing staff in hospital E are aware of these problems occurring in hospital D they notice significant service improvements within their hospitals when there is a low turnover. The nursing staff from hospital D are unhappy that they have to explain basic ward routines over and over again to new staff. Hospital C also prefer low catering staff turnover, as it improves the relationship between patients and catering staff.

### **7.6.4 Contacts catering management and NHS staff**

The nurse assistants in hospital A and the nurses from hospital D have good relationships with the catering management who they consider to be helpful. The situation is the opposite in hospitals C and E, where complaints to the catering management are deemed useless. The nurse assistants of hospital E mention that there is not enough interaction (meetings) between them and the catering management to voice their complaints. They would prefer to have monthly meetings with them, but consider the catering management to be too afraid to assist to such a meeting, as they would be 'shot down in flames'. A nurse assistant quotes:

*P1 "Yeah, we would be up to it (meetings with the catering management). They'd (catering management) be very very shocked".*

The nurse assistants from hospital C believe that becoming more patient oriented implies a better relationship between them and the catering management.

### **7.6.5 Issues with the catering firm's supervision**

The NHS staff in hospitals A, C, D and E are dissatisfied with the catering management supervision. In hospital A and D, the NHS staff mention that the catering staff have been 'left on their own' during the implementation phase of the new steam system. A nurse from hospital D quotes:

S2 *"The supervision on the ward is not good, they don't come and supervise and help their hostesses. We have to do that, we have to check that all our patients are fed. We have to check that all the dirty dishes are collected up afterwards and that the water jugs are changed. We are the monitoring system really they're not here to, they don't supply the monitoring system as such. Which is poor when they know that the hostesses that they supply to us at the moment are not regular hostesses. Once you've got regular people then the monitoring can move away you can monitor at a distance, but when you have different people all the time then you should put more monitoring and support in for them".*

### **7.6.6 Understaffing**

The nurse assistants of the surgical ward in hospital C consider that the catering firm is short staffed, impeding proper food delivery. But within hospital C (and particularly the paediatric ward), the NHS staff also feel under considerable pressure from their own management. Because of understaffing, the NHS staff do not have time to serve or assist the patients with eating the food. The NHS staff in hospital C cannot understand why voluntary people cannot be brought onto the wards to assist the patients during lunch.

### **7.6.7 Validity catering firm's surveys**

The NHS staff in hospitals C and E have doubts over the validity of the surveys conducted on their wards by the private food and service management firm. The nursing assistants within hospital C (surgical ward) consider patients are often intimidated while completing these surveys and then complain to the nursing staff once the survey is completed. This is shown by the two quotes below:

S *"If they come to speak to patients on the ward, and that is very rare. It will always be someone who is with it and composes the menus, because they feel intimidated. If someone comes to you and says what your food like, they will say yes very nice thank you very much, they won't say that it is absolute rubbish. They don't want to make waves and things".*

S *"Then they complain to us once they have gone".*

## 7.7 Operational issues

### 7.7.1 *Material lost by the private food and service management firm*

The nursing staff of hospital E mention that the specialised equipment (e.g. proper feeding spoons) are sometimes sent to the kitchen but never returned to the ward.

### 7.7.2 *Protected meal times not respected*

The protected meal time policy tends to be respected on non-acute wards with long stay patients similar to the paediatric ward in hospital C. It seems to be an issue in hospitals A, D and on the surgical ward in hospital C. The nursing staff of hospital D also regret that other staff groups (the doctors in this particular case) do not always respect the protected meal times in the morning. Protecting meal times is an issue in hospital C, as quoted by a nurse from the surgical ward:

*S "I think that the protected meal times idea is good. But in reality of it, an acute trauma ward can't always be done. It is trying to be achieved by staff as it is common sense and beyond that I don't think that the food provision being hot is not an issue, it is the quality of the food".*

### 7.7.3 *Who should deliver the food and feed the patients?*

#### **The private food and service management firm**

The catering staff in hospital D currently serve the food to patients and the nursing staff are happy with this procedure. It gives the nursing staff more time to focus on medical duties. Some nurses in hospitals A and C (essentially the surgical ward) are willing to hand over the food delivery to catering staff, but clearly stress better (catering) supervision is required in order to avoid having the wrong food served to patients with specific dietary requirements. Good or better supervision and improved training by the catering management seems of paramount importance to the NHS staff in considering delegating more duties to the catering staff.

## NHS staff

The nurse assistants of the paediatric ward in hospital C and E are reluctant in handing over food delivery duties to the catering staff. Safety appears to be the key issue, as the NHS staff fear wrong dishes may be delivered to patients with specific dietary requirements. The skills of the catering staff are clearly questioned by the NHS staff. The nursing staff further consider the interaction they have with the patients is valuable, enhancing the experience they have whilst staying on the ward. The nursing staff in hospital E are aware that in hospital D, the catering staff hand out the food to the patients. The nursing team in hospital E consider this option is simply not working out, deeming it to be quite dangerous when considering patients' safety. Commenting on what they think is happening in hospital D, nurse assistants from hospital E quote:

P2 *"But it's not working (catering staff handing out food to patients)"*.

P2 *"Erm, I mean obviously what I'm giving you is antidotal evidence because I've not, but I go to the systems meetings and at the systems meetings they complain about it all the time because erm, the staff aren't aware of erm their dietary needs"*.

P1 *"No we haven't got hostesses, we've got very good SPA's who know the patients, but with the, you go on other wards and the meal is just left on the table on the tray and that patient may be flat in bed, a bit like the advert that you see with the bloke in plaster and the strawberries and that's why people aren't getting fed"*.

### 7.7.4 **Service levels: week & week end staff rotation**

Apart from hospital B that did not comment on this issue, all hospitals mention the service levels of the catering staff are better during the week than at weekends. Weekend staff are described as not properly trained and often short staffed. The key issues mentioned by the nurses relate to sickness, training and absence.

### 7.7.5 *Complaints handling*

The NHS staff from hospitals A and D feel their food related complaints are taken into account by the catering staff, whilst the staff from hospitals C and E feel rather frustrated as not much is done about their comments.

Complaints are generally made over the phone in hospitals A, C and E. But as hospital C witness no improvements, complaints are progressively made in writing. The overall feeling across hospitals is that complaints must be addressed to the catering management, as the front line staff are unable to improve on the current situation because of a lack of empowerment.

#### **Catering staff not empowered**

The nurses from hospital A do not complain to the catering staff any more, as they consider they are not empowered to change anything about the food. They prefer to get in contact with the catering supervisor directly. The nursing assistants from the surgical ward in hospital C also believe the catering staff are not empowered to change the portion sizes. They do believe however that the catering management would be. The nurse quotes:

*S        "Well the portions that they bring. You are allowed six portions out of that and three out of that and when they have had their menu that is it and no one else can have anymore. (patient name) can't have two portions, oh no. It is so small for men".*

*S        "Maybe the server couldn't do much about the But (catering firm) the company could in that they could send extra meals or extra portions".*

### 7.7.6 *Introduction alternative menus*

An assistant nurse from the paediatric ward in hospital C tends to offer patients a range of menus upon arrival on the ward, as she knows out of experience that her patients enjoy spicy food (because of their medical condition whereby they lose their taste buds). The nurse assistant believes the so called 'blue menus' are most successful, as they offer child friendly food like chicken teddies and chicken nuggets. Long term patients on the paediatric ward tend to favour diversity and try out several menus. In the surgical ward of hospital C, the nurse assistants usually use the white menu, but explain about the blue menus when patients ask about it (usually when they get bored with the white menu).

## Chapter eight: Cross case analysis catering staff

### 8.1 Introduction

Chapter 8 focuses on the outcome of the focus group sessions conducted with catering staff involved in the food service process, based on the structure developed in Table 4.7. Chapter 8 unfolds as a continuous text, but nested tables as used in the cross-case analysis phase of this study are presented in Appendix I.

### 8.2 Patient as a customer

The patient service manager of hospitals D and E (one same employee) is on the food and service management firms' payroll, but is still under a NHS employment contract. She believes the objectives of the Better Hospital Food programme have been reached, with regard to the development of a guest-host relationship with patients. She is positive about the introduction of ward housekeepers on ward level (in hospital D) quoting:

*"I think the relationship between patients and services on the wards have improved and the Trust has also brought in new roles regarding housekeepers. It is just getting everybody working together but it ideally at the end of the day should be moving towards that and I think it is."*

The NHS staff in hospital E (paid by the food and service management firm) say they assist patients whenever needed, getting to know who needs the food cutting up for them and putting the tray next to them. The staff believe good food service is about getting exactly what is ordered, well cooked and hot. Preparing patients for their meals is another core duty of their job. Describing what works best with patients, NHS catering staff in hospital E speak about Tender Loving Care (TLC). Within hospital A, the food and service management staff consider patients as customers by meeting their basic needs and trying their best within their possibilities. The focus is clearly on the basic needs of the patients. The food and service management staff are very proud of the service they deliver. Staff within hospital B believe patients should be treated even better than customers.

### **8.2.1**     *Issues of patient involvement*

#### **Patient involvement is sufficient**

The site manager in charge of food services in hospital D/E mentions the creation of a little information booklet giving patients some basic information about the food. The idea is to involve more patients who are interested in the food process. The site manager realises that few patients will read the booklet, as most patients do not ask for this type of information. On the contrary, hostesses from hospital B mention that patients often ask questions about the origin of the food. Hostesses from hospital A say that most patients are involved enough as they do choose the food by themselves. Apparently, patients on the elderly ward tend to ask the nurses to choose for them, or negotiate what they want to eat. The hostesses point out that sometimes they have to present alternatives to patients, trying hard to be flexible and giving even more of their time.

#### **Involvement is not sufficient**

Catering staff in hospital E believe that surveys are not conducted often enough and are rather useless because many patients can not fill them in properly (because of their medical or mental condition).

### **8.2.2**     *Importance of interactions with patients*

Catering staff across the various hospitals agree that interacting with patients is essential in developing customer-oriented food services. In some hospitals, catering staff simply do not have the opportunity to interact with patients because they do not hand out the food to them (hospitals A, C and E). Patient-oriented food services also entail frequent interactions with other staff groups involved in the food process. The 'NHS' catering staff in hospital E are unhappy that the kitchen staff are not more accessible to them. Sometimes patients get angry because they are frustrated by the food service or quality of the food itself. The catering staff then explain to the patients that they do not have access to the kitchen and can not do anything about the quality of the food. The patients' services manager of hospital D/E explains how domestic assistants would like to move towards a ward hostess position, thus promoting the enjoyment of contacts with patients. The patient service manager quotes:

*S* “They are quite happy, they are domestic assistants. But they probably want to be trained in that job. It's better for us when we have a service to run, but it keeps them interested and if any vacancies come up then they might say that they want to do that. But with the hostesses we've recruited two of them and nobody has really left, because they like the interaction with the patients and it is a totally new role and they like that.”

Hostesses in hospital A state they know the patients' preferences well because they interact with them on a daily basis. A hostess explains how her duties go beyond the sole delivery of food, stressing it is also about words of encouragement and reassuring patients. However, conversations with patients remain rather limited and are described by a hostess of hospital A as follows:

*S2* “Just give a smiley face when you are going by their bed they are sickly they need to be comforted. Just a small relationship between us and the patient. They like talking to us. We are them. They want to know how many children you have and when you finish.”

## **8.3 Food issues**

### **8.3.1 Key issue: food or service**

#### **Service is the issue, food is fine**

Contradicting the overwhelming negative comments from both patients and NHS staff in hospital C, the catering staff believe the food is absolutely fine. In their view, it is the patients' responsibility to choose what food they like. A member of the catering staff quotes:

*S2* “Well that complaint would only come if they ordered the wrong food. Because if you ordered something that you really like then there would be no complaints.”

#### **Thinking about food only**

When asked what the ideal picture would be, catering staff from hospital B only refer to food issues (hot desserts in the present case). Catering staff from hospital E believe that it comes down to having good, hot food and the service components don't come into it.

### **8.3.2 Specific age groups**

#### **Children**

When serving the food on the paediatric ward in hospital C, the catering staff often receive indirect criticism about the lack of choice. Parents are not really complaining but just mention it. The catering staff tend to keep quiet when the food is criticised.

#### **Elderly people**

Catering staff in hospital E agree with the statement that elderly patients try not to bother them and are inclined to keep quiet. The catering staff report back to the nurses about their food consumption when it is an issue.

### **8.3.3 Food production method**

#### **Steam method**

Comments on the steam system are very positive across all hospitals where it has been implemented (A, B and D). The catering service manager from hospital D/E is positive about the steam method implemented in D, receiving nothing but positive feedback from the questionnaires conducted with patients. Describing how the implementation of the steam system has set a precedent, the catering manager quotes:

*S "We do have a lot of visitors from hospitals around the country. They do say that it has set a precedent and it is the one that everyone wants to come and see the service. We have a lot of people who will come and oversee the meal service and the progress and some will sample. Some people say oh I don't know about (the steam system) but then they sample it and they are happy with it."*

Within hospital A, catering staff believe patients are satisfied with the new steam system put in place on the wards. This is in comparison to the traditional cook-chill system as preparation with the steam system is considered to be easier. In terms of the menu, the catering staff believe the menu should be developed for patients who are staying long periods of time on the ward (more than a month). Catering staff explain there is no issue in terms of association of the ingredients on the dishes, as there is a large choice on offer. Staff deem themselves properly trained to serve all menus. Patients from different

ethnic backgrounds prefer to switch straight away from the steam menu to halal or kosher. Within hospital B, the catering staff believe patients are happy with the steam system in approximately 80% of cases. Sometimes, patients complain, but this is often due to their medical condition.

### **Canteen**

Catering staff in hospital E think the canteen is far too expensive because staff can not afford to eat there.

### **Other food production methods**

Even though the steam system is recognised as being the best solution on offer, catering staff think producing fresh in-house plated food would be the ideal alternative (hospitals B and E). Referring to a few wards where the steam system has been implemented in their hospital, catering staff from hospital C believe the steam system is more hygienic than the previous system.

Within hospital B, the catering staff also prefer the steam system (because of the large choice), even though the plated system is recognised as offering even more fresh food. NHS staff working under supervision of the food and service management firm in hospital E are aware the steam system is in use in hospital D. They agree it is a bit more popular with patients than the plated food system used in their hospital. However, the catering staff believe the plated food system is the best system, but ideally not provided by a private food service management firm. A NHS staff member from hospital E quotes:

*S1 "I personally think that it should come back in house. Like it used to be. Well I started 19 years ago, it was better then."*

Catering staff of hospital C stress some patients seem to like the food very much and clearly do not want to be critical in any way towards the food served on the wards.

### **8.3.4 Availability chosen food**

Catering staff within hospital A say the nursing staff are pretty enthusiastic about the steam system, especially because there is always food available on the ward. When asked if they sometimes try to get rid of their shelf stock, they argue that all stock is available all of the time. If it is not the case, they ring to the kitchen and the plates are brought. NHS staff under supervision of the food and service

management firm in hospital E complain about the lack of choice or availability of food ordered. A domestic employee quotes:

*S1 'It like the other day a lady ordered cold chicken and salad stuff and they sent beef. She said to me I've got beef and I said yea and she said but I ordered chicken and I said that's because they have run out of chicken. She said well I can eat beef but I wanted chicken. Also the sandwiches now, they are what they send. See you don't have a choice with sandwiches anymore. Trying to get a cheese and tomato sandwich is like asking the moon to drop out of the sky. They don't put butter on the bread either that's another thing.'*

### **8.3.5 Portion sizes**

Within hospital A and B, the catering staff believe the portions are too small. Some patients even ask for another portion. The NHS catering staff working in hospital E complains about the inconsistency in portioning. Catering staff from hospital C regret there is a lot of food wastage on the paediatric ward, where children receive portions similar to those of adults.

### **8.3.6 Separate room**

Only the NHS catering staff of hospital E believe it might be useful to have a separate room for some patients to eat in, depending on their medical condition.

### **8.3.7 Menu fatigue**

Catering staff on hospital A believe patients staying more than a few months on a ward need to see the menu developed further. The NHS staff under supervision of the food and service management firm in hospital E state that with a 2-week rota on the wards, the patients become quickly tired of the menus.

### **8.3.8 Choice available**

Catering staff in hospital A and B consider there to be enough food alternatives on offer for the patients. They believe this is a key factor leading to patient satisfaction.

### 8.3.9 Room for improvement

Within hospital A, catering staff believe pictures would be useful on the menu. As quoted below, breakfast should also be improved:

*S2 "I think that maybe once or twice a week they could give bacon and eggs. It's not too expensive at all because you can get a pack of eggs for £1.00 so if they were buying it in quantity then it would be even cheaper about 20p."*

Within hospital B, catering staff do not think any further improvements are necessary as the current situation is fine. Within hospital E, the NHS catering staff believe the food provision has improved significantly over the last 4 to 5 years. However, some say it could be cooked much better and the staff are critical about the texture of the ingredients, i.e. the skin on the porridge and no sauce with the fish. As quoted below, the trolleys are said to be absolutely disgusting:

*S2 "They need new trolleys to start with. The trolleys are disgusting, what the meals actually come up in. Ours is taped up with Elastoplasts. It is constantly dirty inside."*

Describing the current strain in the NHS, a NHS catering staff member of hospital E summarises the situation with both quotes below:

*S13 "I think it comes down to money and pressure and figures. There is too many targets to reach that are unreachable. I don't know where all the money is going that we are paying in. You don't work for the NHS do you?"*

*S1 "You just need to have more money because there is enough going in and you need attention to detail. It seems a slippery slope to oblivion."*

Catering staff from the paediatric ward in hospital C suggest implementing a system where food can be ordered on the spot.

## 8.4 NHS Staff

Collaboration with NHS staff is relatively good across hospitals. Good relationships between the two staff groups can be related to a low turnover, thus enabling the catering staff to know both NHS staff and patients better. Within hospital E, NHS staff under supervision of the food and service management firm have a good relationship with the ward housekeeper (NHS staff). The ward housekeeper reports to the ward sister and liaises with the food service manager in order to ensure positive food experiences for patients. The (NHS) catering staff in hospital E sees no problem in working under supervision of the food service management firm, but they still identify themselves as being NHS staff. The quote below illustrates this view:

*S 'No not really. Like I say myself and Elaine we have been with the Trust for 17 years we are Trust staff, but because of the job we do (the food and service management firm) now pay our wages. Once you get to supervisory and managerial level, because of the job that we do and the contract they've got they pay our wages. So we have always had the background and from working with the Trust and these people. They don't see us as (staff from the food service management firm), but still see us as Trust Manager really.'*

The NHS catering staff in hospital E clearly feels that they are better off with a NHS contract than they would be with a 'private' contract from the food service management firm. The NHS catering staff working in hospital E under supervision of the food and service management firm emphasise that the NHS is under considerable financial strain. This in turn can lead to very low morale amongst nurses and doctors. Within hospital A, the relationship between catering and nursing staff serving the food is generally fine. Some catering staff feel they are looked down on by doctors or medical staff, but in most situations the collaboration is a positive one. The fact that the catering staff know the nurses as well as they know the patients needs is helpful here (hence the importance of a low staff turnover). Catering staff regard the nurses as being busy enough with usual medical duties and believe they could easily hand out food to the patients instead of the nurses. Catering staff in hospital C also feel nursing staff are under significant pressure.

## 8.5 Major issues between staff groups

Within hospitals A, C and E the catering staff sometimes feel looked down on by NHS staff (nursing or doctors and consultants). Overall, issues between staff groups relate to communication in a generally strained context within the NHS (in financial terms and ensuing resources). The patient services manager in hospitals D and E is aware of the fact that wrong food might be served to some patients when delivered by catering staff instead of medical staff. She considers the trolley system in place in hospital E can lead to such situations. Whilst the steam system, whereby nurses fill in special diet sheets, is supposed to rule out such occurrences (as used in hospital D). The patient services manager of hospitals D and E quotes:

*S "This is why, I don't know if you have seen it at the (hospital D), have you seen the special diet sheet? That is the nurses responsibility to fill that in so everybody has the right meal and no-one gets the wrong meal. The problem that we have down here is because it is a trolley to bulk service you will have the meal that somebody ordered yesterday because they have gone home. You could be eating something that you don't even like."*

Within hospital B, the catering staff receive frequent feedback from the nurses with regard to food. This feedback is then transmitted to the food and service management. Catering receives all information required in respect to special diets for some patients. Within hospital E, NHS catering is short-staffed and feels a certain strain within the NHS. Morale with nurses and doctors is considered to be very low. But the NHS catering staff stress that receiving assistance or support from nursing staff depends on the character of each nurse. Overall, NHS catering staff in hospital E are very satisfied about the relationship they have with the nurses. The NHS catering staff only regret there is almost no communication between themselves and the kitchen. In hospital E, the NHS catering staff receive a sheet that is kept on the zenith once the nurses have had their handover and they will write down either soft menu, or diabetic. When nurses trust catering staff, the former tends to delegate many more tasks that are normally not completed by catering. For instance, the thickening of food needed for specific patients. The NHS catering staff insist on the fact that cooperation with the kitchen, largely depends on the interpersonal skills used by the NHS in communicating with the kitchen staff. Offering to go to the kitchen to fetch a meal is highly appreciated by the kitchen staff. However, this situation is quite different from the surgical ward in hospital C. Here the catering staff have been eating out with the nurses on a social basis.

## 8.6 Comments on the catering firm

Catering staff in A and C regret they have little support from their management. They feel 'let down' and face a rather difficult working environment alone. NHS catering staff in E are critical towards the kitchen staff, but understand the food and service management firm is operating in difficult conditions within a tight budget. The patient service manager explains how the situation in hospital D has stabilised as domestics are fully trained and moving towards a hostess role. According to the patient service manager, staff turnover in hospital D has decreased dramatically.

The early days of the implementation of the steam process in hospital D were combined with a move from the old to new buildings. Because of this, the food and service management firm had to be contracted out to agencies for support, recruiting a huge amount of Polish employees. At this point there was an issue about the language barrier, but the Polish are considered to be excellent workers and they overcame the hurdles. The patient services manager admits there may have been a little bit of inconsistency at the start, but the staff settled in and were given permanent jobs. During this time the ward sisters were considered to be very supportive.

Domestics in hospital A do not feel they are respected by NHS staff and they are disappointed the management does nothing about it. According to the domestics of hospital A, nursing staff treat them better when patients are around. The domestic cleaners sometimes perform tasks usually attributed to the hostesses, but prefer to keep their current job as it pays better (£5.50 versus £5.36). However, the catering staff, feel let down by their management (team leader), quoting:

*S2        "We have team leaders they have to come to the ward to look at what is happening between the patient and the hostess. They have to come to see what is going on whether the hostess can serve the food, but they don't come."*

## 8.7 Operational issues

### 8.7.1 Complaints

According to catering staff in hospitals A, B and E, feedback from patients is thought to be of little use. This is because the current situation cannot be changed because of financial constraints the NHS is operating in. Within hospital E, the NHS staff under supervision of the food and service management firm believe patients would normally address complaints to the hostess as they know the meal. If the hostess is not available they would probably go to a Healthcare Assistant (HCA) on the ward. Within hospital A, catering staff also mention that when the patients have a complaint they go straight to the hostesses instead of the nursing staff. In a situation where the patient complains to a nurse, the nurse will feed back to the hostess. The hostess will then go back to the patient in order to find out what is happening and resolve the situation. Catering staff from hospital B think patient feedback forms are read by their management, but again, they believe not much can be changed about the current situation. The quote below illustrates this:

*P1 "I think they change some of the things. Most of the time they really, I mean, they are struggling to change everything now they just ignore it as I see the managers, my leader, my team leader always just reads it and I think that's in a way they are proficient, but I don't know how they would change."*

### 8.7.2 Food served by...

Apart from the catering staff in hospital C, all the other hospitals would like to see the ward hostesses hand out food to the patients. NHS catering staff in E, under supervision of the food service management firm, consider the 'ideal' situation to be when ward hostesses do the bulk of the food service (like in hospital D). A member of the catering staff in E quotes:

*S "I think the ideal picture is the ward hostess at (name of hospital D). Where they do the bulk of the meal service. They take the menus, they take the food orders, -stocking comes from catering they actually serve the meal, hot prepare it. The only thing is that the re-stocking comes from catering and we have that link with catering, but the majority of the meal services come from the hostess that we manage. With exception of the patients that are identified by the nursing staff and have assistance with feeding and the HCA will sit and feed."*

Within hospital A, the catering staff believe hostesses should hand out food to the patients (instead of the nurses). Catering staff state the steam system is easy enough for them to use and do the food service themselves. Surprisingly, the catering staff have issues with the 'hygiene of the nurses' and with them using work pressures as an argument, quoting:

*S2 "I think the hostess they have to do it (the food service). Because some of the nurses are tending to the patients with the dressings or something like that. Or helping them put their clothes on. If you call them and they come to the kitchen they forget to wash their hands. Some of them after they've finished with the dishes they forget to wash their hands. It is the nurses that have contact with the patients.*

*S2 "At first we were serving the food, but they think it was too much for us and they asked the nurses to do it. But now (the steam system) is so simple that the hostess should serve the food."*

### **8.7.3      *Serving order***

Only on hospital C do the patients sometimes complain about being served last.

### **8.7.4      *Protected meal times***

The NHS catering staff in hospital E complain about the fact that medical staff (doctors essentially) do not respect the patients' 'protected meal times' agreements.

# Chapter nine: Discussion based on inter-hospital comparisons from various perspectives

## 9.1 Introduction

A key contribution of this study is an in-depth, comparative look at 5 acute NHS hospitals from the perspective of patients, NHS staff and staff from the food and service management company operating in these hospitals. Despite operating within the NHS and using similar approaches to evaluate and prioritise their food service operations, the 5 hospitals exhibit numerous differences regarding patient and staff satisfaction. By bringing together the views of patients, NHS and catering staff around key themes which emerge from both literature review and the data collected, this paragraph builds upon the cross-case analysis completed above for each category of respondent and is dedicated to the discussion and interpretation of the research findings. Following the overall structure of the thesis and integrating the output of the data from patients and other stakeholders, this discussion chapter is divided into two main parts. The first part (9.2) focuses on the patients and the second part (9.3) focuses on implementation issues of patient-oriented food services as encountered by the staff groups involved. Chapter 9 provides the opportunity to answer the research questions listed in Table 1.1. With regard to the patients and for convenience of the reader, the central research questions will be repeated at the beginning of each paragraph. These questions will then be briefly answered at the end of the paragraph concerned and will be based on the discussion which integrates all data sources at hand. The second part focusing on the discussion of the focus group sessions held with the staff groups involved in food services will follow the same process.

## 9.2 Patients

The third main research objective of this study has guided the research on patients:

C. to identify the patients' core psycho-social determinants leading to satisfactory food service experiences and investigate how these can be facilitated by the various stakeholders involved

Four research questions relate to this objective. These are listed below:

1. How do patients in acute NHS hospitals experience food services delivered by a private food and service management firm?
2. Can patient profiles be developed, relating to specific patterns of food acceptability, choice and satisfaction?
3. Can common defining constructs of relationship marketing and consumer food behaviour serve as a foundation to underpin the development of patient-centric approaches to food services in acute NHS hospitals?
4. Is a personalised food service experience focusing on the development of relationships between patients and medical or non-medical staff likely to achieve increased satisfaction levels, eventually leading to a shift of attitude towards hospital food services?

These research questions will be answered at the end of paragraph 9.2 which is dedicated to patients. But first the author will use the framework of the interview schedule (Appendix A) in order to distill the data required to answer the research questions listed above.

### **9.2.1 *Involvement***

Central research question, related to theory questions 1 to 5 (see Appendix A):

*What is the role of patients in acute NHS hospitals, as co-producer of value through communication and interaction in the food process?*

#### **9.2.1.1 *Involvement, communication and interaction***

Food appears to become more important over time for patients, breaking the monotony of their stay in hospital. The fact that food is not a key issue during the first days after admittance on the ward is often due to the lack of appetite after medical intervention. Initially, patients tend to focus on core aspects such as temperature, texture, cleanliness, taste, hygiene and correct service delivery. As the length of stay increases for patients, their focus shifts from the quality of care to other factors such as food (service) aspects. This observation from this study contradicts the usual assumption that the longer the length of stay the more important becomes the dimension of food quality compared to service quality.

Within this study not a single patient received information about the food served, in terms of origin or production methods, and only few showed an interest in doing so. It seems additional information is not a priority for patients, especially when they are satisfied with the food offered. It is only when patients or their guardians are dissatisfied with the food (in the case of the paediatric ward in hospital C), that they mention it would be helpful for them to receive information about the alternative menus on offer. Within this study nursing staff on the paediatric ward in hospital C did not think neither parents nor patients would be interested in receiving more information about the way the food is produced or where it comes from. This is because they believe the parents focus is on the acute medical condition of the children on this particular ward. In hospitals D/E the patient manager mentioned a booklet with basic information about the food which is developed for patients. In B only one member of the catering staff said patients often ask for information about the provenance of the food.

### **Communication between patients and catering staff**

Direct contact between catering staff and patients (disintermediation) would stimulate interaction and lead to a trust between both parties. The nursing staff in hospital E believe patients in their hospital do not have the opportunity to interact with the catering (kitchen) staff. If they did it would give kitchen staff the opportunity to learn about the patients' likes and dislikes. Across hospitals, this is further emphasised by the catering staff who consider interaction with patients and other staff groups to be essential in developing patient-focused food services. As stated in the literature on relationship marketing, a productive two-way communication process between the customer and the company is essential in developing relationships, trust and confidence. With this in mind, it is surprising to note that various hospitals (A, C, E) do not facilitate contacts between patients and catering staff.

This situation implies a key characteristic of marketing communication in a RM context is not fulfilled in the hospitals under scrutiny. There is no multi-way communication process across stakeholders involved in the network surrounding the patient (NHS and catering staff in the present study). From the patients' perspective, there is certainly no access to what Bohm (1996) defined as the ability to build a common meaning or shared field of knowledge related to the food experience. Despite this, catering staff in hospitals A, C and E would like to interact more with patients in hospitals where they do not serve the food to patients. Certainly in those hospitals, the resources of the NHS interacting with a private food and service management company are not used in a way to enhance patients' trust towards food services. According to Conway and Swift (2000), if they were, this could lead to a more positive attitude and increased level of customer understanding.

As considered by Bélanger and Dubé (1996), frequent interactions between patients and catering staff might eventually lead to a situation where patients benefit from the emotional support given by this particular staff group. As illustrated by these authors in the context of Canadian acute hospitals, interpersonal aspects of food services have more impact on ratings of satisfaction than technical aspects do. This implies that positive interactions between patients and catering staff are an underlying dimension of patient satisfaction and could be helpful in improving ratings. The same applies to interactions between patients and NHS staff serving the food. The catering staff of hospital B stressed that small hospitals facilitate fruitful interaction with patients, in line with the positive feedback from patients in this particular hospital.

When considering the first research question and according to the above, it is difficult to consider today's NHS patients as co-producers of value through communication and interaction in the food process. The role of patients when considering food services is limited, even though patients would like to take up a more active role when hospitalised for longer periods of time (usually when exceeding one week, which applies to a minority of patients in NHS hospitals). Unless patients are dissatisfied about the food on offer, they do not require information related to food production methods. Across hospitals and depending on operational arrangements (food production method and staff group actually serving the food) there appears to be a lack of understanding and implementation of patients' preferences. This is partly due to a lack of constructive interaction and exchange of information between all parties involved (patients, NHS and catering staff from the private food and service management firm).

Disintermediation between catering staff and patients would facilitate the development of an understanding of patients' preferences when it comes down to food issues. This would eventually lead to patients benefiting from the emotional support of catering staff.

#### **9.2.1.2 *Involvement and satisfaction***

Central research question, related to theory questions 6 to 9:

*Does involvement of patients in the food process increase their level of satisfaction?*

### **Patient involvement in food issues: the case of hospital C**

The issue of involving patients (and children) in the food process seems to be paramount for patients on the paediatric ward in hospital C (by using tasters or displaying the food on offer). By giving patients a chance to experience the food before ordering large portions reduces the amount of waste. The NHS staff in hospital C is critical about the food system in use on their wards and are in favour of a system where it is possible for patients to choose on the spot from various options displayed. As emphasised by Bélanger and Dubé (1996) the importance of perceived control over a situation influences satisfaction judgements. This is mostly applicable in hospital C that faces many complaints about the intrinsic quality of the food. It is a fact that patients in hospital C have little control because of the food system in place which is trolley and 24 hour advance ordering.

### **Patient involvement in food issues: advantages of the steam system**

The NHS staff working in hospitals where the steam system is in use believe it has increased patients' involvement as they are able to choose from the food on the day of consumption. According to Bélanger and Dubé (1996), patients feel more in control over the situation which in turn positively influences satisfaction with interpersonal aspects and food services in general.

### **Patient involvement in food issues: when comments from patients are not considered to be taken into account**

Various patients across wards and hospitals believe they are not sufficiently involved in the food process. They feel their comments are not taken into account by NHS or catering staff. Patients would like to meet with someone from the catering management in order to voice their comments because they believe front-line catering employees are simply not interested in receiving feedback or not empowered to act upon it.

This inability to provide feedback has been previously outlined by Watters et al. (2003), together with the request for more personal contact. Interestingly, the data collected from these authors was obtained through qualitative research including focus groups and meal rounds. The NHS staff from hospital D stress their patients are given the chance to share their opinion on the food through experience groups run by the Trust. Patients consider regular surveys would help in avoiding a large amount of food waste. This would provide catering management with the necessary feedback to implement changes that the catering (front line) staff are not able to conduct. The patient services manager of hospitals D & E would like to see more surveys conducted.

Across hospitals, the NHS staff would like to see more involvement from the catering management (as well as kitchen staff) in the relationship with patients. However, the idea is to involve catering staff in dealing with patient complaints, as the nursing staff can not respond to these. These complaints predominantly relate to the low quality of food offered. Patients across hospitals believe front-line staff can not improve much about the food. This contradicts the findings from Bélanger and Dubé (1996), as situation-attributed negative emotions are negatively related to satisfaction with interpersonal aspects of food services. This observation reflects the frustration patients experience in the lack of ownership front-line staff (both catering and NHS) take when food-related problems arise. It also highlights the benefits associated with building a concern for patients' emotional states in daily practice. Across hospitals where patients are able to interact (mostly with NHS staff), they benefit from the emotional support received and are likely to transfer this 'added value' to their satisfaction judgements. With this in mind, regularly monitoring the emotional state of patients in the delivery of food services would be helpful. As Bélanger and Dubé (1996) believe, satisfaction is related to word of mouth, consumption and compliance behaviours. However, as described in the paragraph below, there appears to be no real communication between patients and catering staff from the private food and service management firm. Redesigning the role of catering staff and informing patients and NHS staff about this might be helpful in stimulating interaction between patients and the staff actually serving the food to patients. The sole exception to what is considered to be a lack of patients' involvement in the food service process is found within the catering staff of hospital A. Here patients are considered to be fully involved in the food process as they are able to choose the food themselves.

### **Discussions between patients and catering staff (front-line and management)**

There appears to be no real communication between patients and catering staff because most patients think that this is not part of the catering employees' job description. Patients do not want their relationship with the catering staff to change; neither do they want to discuss issues more in-depth with this staff group. This is essentially due to two reasons:

1. the fact they don't know the catering staff well enough and prefer to stick to the NHS staff they interact more with;
2. most patients believe front-line catering staff are simply not empowered to improve the food in any way (key element in hospital C). Therefore, more interaction with this staff group is thus deemed to be useless.

Consequently, most patients consider catering staff are there to present the menu, take the order, prepare and serve the food (in the hospitals where this is not done by the NHS staff), without any additional service components attached. The age, gender or food habits of the patients do not directly influence their views on the relations with the catering staff. Interestingly, Lau and Gregoire (1998) and O'Hara et al. (1997) have found few differences in satisfaction ratings on the basis of demographic characteristics of patients. This is unlike Dubé et al. (1994) who focused on patients in an acute-care hospital. At best, the patients refer to discussions they have with catering staff as 'small talk', and keeping a status quo seems most appropriate. However, two patients stressed that communication with catering staff is sometimes difficult because of language issues. This was confirmed by the nurses of hospitals A and D, who were critical about the poor language skills of catering staff. Various patients across hospitals A, D and E complained about the fact they never get the opportunity to talk to the catering management to voice their complaints.

### **Discussions between patients and NHS staff**

Patients tend to have discussions with NHS staff more easily than they do with catering staff and this also applies to food issues. NHS employees are the first contact point for almost any matter, as patients feel they are 'closer' to them because they see them more often. Only one author in the literature emphasised this privileged role of nurses. Tredger (1982) stated that nurses are members of a team who will probably develop the closest relationships with patients as they have most contact with them. All patients which were interviewed gave much more credit to the nursing staff than to the catering staff, even with regard to food issues.

Patients across hospitals feel it should not be the nursing staffs' task to deal with food-related issues, as they have enough medical duties to do without dealing with the food issues. Parents from the paediatric ward (hospital C) avoid food-related discussions with the NHS staff so as not to interfere with their medical duties. The parents are very much involved in the medical aspects of the treatment their child is undergoing and food is a secondary thought. The parents of the children on this ward are very supportive and understanding towards the medical staff taking care of their child.

### **Food requests and complaints: who do patients address?**

Patients from hospital A and hospital D are inclined to address catering staff directly for special requests or specific complaints. It is relevant to note that, in these two hospitals, the food is brought by catering staff to the patients. Once again, the fact whether patients interact with staff members involved in the food process is significant. Whether patients consider front-line catering staff to be empowered

on food-related issues also determines who they complain to. In this respect, various patients in hospitals C and E would prefer to interact directly with a catering manager who has the ability to act on the situation. This observation is in line with Hartwell et al. (2006) who note that a post of hospital food service manager would be helpful in overseeing the whole meal process from kitchen to consumption. Patients in hospital C even mention that the NHS employees are simply not empowered to improve the quality of the food and so they consider it useless complaining about it to them.

In the occurrence of a complaint, patients 23, 26 and 30 would prefer to deal with the nursing staff. This is due to the fact that they do not know which manager is in charge of the food on the ward. There appears to be no direct link between the food production method and the notion of empowerment of catering staff across hospitals. Various patients feel sorry for NHS employees who sometimes take the blame for food-related problems they can't do anything about. Three out of four parents and patients who were interviewed on the paediatric ward (hospital C) feel sorry that nursing staff have to deal with any problems which result from the poor quality of food on offer. Again, the food production and delivery method resulting in the delivery of poor quality food in hospital C is evoked by patients.

### ***9.2.1.3 Factors contributing to satisfaction***

Most patients only look at basic, tangible characteristics of food to make satisfaction judgements. This is partially due to the low level of expectations towards hospital food. It is only long-stay patients and so-called food 'experiencers' who look beyond tangible characteristics of food to build up their satisfaction judgements. Where Olsen (2001) noted involvement with food in daily life has a strong, significant and expected consequence for frequent food behaviour, it appears the opposite occurs in acute NHS hospitals. Patients that are highly involved with food in their day-to day life tend to be more critical about the food served on the ward and actively seek alternatives. Contradicting the findings from Marshall and Bell (2004), the effect of food involvement in the hospitals under scrutiny can not be extended to the patients considered to be 'experiencers' or making healthier food choices. Patients with little involvement in food matters who are used to consuming convenience food tend to be much more satisfied with the food on offer. This confirms the findings of Candel (2001) who states that involvement with food products is negatively related to the perceived convenience orientation of an individual. Hospitals B and D stand out in terms of patient satisfaction, even though hospital A use the same food production system. Service aspects as well as the infrastructure of the hospital are significant

variables in this regard. Hospital B is a small-scale and rather luxurious hospital, whilst hospital D has recently been refurbished. Noticeably, food is delivered by catering staff in hospitals B and D. According to Nguyen and Leblanc (2002), the infrastructure and the physical environment service components influence acceptability of the food, customer satisfaction and the perception of service quality. This confirms the observation made by McKenzie (2003) that good building design is important with regard to patient recovery. An in-depth understanding of the atmosphere and contextual influences surrounding the consumer-related place (Stroebele and De Castro, 2004) are essential in properly interpreting the meaning and significance of food choices.

From a marketing point of view, Pine and Gilmore (1999) argue that satisfaction comes from the peripherals that surround the core service. In situations where patient satisfaction is high (hospitals B and D) and where basic quality of food is satisfactory, the patients' focus lies on peripheral services or what Cardello (2003) refers to as extrinsic factors. In the other hospitals the focus is still on the core product such as the cognitive aspects of food or the intrinsic sensory characteristics of the products. Contradicting with Hartwell et al (2006), food quality is not always the driving factor for satisfaction but is a basic requirement to it.

These observations lead to the conclusion that even though the negative image of hospital food is widespread, acceptability is not solely related to exposure to the food itself (in line with Cardello et al., 1996b; Cardello, 2003) or to the intrinsic quality of the food (Dubé et al., 1994; O'Hara et al., 1997; Lau and Gregoire, 1998; Hwang et al., 2003). However, many of these studies have been conducted in continuing care hospitals or different settings (in other countries but the UK) and their transposition to the NHS is questionable. Customisation of service and food aspects, whereby catering staff serve the food in comfortable small scale operations, (hospital B) or new facilities (hospital D) increases patient satisfaction. This adds to the interaction they have with the person serving the food. This is in line with Bettencourt and Gwinner (1996) who compared customised and standardised service encounters.

Considering the second central research question outlined above and in line with Hartwell et al., (2006), Bélanger and Dubé (1996) and Faulkner (2001), it can be concluded that where patients have increased involvement with the process of food service, satisfaction has also increased and dependence has decreased. However, even though patient empowerment has been identified as a tool in the provision of a quality service and is advocated in a number of professional guidelines with a specific focus on older patients (Faulkner, 2001), this aspect remains in little use across hospitals under investigation in the present study. The steam system has enabled patients to choose on the day of consumption, but does not allow patients to choose quantities or combinations of the ingredients on the plate. The

concept of a 'newly empowered consumer-patient' has developed over the past few years but is still far from reality in the acute NHS hospitals investigated. A key component of patient involvement relates to the way patient's feedback is handled and whether front-line employees are empowered to act. Patients are currently facing a dilemma that does not leave much room for improvement. On one hand patients consider the job description of front-line catering staff should not include 'relations and discussions' beyond the usual 'chit chat'. However, on the other hand patients do not want to bother NHS staff (essentially the nursing staff and often also the domestics) with food-related issues.

Strategies already developed and partially implemented in the NHS (like the food service managers) do not, at this stage, offer a way out. While patients wonder who they might complain to in order to see the (food service) situation improved, action needs to be taken to solve the dilemma effectively.

### **9.2.2 Values**

Values are considered to be an essential determinant for the explanation of consumer and nutritional behaviour. The first central research question (CRQ) about patients' values is related to theory questions which look at the relationship between food choice, food intake and satisfaction:

*CRQ1 What is the patients' value generating process leading to specific food choices?*

When designing the research schedule based on the model of Wengraf (2001), the other central research questions related to values were separated. But when collecting the data and analysing it, it became obvious that answering CRQ1 implied answering CRQ2 to 5 at the same time. Because of this, CRQ2 and 3 are listed below and are linked to the theory questions 1 to 8 related to Values which are to be found in the interview schedule (Appendix A):

*CRQ2 What is the relationship between satisfaction, food intake and food choice?*

*CRQ3 What events and experiences over the life course are viewed as shaping food choices and customer satisfaction in a healthcare setting?*

The CRQ 4 and 5 feed the answer to CRQ 1, and will be discussed in the paragraph dedicated to 'categorisation of food' below. Once the CRQ 2 to 5 have been answered, a model focusing on the food choice process and based on the one of Furst et al. (1996) will be developed.

### **9.2.2.1 *Life course events and food choices***

#### **Monetary issues**

Patients that are satisfied with the food tend to be happy with the investments made by the NHS in this respect. Hospital restaurants are generally considered to be too expensive offering poor value for money. Most patients who frequently have full meals brought in do not care about the financial cost attached. Patients in hospital C consider resources at their disposal (e.g. alternative menus) are not used and explained well enough to them.

#### **Change of ideal food due to hospitalisation**

Patients intend to go back to their usual eating habits once dismissed from the wards. With respect to nutritional learning, there is no information available for patients to enable them to learn to eat in a healthier and balanced way and take into account their overall health condition. But this is absolutely no priority for the patients interviewed in this study. The type and overall quality of food served is certainly partly to blame, but as Rappoport and Peters (1988a) believe, the fact of challenging someone's eating habits by suggesting change implies challenging the cultural and personal values embodied in these habits. Therefore it is important to understand these personal values, but this is currently not done within the context of acute NHS hospitals.

#### **Friends and relatives**

Most patients talk about the food with their relatives, who tend to bring in fruit, sweets and sometimes home-made or convenience food. Word of mouth plays an important role between both patients and their relatives. When the food is not satisfactory, patients complain or make cynical jokes about it with friends and relatives. This feeds wider negative attitude towards hospital food. In the majority of the cases, the food brought in from 'outside' by friends and relatives is limited to 'small food' that complements rather than substitutes the food received on the ward. Exceptions are long-stay patients or patients who are dissatisfied with the food. The relatives of these patients often bring in full meals from either the hospital restaurant, home or from convenience stores. Frost et al., (1991) pointed out that elderly patients do not make up their intake with foods brought from outside the hospital. This

particular issue with this specific group of patients has not been identified in the present study, partly because of the small sample size.

The cook-chill method is highly unpopular in hospital C where many patients have their families bring in full meals as a substitute for hospital food. This is particularly true with the paediatric ward of hospital C, which combines long stay patients and unpopular food. These two key factors lead to patients asking their relatives to bring in full meals. Parents of children on the paediatric ward often neglect themselves, with regard to food, in the first days or weeks of their child's admittance on this acute ward. They rely strongly on family and social networks to have food brought in for them. So in the case of this particular paediatric ward, food is not only brought in for children, but sometimes for their parents or guardians as well.

In the case of patient 5, the hospital dietician suggested her family bring in fresh food and vegetables for her to get better. This was because the food provided in the hospital does not provide sufficient nutritional value. Within the present study, there was no direct mention of inconsistencies of foods served in relation to recommendations for healthy eating (e.g. Watters et al., 2003). However, patient 5 came closest to phrasing this rather common feeling amongst respondents. The fact that patient 5 showed extreme menu fatigue confirms the observation from Edwards and Hartwell (2006) who note that the steam system's menu might lead to menu fatigue for longer stay patients. However, menu fatigue has been observed across various food production methods, noticeably with the cook-chill system (Watters et al., 2003). When replacement food is brought in by relatives or friends, this generally happens without any communication or cooperation with nursing staff or dieticians. This contradicts the suggestion of Tredger (1982) who recommended open communication on the issue in order to facilitate what can be of real value to some patients. This study has not confirmed or contradicted the observation from Davidson and Scholefield (2005) that the presence of relatives or carers results in patients being interrupted or limiting their food intake at mealtimes. Such an issue was simply not mentioned by patients during the interviews or during the focus groups with the various staff groups involved in the food service process.

## Location of consumption

Patients generally expressed their preference to eat in bed or besides their bed. Sharing a common room for lunch or dinner was not an interesting option for most patients, as they considered having enough social contacts with the other patients on their ward already. Even though some authors believe eating is a social activity which may be enhanced if patients sit together (Hotaling, 1990; Hartwell and Edwards, 2000; Allison, 2003), the majority of patients interviewed in this study did not want to make use of a separate room to consume their food. As a result, there is a difference between the focus on nutritional intake from the medical and para-medical corpus, and the meal as experienced by the patient. However, there are two exceptions:

- a) First, long-stay patients would prefer to consume their meals in a separate room to break daily routines on the ward and avoid social isolation. This largely depends on the medical condition and mobility of the patient;
- b) Second, parents from children admitted on the paediatric ward would like to be given the place and opportunity to share meals with their children. The parents' focus is on nutritional intake of their child and they consider their recreating a home-like environment to be helpful in this regard.

This last observation is in line with Clendenen et al. (1994) and Engell et al. (1996) who note the relationship of the individuals eating meals together has a significant impact on social facilitation of eating. This implies eating with a stranger might not be that helpful when considering nutritional intake as the outcome of a social facilitation process. Eating together is supported by comments from the NHS staff of the paediatric ward in hospital C, which considers having a separate room on the ward to be an interesting option. This confirms the observation from Gibbons and Henry (2003, 2005) who stress the eating environment to be a factor affecting food consumption. The parents interviewed expect to have a situation where there is a correlation between the strength of the relationship between people sharing the meal and the amount of food consumed. The parents confirm the approach from Elmstahl et al. (1987), Whitten (1996), Areni and Kim (1993) who consider the importance of considering ambient influences on food intake and food choice in an attempt to alter eating behaviour.

As the data collected on the paediatric ward in hospital C comes from oncology patients that tend to eat very little and are rather insensitive palatably, positive ambient influences should be facilitated. However, the parents were not given the opportunity to experience the outcome of this strategy during the data collection phase of this study. As it was not an objective of the present study, the nutritional outcome of social observation as observed by Goldman et al. (1991) was not investigated any further

across the hospitals under scrutiny. However, the positive role of parents on nutritional intake is evident as parents and guardians deliver food that is actually liked and enjoyed by the children. From the study it appears patients tend to have the possibility to sit and eat at a small table close to their bed. However, contradicting with the Council of Europe Resolution (2003) there is certainly no focus on the presence and support of other people.

### **Conversation with other patients**

Patients talk more about the food with fellow patients than they do with their friends and relatives. These discussions are more descriptive than directive. Suggestions from other patients form a key factor in making specific food choices in hospital. Patients dissatisfied about food tend to talk about it much more often with other patients, hence influencing food choices even more. For example on the paediatric ward parents make caustic, bitter jokes about the food. This is because there is nothing else they can do about the food as feedback is not taken into account.

### **Specific age groups**

On the paediatric ward in hospital C, all nursing employees recognise children have specific food patterns that are related to their medical conditions and food habits at home. Nurses try to push forward healthy food options to the children, but realise the patients tend to choose comfort food because of their medical condition and eating habits at home. Bernstein (1989) noted patients with cancer often develop aversion to certain foods. But even though the data was collected on a paediatric oncology ward (hospital C) within this study, both children and parents were critical about the food as a whole and did not complain about specific food items. Parents of long-stay patients/children often bring in food or go to the hospital restaurant to get food for their child. It is important to note that what nursing employees consider being 'healthy food' largely depends on the nurses' own dietary habits. This is often questionable as the curriculum of nursing school offers little training in food behaviour. The nurses in hospital C (surgical ward) believe the portion sizes given to elderly people are too large and lead to significant waste levels. In terms of eating environment, ageing patients consumed their meals in bed or close to their bed. Overall and across hospitals, no attempt was made to enhance the meal environment, something which was suggested by Elmstahl et al. (1987) 21 years ago already.

### 9.2.2.2 *Categorisation of food*

Feeding the debate to answer CRQ1 noted above, CRQ 4 and 5 also relate to patients' values and are listed below for convenience of the reader:

*CRQ4 Does the categorization of food in specific values (health, taste, cost, convenience and relationships) apply to healthcare customers?*

*CRQ5 Which values do healthcare customers prioritize?*

#### **Influence of staff on food choices**

Medical staff (nutritionists and NHS staff) have a significant influence on patients' food choices, especially elderly patients. In this study and according to Breemhaar et al. (1990), elderly patients have a more external locus of control, are more fearful of complaining and show more gratitude. Elderly patients interviewed across hospitals have a stronger wish not to bother nursing staff, and can certainly be called 'good hospital patients' (Taylor, 1979). When considering the decision-free environment elderly people live in when in hospital, it might be interesting to consider enhanced personal responsibility and choice. This was advocated more than three decades ago by Langer and Rodin (1976).

However, in the hospitals under scrutiny, advice is only given when medical reasons come into play (e.g. over-or underweight patients, low food consumption etc). Noticeably and contradicting the guidelines from the Essence of Care Benchmarks on Food and Nutrition (2001), very few opportunities are used to encourage patients to promote their own health. One of the main underlying reasons is that various staff groups (especially in hospital C) consider the basic quality of the food served in hospital to be insufficient in guaranteeing healthy eating.

#### **Expectations towards hospital food**

As outlined by Cardello et al. (1996b), most patients interviewed in this study have very negative expectations towards hospital food before their admittance on the ward. Cardello et al. (1996b) rightly called this negative perception towards hospital food 'institutionalised stereotyping', and it has been encountered across hospitals under scrutiny in the present study. However, almost all of the patients interviewed in this study are positively surprised by the quality of the meals offered once admitted in hospital. This has also been observed in a qualitative study on patient satisfaction with food conducted by Watters et al. (2003). The negative expectations do not override the positive effects of the cognitive

components (e.g. texture, temperature) in patients' satisfaction judgements. According to Mela (1999); Meiselman et al. (2000), even though the assimilation model applies as patients shift towards the direction of prior expectations (very often negative as outlined above), acceptance of the food is increased with positive food experiences (mainly encountered in hospitals B and D, A to a lesser extend). As phrased by Avis et al. (1995):

*“These negative expectations may be influential in determining patients' level of satisfaction, since failure to realise their worst fears may, paradoxically, be a cause for satisfaction.”*

A significant exception is the case of hospital C where comments on the food were negative. Hospital food is often compared to school dinners, in line with the concept of recipe standardisation. The positive word of mouth appears to be a powerful tool in modifying the patients' expectations towards hospital food.

### **Food choice strategies**

Across hospitals, very few patients choose healthy options from the menu. Most patients choose according to what they would like in order to satisfy a need to eat. Patients who are considered to be 'experiencers' do not automatically make healthy food choices.

This is in line with an observation Brown (1976) did 32 years ago, which states there is no significant relationship between adequate diet and income, age, religion, education and culture. The fact that patients do not choose healthy options, even though they are in a situation where good nutrition might speed up their recovery process, raises the need to understand the underlying causes of behavioural nutritional health problems. In order to find appropriate means of altering consumption patterns, better understanding of their meaning is needed (Rappoport and Peters, 1988a). Money might be spent on the food itself in order to improve the quality of basic ingredients, but if patients' values and attitudes towards food that tend to sustain healthy food choices are not understood and acted upon, this is likely to remain a useless investment.

Food choice strategies of very long stay patients are very specific across the hospitals under investigation. These patients systematically show extreme menu fatigue, they know the menu by heart and strongly rely on relatives to bring in dishes cooked at home or convenience food bought from retail shops. This observation contradicts the findings from McGlone et al. (1995) who state that patients spending extended periods in hospitals rely almost entirely on the food provided. The menu fatigue

observed with long-stay patients in this study is in line with Hetherington et al. (2001) who stated that repeat presentation of food leads to consumers disliking the products presented because of monotony. This is in line with Lennard-Jones (1992) who argued that malnutrition often becomes worse during prolonged hospital stays. It is therefore a logical consequence that patients and their relatives try to develop alternative food choice strategies to guarantee sufficient nutritional intake as well as a certain degree of satisfaction.

The findings of this study support the work from Stanga et al. (2003) who observed a negative correlation between duration of hospital stay and satisfaction with meals. It is interesting to note that despite the Food Safety Act (Ministry of Agriculture, Fisheries and Food, 1990) and the ensuing reduction in number of ward kitchens, some patient categories still manage to have food brought in from 'outside' (home or retail shops). The fact that friends and relatives bring in food for long-stay patients is a matter of changing the availability of food for the patients. This process is considered to be one of several social facilitation processes by Feunekes et al. (1998), with persuasion to consume or avoid eating certain foods as other examples applicable in a healthcare setting. However, quantification of the social facilitation process appears to be complex, and is not the purpose of the present study. Food bought in the hospital restaurant is a temporary alternative, considered to be too expensive if used continuously. Nurse assistants from the paediatric ward in hospital C confirmed long-stay patients on their ward are tired of the food served and have relatives bring in food for them.

Within the surgical ward in this same hospital, the nursing staff also mentioned long-stay patients become aware of the menu rotation (2-week menu cycle) and get bored with the food on offer. These patients choose according to the day of the week (knowing the menu by heart) or switch to Hallal/Caribbean menus which both nurses and patients believe are much better because of the freshness and larger portion sizes. The observation that traditional menus are preferred over more exotic ones (Hallal or Caribbean in the present case) applies to short-stay patients, but definitely not to patients staying more than a couple of weeks on the ward.

Menu fatigue was addressed by the NHS and caterers using menu rotation and the introduction of celebrity dishes. But even with these strategies in place, almost all long-stay patients show menu fatigue and appeal to their relatives to bring in hot food. The recommendation from the NHS Executive (1996) stating sufficient variety of food to allow menus to cover a 14-day period without undue repetition does not seem to allow for enough variation for long-stay patients. Alternative approaches need to be developed for this specific patient group, even though it remains a minority of the population in acute NHS hospitals. The 'leading chefs' menu is considered to be a public relations stunt

by hospital catering professionals (Research Forum, London, June 2005). However, these alternatives are highly appreciated by long-stay patients. The balance between proposing alternatives to this particular category of patients and the cost inherent to this approach must still be weighted. It is interesting to note the management from the private food and service firm would prefer to scrap Hallal and Caribbean menus altogether, as these are more expensive in terms of production cost. Ideally and according to the management, special menus should only be presented to patients who have religious beliefs or specific cases of ethnic minority origins.

The difference between what the description on the menu and that delivered is of great significance to the patient. The positive expectations the patient has of the menu is shattered when delivered. This surfaces in all the hospitals under investigation (especially where cook-chill or plated food is in use). Trial and error of the food is associated with the cook-chill preparation method. The patients are more confident towards the food prepared by the steam system. The limitations of food choice considered by the patients are the production method itself. Few patients consider the microwave to be a doubtful method to prepare hospital food. They also realise that the use of the trolleys system (hospitals C and E) is inconvenient as it leads to cold food and very dark, strong tea served to patients at the end of the service round on the ward.

It is noticeable that patients talk more about the food with fellow patients, than they do with their friends and relatives. These discussions are more descriptive than directive, but most of the interviewees have taken into account suggestions when deciding which dishes to choose from the menu. The pointing out of alternative menus in hospital C (surgical ward) are made by other patients as opposed to the staff.

### **Hospital restaurant and shop purchases**

Unless patients receive consistent food, made at home, from friends and relatives on a regular basis, they quite often look to the food in the hospital restaurant (when their medical condition allows this) and compare that to the food served on the ward. This is not, (or less), the case in the hospitals where patient satisfaction with the food is high (i.e. hospitals B and D). Many patients and their relatives buy small food items (sweets, fruits or drinks) in the hospital shop, thus complementing rather than substituting the food received on the ward.

### **9.2.2.3 *Developing relations with a single contact person***

Patients express that over a period of time they get to know the catering staff better. They are disappointed that they have to build up relations from scratch whenever a new employee arrives to work on the ward. A few patients specify that the ward housekeeper should be empowered to improve the issues relating to the food. As stated in the literature on relationship marketing, the creation of value for patients appears to come over time and on the condition that the same catering staff serves the food. Therefore, personal interactions with the same catering staff are essential and the creation of value in the food service process mainly applies to long-stay patients. This process can be compared to what Grönroos (2000a) labelled the 'customer value generating process'.

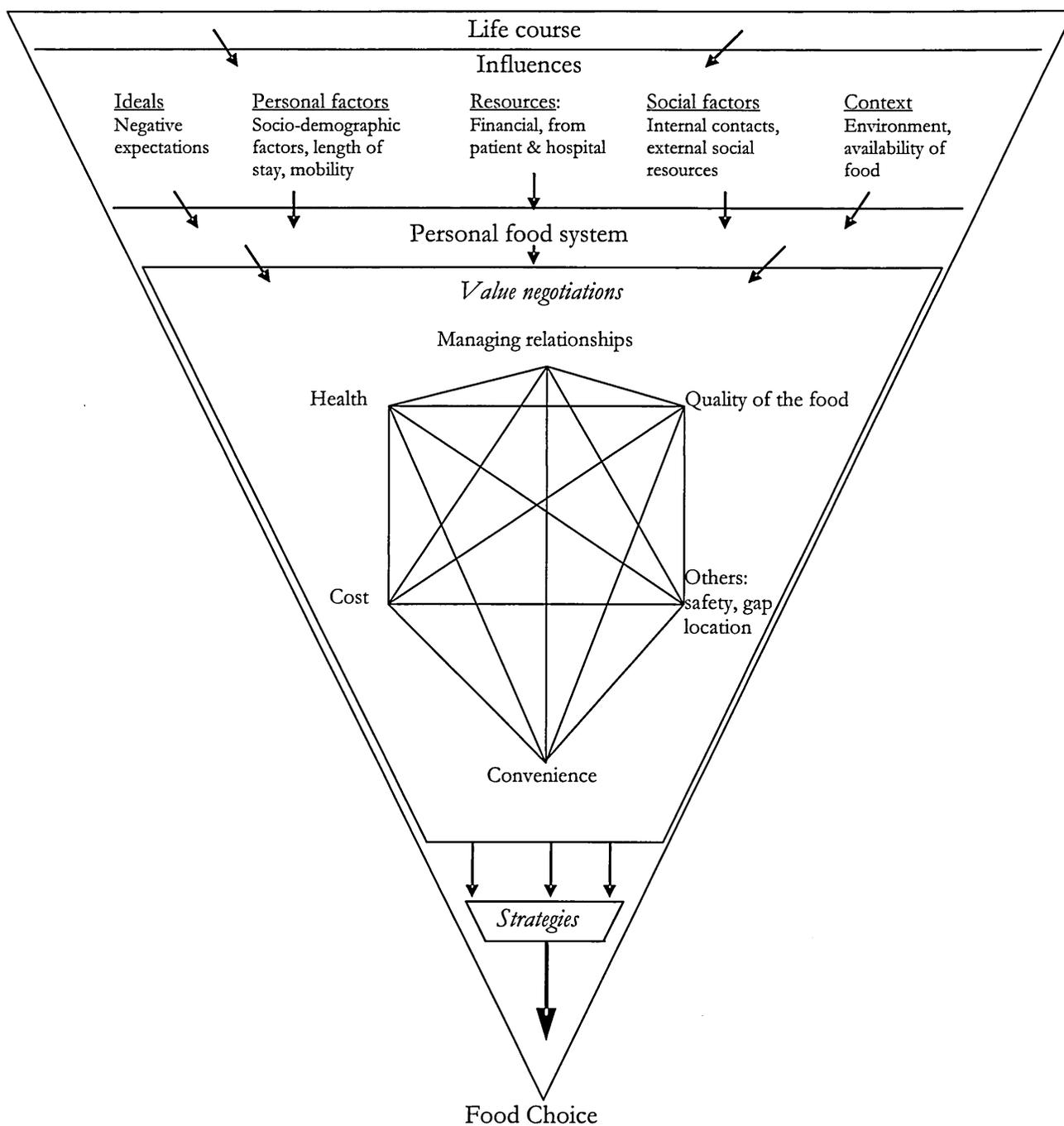
### **9.2.2.4 *The food-choice process model as identified in acute NHS hospitals:***

Model 9.1 below integrates all the above related to patient values, based on the food-choice process model developed by Furst et al., 1996. Analysing the data at hand enables answering CRQ1, stated again below for convenience of the reader:

*CRQ1, "What is the patients' value generating process leading to specific food choices?"*

The food choice process contextualised to acute NHS hospitals and developed below aims to, broadly at least, portray patients' conceptualisations underlying food choices when staying in hospital.

Figure 9.1 Food-choice model in acute NHS hospitals



## **Life course**

The life course of patients as well, as any customer outside healthcare, includes past influences of personal experiences, current involvement in trends, transitions, and anticipations of future events (Furst et al. 1996). In the present study, the age, maturity and socio-professional background of the patients influences their approach to food. Future roles visualised by patients after their stay on a ward influences their food choices as well as food choices of their relatives sometimes. This is especially true when their (future) physical condition influences their ability to prepare food at home. The patients' background can often be overlooked when first admitted to hospital. This in itself could provide useful insights in understanding patient's food choices when in hospital.

## **Influences**

The five major categories of influences initially developed by Furst et al. (1996) are applicable to a NHS context, but the content of these categories is very different. The influences on food choices interact and compete with one another, leading to fuzzy boundaries between influences. Even though the setting of 'traditional' hospital food can be linked to well-known paradigms, every patient has different food choice perceptions due to their individual situation, socio-economic situation and life stage. The description of various categories of influences are set out below, providing a brief overview of what has been extensively developed in the paragraph above, dedicated to values.

Ideals in a NHS context is closely related to the negative perception patients have from hospital food, with expectations and standards for food choice internalised and imprinted on people's consciousness (Furst et al., 1996). To most patients interviewed, the influence of ideals in the model leads to the expectation that hospital food is deemed to be of poor taste and quality. This is conflicting with the conviction patients have that when being in hospital, good, healthy food should be an absolute necessity to aid recovery. The sole exception in this case is found on the paediatric ward in hospital C, where patients and parents are told to eat 'whatever they can' because of their medical condition. The fact that patients change their perception towards hospital food, when positively surprised by what is on offer, illustrates how ideals can change with experience, reflection and re-evaluation.

Personal factors are an essential influence central to food choice and include various attributes specific to the NHS context: food centeredness as evaluated in the patient interviews, gender, age, health status (physical and psychological condition, mobility), and state of hunger and length of stay. Patients that are less food centred are more satisfied with the food on offer. There is a relationship between the satisfaction of the food type and the length of stay, as patients tend to become dissatisfied with the food the longer they stay in hospital.

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As such, patients' negative ideals about hospital food enable them to cope with what is on offer for a short period, i.e. one or two weeks. But the restricted choice listed on the menu forces patients into alternative food choice strategies when hospitalised for longer periods, depending also on their resources and social frameworks as developed below.

Resources in a NHS context relate to the tangible, financial situation of the patients. Considering the respondents involved in this study along with the public generally treated in NHS hospitals, the level of income is relatively low and influences food choices. The use of the resources at hand depends on the length of stay of patients in hospital, as well as their degree of involvement (personal factor) with food. Patients who stay for longer than two weeks and are rather concerned with food tend to have full meals brought in by friends and relatives, whether it is ready meals, food from the hospital restaurant, or food made at home by relatives. The spending of money significantly affects the scope and nature of food choice decisions (long-stay- patients) make during their stay. Furst et al. (1996) state resources are subject to fluctuation over the life course, depending on people's characteristics. The present study only took a snapshot of the patients' situation at a particular point in time, but future longitudinal studies may provide useful information to analyse patients' changing consumer food behaviour throughout their life cycle.

Social factors in a NHS food service context relate to the composition and dynamics of the patients' social network, the conversations with fellow patients and, to a certain extent, the dietary habits of NHS staff. Adding to the findings from Furst et al. (1996), key dimensions of the social framework were not only interpersonal relationships with relatives, but also with fellow patients on the ward. These are determinant elements when considering food choices in the NHS context. Long-stay patients tend to rely on friends and relatives to have full meals brought in on a regular basis. In the case of the paediatric ward in hospital C, parents rely on these social networks to have food brought in for their own consumption too. In such situations, the 'provisioner's' (family or friends) role was to discuss with the patient about the food delivered in the hospital and then bring in food that would meet the needs and desires of the patient. For ageing patients, the provisioner sometimes takes an active role, by looking at the menu first and then seeing the delivered food before deciding whether to bring in substitute meals.

The food context in hospital is very particular and closely linked to ideals, resources and social frameworks at hand. The food context not only encompasses the physical surroundings on a ward, which act as a constraint to the normal forms of social facilitation (eating around a table), but also specific food supply factors and sometimes production methods. Overall, the food situation in hospital does not give choice possibilities to the patients.

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Depending on the financial resources and other influences such as the length of stay, social frameworks and the overall medical condition, the situation of some patients will strongly influence their food choices. Other patients are influenced less in their food choices by contextual factors and request relatives to bring meals in. A lack of availability of food listed on the menu is another issue patients sometimes face. Two patients at hospital C could not have items listed in the steam menu, as there were no plates left on the shelves on ward level.

### **Personal food system: value negotiations**

Making food choices over the life course is an ongoing experience, which leads to developing personal systems for food choices. However, once admitted on a ward, in an environment that is generally unfamiliar and rather unpopular, the usual personal systems for food choices is questionable to the patient. Based on the model of Furst et al. (1996), the present study has re-defined the different importance patients make in respect of their food choices. When reflecting on food choices and attitude towards food, patients most frequently referred to values that can be categorised within the initial classification of Furst et al. (1996). Therefore, even though the content and applicability from the values identified in a NHS context are very different from what is to be found in every-day life, the initial categories were used in the present study: managing relationships, quality of the food, others, convenience, cost and health. Within their personal systems, patients tend to consider and accommodate values to the hospital context. The value negotiation, as described below, aims to look at the interconnectedness of the values in the negotiation process (see figure 9.1). The data identified in the present study indicates that the dominant values are the quality of the food, length of stay (others) and cost issue.

### Managing relationships

Even though patients are often alone when hospitalised, and don't need to take other's preferences and needs into account when making food choices, however the management of relationships with various parties tends to influence this choice. Four themes emerged from the present study, all relating to relationships and food choices:

- a) In some situations, dieticians give advice to patients during their stay on a ward. This will clearly determine their food choice, providing the word 'choice' is applicable here;
  - b) Almost all patients have 'small food' like nibbles or fruit brought in by friends and relatives. Key exceptions to this practice are the patients staying more than two weeks on a ward and the children and their guardians (paediatric ward, hospital C). This category tends to rely on parents
-

or social networks to have full meals brought in as a substitute to what is served on the ward. The length of stay, food production method, the age of and the relationships patients have within their external social resources (social factors) influence the patient's (or guardian's) food choice. Also with the overall satisfaction of the food consumed. Concerning the food production, the cook-chill method as used in hospital C is the least popular amongst patients;

- c) Food-related conversations with fellow patients do strongly influence food choices. Dissatisfied patients tend to voice their complaints much more loudly than satisfied customers would compliment staff about their degree of satisfaction. It is relevant to note that in hospital C, patients were told by fellow patients about the existence of alternative menus like the Hallal or Caribbean options (and not told by catering or NHS staff involved in the food service process);
- d) Patients that are hospitalised for longer periods often mention that personal interaction with the same staff serving the food is essential in developing valuable relationships.

### Quality of the food

Across hospitals, three main factors influence the perception of food quality:

- a) The ideals (negative expectations) patients have towards hospital food, being part of the influences as described above;
- b) Food production method; the steam system being most popular and the cook-chill method the least. The production method relates to the context of healthcare operations and has a major influence on the personal food system of each patient;
- c) The significance of food quality for each individual patient comes from the patients' life course and personal factors - like food centeredness influencing the perception of what is considered to be good quality food, which in turn leads to specific behaviours when considering food choices. Patients who tend not to put too much emphasis on the food they eat and consume lots of convenience food are inclined to appreciate what is served on the wards.

And again here, understanding what 'quality' means for each patient upon admittance on the ward might be helpful in developing an estimate of how the patient will react to the food served in hospital.

## Others

Across hospitals, patients frequently describe the gap between the description on the menu and the food served on the ward. The staff makes no formal promises to patients in respect to the food on offer (quality and quantity), but the outline of the menu creates an implicit set of expectations. The ensuing gap leads to deception.

The gap has, however, narrowed down with the implementation of the steam system. The location of consumption as well as the physical environment of the ward does form significant factors influencing patient satisfaction and acceptability of food.

## Convenience

Several patients stressed the evening meal is served too early, leaving a very long gap between dinner and breakfast the next day. Nevertheless, the convenience for patients to choose their food on the spot means it is at the closest possible to the time of actual consumption.

## Cost – monetary considerations

As the charging for food on the ward to the patients is not direct, one might think that monetary considerations do not form a salient value for NHS patients. However, cost is sometimes an important issue for long-stay patients who tend to have full meals brought in. The served food on the ward influences their food choices and forces them to eat the meal that arrives on the ward. This is certainly not their ideal way of proceeding, but illustrates the weighing up process between length of stay, taste, managing relationships with relatives and the inherent cost of having full meals brought in. The restaurants in the hospitals under scrutiny are considered to be over-priced, offering poor value for money.

## Health

Patients considered to be ‘experiencers’, across the hospitals tend to make healthier food choices, as they have a high degree of involvement with food. Patients with little involvement in food matters (a vast majority within the present sample) and used to consuming convenience food tend to be more satisfied with the food on offer and pick ‘whatever they feel like’ from the menu. Health is not at all a dominant factor when considering patients’ food choices in acute NHS hospitals. In the rather interesting case of patient 5, the issue of healthy food was balanced or influenced by the relationships the patient has with the dieticians, influencing the patient’s relationship with friends and relatives. On the paediatric ward in hospital C, nursing staff try to push forward healthy food options to the children,

but realise patients and their carers tend to choose for comfort food, because of their medical condition and usual eating patterns. The fact that patients do not choose healthy food options in hospital raises the need of understanding patients' values and attitudes towards food, as significant investments in healthy hospital food might otherwise turn out to be a useless investment.

### **Personal food system: strategies leading to specific food choices**

Even though the NHS offers a rather constrained environment when it comes down to alternatives between dishes on offer and ensuing food choices, this study aimed to uncover the underlying causes to recurring, routine food choice strategies. Although each opportunity a patient has to make a food choice is unique, looking at a larger sample of patients across various hospitals allowed identifying similar patterns for making food selections. It is useful here to note that the food patients might have is not limited to what is listed on the hospital' menu, however it includes food from the hospital restaurant, hospital shops and food brought in by friends and relatives (whether prepared at home or bought from a convenience store). Life course influences and forms the determinant factors in the development of strategies in the patients' personal food systems. When summarising the main strategies identified within the present study, it emerged that:

- a) Few patients choose healthy options from the menu when in hospital. Choices are simply made according to what patients 'feel like';
- b) Elderly patients tend to eat lighter in the evening;
- c) Long stay patients show menu fatigue and tend to rely on friends and relatives to have full meals brought in. These patients might initially buy food in the hospital restaurant, but as an option, it is expensive. Long stay patients however, soon switch to 'alternative menus' like Hallal or Caribbean options when applicable, as the usual menu rotation or celebrity dishes are not sufficient to avoid menu fatigue;
- d) Patients staying on a ward for a short period of time (one to two weeks maximum) tend to choose from traditional dishes as listed on the menu;
- e) Children tend to systematically choose the same dishes from the menu, sticking to set routines;
- f) When satisfied with the food on offer, patients do not request friends and relatives to have meals brought in and do not use the hospital restaurant.

Overall, when considering that the vast majority of patients who stay less than a week on a ward describe their food choices as a 'trial and error' process.

### 9.2.3 *Trust*

Central research question, related to theory questions 1 to 4:

*CRQ1. "Is trust a key determinant leading to increased levels of satisfaction for patients?"*

#### 9.2.3.1 *Patients' contacts with catering versus NHS staff involved in the food service process*

Overall, patients consider the catering staffs' duties should not go any further than the sole duties of serving and taking back the waste food. Across all hospitals under investigation, talking about any form of trust between patients and catering staff is certainly not applicable. The low degree of trust from most patients towards catering staff leads to a rather negative attitude about the food (in accordance with Conway and Swift, 2000), even though in an initial phase, patients mostly focus on tangible aspects of the food to build up their satisfaction judgements.

When considering various key dimensions of trust, it is apparent that patients are not encouraged to cooperate in the food service process (whether the situation is where the food is served by NHS or catering staff). Other dimensions of trust like safety and credibility are, according to patients, found within NHS staff instead of catering staff. This implies patients feel more confident when interacting with NHS staff, taking into consideration they are more knowledgeable about food issues than catering staff. Dimensions of trust, similar to safety and credibility, as developed by Egan and Greenley (1998), is not identifiable in the relationship between catering staff and patients along the data collection phase of this study. When knowing that trust is a key aspect of relationship marketing, it is highly questionable that the current lack of trust and interaction between catering staff and patients will ever lead to 'relations' between them. This observation is mainly applicable to hospitals where the NHS staff serves the food to patients and where interactions between catering staff and patients is rather limited (hospital A, C, E). Without facilitating and enhancing direct interaction between catering staff and patients, this viewpoint has little chance to be reversed in line with the approach from Conway and Swift (2000), who state that trust is likely to bring a more positive attitude, which in turn is likely to increase the level of customer understanding.

There is no clear link between the patients' profiles and their attitude towards the catering staff. In line with the document 'State of Healthcare 2007' edited by the Healthcare Commission, most respondents

said that they had trust and confidence in the healthcare professionals treating them (State of Healthcare, 2007).

It seems the 'health professionals' referred to in the document do not include the catering staff from the private food and service management company collaborating with the present study. Trust towards hospital food service products has been touched upon in the research from Hartwell et al. (2006). However, in the present study, patients have not raised any potential interest in branded products to develop trust in a known product.

### ***9.2.3.2 Length of stay and contacts with staff***

The patients do not speak about real 'trust' when considering their relationship with the catering or NHS staff serving the food. Patients rather allude to the frequency with which they interact with these staff groups. Relationships with the staff serving the food remain very superficial. It plainly appears the NHS (interacting with the private food and service management company) does not use all resources available to them in a way that patients' trust in the resources strengthening at the same time. Patients perceive frequent interactions with staff members as a way to feeling more comfortable with them. As patients interact much more often with the NHS Staff than with the catering staff, so they feel more comfortable with the former to develop any discussion. Length and frequency of stay, as well as staff rotation appears to be significant factors when considering the development of relations between catering staff and patients. Bearing in mind the observations that the mere presence of others positively influences intake and the relationship of dining companions is an important factor contributing to social facilitation (Clendenen et al., 1994). One might assume that this applies in hospital if the long-stay patient manages to develop a 'relationship' with staff through frequent interactions.

There is a contradiction in the present study, by the few long-stay patients interviewed as well as the outcome of the various focus groups, as long-stay patients rely on external parties to have alternative food brought in. The relationships that various staff groups have with these patients does not influence intake of hospital food itself. Going one step beyond a 'relationship' and when considering the definition of trust developed by Moorman et al. (1992), it is obvious patients simply cannot trust the catering staff as there is no confidence in the abilities, skills and knowledge of this staff group. Patients consider NHS staff as better skilled, and the fact that patients have more opportunities to interact with this staff group only enhances the development of confidence and trust.

### **9.2.3.3 Food promises made**

There is no making of promises in respect of food to any of the patients interviewed, though it is a core construct in relationship marketing. As Claycomb and Martin (2001) highlighted the existence of a link between trust and promises built on concrete actions (Zineldin and Jonsson, 2000). It is significant to note the fact that no making of promises and the frequent deception that occurs, because of the gap between that described on the menu and what is delivered to the patients. This observation applies to all hospitals under scrutiny, even though satisfaction levels are better where the steam system is in place. This observation is in line with the conclusions of Edwards and Hartwell (2006), who conclude that all stakeholders agree that patients are generally more satisfied with the steam system.

When considering the CRQ related to trust, it appears this core variable of relationships may become a key determinant leading to increased levels of satisfaction for patients. Nevertheless, the development of trust between patients and catering or NHS staff implies frequent interactions between the parties. Considering current processes in place across the hospitals there is no such facilitation.

### **9.2.4 Food**

After completing the literature review of the present study and when designing the interview schedule focusing on patients, the focal point was on investigating three common core variables identified in the literature on relationship marketing and consumer food behaviour; involvement, values and trust. As the existing literature on food in healthcare was extensive and the initial statement was that the BHF attained the aims and objectives in 2004 already, it was therefore not the author's aim to focus on food as such. However, from the pilot study conducted within hospital C it became clear that patients were still dissatisfied with the 'core product' or food itself. Instead of restraining the patients' responses to soft factors as initially intended, integrated into the study are the patients' numerous comments on food. These were then categorised under 15 themes, starting with food texture up to comments on the various food production methods. The outcome of the qualitative research conducted in this study builds up on the extensive quantitative research conducted on consumer food behaviour in healthcare that traditionally focuses on nutritional intake and 'hard' components of food. The themes related to food and shown below, confront the data from this study with the literature.

#### **9.2.4.1 Food texture**

Patients are satisfied about the food texture in the hospital where the steam food system is in place. However, they regret there is no production of crispy food (like chips), confirming this issue initially raised by Edwards and Hartwell (2006). The most important things to patients when judging food quality are sensory characteristics, the majority being texture, (Cardello and Maller, 1982; Clark, 1998). This has been confirmed in this study as well as by Edwards and Hartwell (2006) and Hartwell et al. (2006) who note better scores on quality components of the steam dishes compared to a traditional cook-chill system. There is evidence for the interaction of sensory characteristics, as developed by Prescott (1999). With respect to this, elements like temperature, presentation and portioning are developed below.

#### **9.2.4.2 Comments on the presentation**

Presentation is a key factor leading to satisfaction for only three patients. The patients accept physical issues on the ward, in terms of place and facilities available, inhibit the presentation of the food. Across the hospitals and the various food production systems, patients are satisfied and dissatisfied with the presentation of the food. Most complaints about presentation relate to the cook-chill preparation (hospital C) method, as well as plated food in hospital E. In terms of presentation, the steam system appears to stand out compared to traditional food production methods.

#### **9.2.4.3 Portion sizes**

For elderly patients, having three full meals a day is too much. Ageing patients tend to favour eating later and somewhat lighter meals in the evenings. The physical or mental condition of the patient is not taken into account when determining the portion size (e.g. when the patient cannot eat much because of medical reasons). Several patients found that the food portions are too large, especially for the initial phase on the ward after undergoing surgery. The issue appears to be about the willingness of the catering staff to have flexibility when it comes down to portions for patients. The catering staff of hospitals C and E believes there are inconsistencies in the portioning and should be improved. Hospital C shows dissatisfaction in respect of the catering staff not showing any flexibility in portioning the food for patients. There is no clear link between food production method and issues related to portioning. Catering staff in hospital A and B thinks that the portions are too small, whilst the NHS staff has no

particular comments on this issue. Overall, there appears to be a clear link between the portion size and patient satisfaction.

#### **9.2.4.4 *Diversity***

Variety appears to be a key element leading to patient satisfaction. Apart from the patients staying more than two weeks on a ward, most patients are satisfied with the diversity of the food on offer, but are critical about the basic quality of the food. Taking into consideration that food quality is the best predictor of overall satisfaction for patients (Lau and Gregoire, 1998; Hartwell et al., 2006) in this study too, and the fact this has been a topical matter for a few decades already, raises the question why basic food quality has yet not improved to a satisfactory standard? Patients on the surgical ward in hospital C do not know of the availability of alternative menus early on in their stay and they are unhappy with this. Catering staff in hospital A is satisfied with the large choice on offer.

#### **9.2.4.5 *Temperature of the food***

Ten out of the thirty-one patients interviewed consider the food is sometimes too cold. The most stinging comments relating to the temperature come from the paediatric ward in hospital C, where the food (cook chill) is 'just warm'. This is due to the way the food is delivered to the patients (trolleys) and parents sometimes consider they are better off going and getting the food from the trolley themselves. There were no complaints about the food temperature in hospitals A and B. The texture of the food, along with the temperature is an important factor leading to patient satisfaction (Hartwell et al., 2006) and appears to be improved with the steam system.

#### **9.2.4.6 *Catering food***

Many patients do realise hospital food is produced on mass and accept it. They realise there is no alternative when considering the amount of meals that have to be produced and delivered within a tight timeframe. Across hospitals, NHS staff considers fresh food produced on site would be the ideal option. But overall, the patients do understand the difficulty of producing masses of very fresh and high quality food in such a situation. This increases their acceptance of the food received on the ward, as their level of expectations are already low. This is in line with the philosophical and moral approach of de Raevé (1994), who considers institutional meals simply cannot be meals in the same sense in

which we originally talk of a meal. Too much is different and this leads to the question whether, in the current situation acute NHS hospitals do evolve in and the subsequent financial restrictions, it is useful to strive for food services that match replication of home meal experiences?

Apart from hospital B, the data collected for the present study comes from large hospitals ranging from 495 beds (hospital E) up to 1200 beds (hospital A). The NHS currently evolves towards an up scaling in hospital provision, as many are grouping together, building larger ones (whether it is on PFI or more conventional bases). The achieving of a high degree of customisation is not foreseeable in this context.

#### 9.2.4.7 Convenience

The issue of receiving what is considered to be ‘fresh foods’, by ordering on the spot is of paramount importance to patients.

#### 9.2.4.8 Patient and staff suggestions

Various patients across all hospitals would like to have a wider variety of fresh vegetables and fruits on offer. Particular suggestions appropriate to each hospital developed in the table below, with the number reference of the interviewee:

**Table 9.1 Patient suggestions classified by hospital**

Hospital	Suggestions
A	Serve food immediately after production to avoid drying out (3) Recruiting catering staff with decent language & service skills (5)
B	Make herbal teas available (11) Medical condition should be taken into account in order to avoid wasting food (11)
C	Regular surveys would help avoid food waste (15,18), or more contacts with catering staff in order to give feedback (21) Catering staff should present all menus to patients (13 to 18) Involve children by using tasters or displaying the food, implement a ward cash cafeteria (21) Improve quality & choice for breakfast (14)
D	Know the names of & basic information about the catering staff (26) More time to choose from the menu (24) Quality needs to be improved first: taste, texture, freshness (26) No improvement is possible because of financial constraints (26), in line with Hartwell et al. (2006)
E	Would like to have catering staff coming on the ward in order to give feedback (30) More communication between NHS and catering staff/kitchen (30) Match opening hours restaurant with visiting times during weekend (31)

The patients' suggestions listed above are integrated throughout this chapter, but come down to increased involvement of catering staff with patients and an improvement of induction standards for catering staff. Ideally, NHS staff from hospitals C and D would prefer to have the food dished out directly from a trolley on ward level – offering various choices on the spot to patients. Hospitals C and E would like to see the quality of the food improved. According to the catering staff of hospitals A and B, breakfast should be better and by pictures on the menu would be helpful in choosing for patients.

#### ***9.2.4.9 Patients' worries related to the production method of food.***

The use of a microwave in the case of the steam system is an issue for few patients, who consider that food loses vitamin value. Overall, patients' food choice perceptions of potential risks may not be affected as defined by Cardello et al. (2007) and associated with the new steam technology in the present study. Cardello et al. (2007) state a lack of knowledge among consumers regarding innovative food technologies can serve as a major impediment for their acceptance and propose effective communication in order to achieve successful marketing of such products. This appears not to be applicable to the context of acute NHS hospitals, as the majority of the patients in the sample of the present study are simply not interested in receiving communication about food processing methods. The normative/value model of perceived risk as inspired by Cardello (2003) does not apply in current NHS food service operations, even with the introduction of new food systems. A higher degree of involvement with the food process is important for patients, but not to overcome a possible feeling of risk associated with new food production techniques.

#### ***9.2.4.10 Availability of food items***

Within hospital A, patients do complain about the fact that the dishes listed on the menu are not always available. The nursing staff of both wards in hospital A support this. They also do not like the idea that there is no provision of hot food on 24-hour bases, as the catering staff locks the fridges of the ward kitchen every night. The trolley service in hospital C is unpopular with most patients, as sometimes the food ordered is not available, as it is requested by other patients' first. Therefore, the remains will be all that the last patient has. Leftovers or remainders are rather popular, though, for incoming patients or for children on the paediatric ward who prefer choosing on the spot from the food displayed.

#### *9.2.4.11 Comments on the meal experience*

Even though all patients agree that hospital food is important, several do mention the quality of the food on the ward is not good enough to support proper recovery. Nursing staff in hospitals C and E, support the comment above who think that the food is not good enough to enable a customer-oriented food service. Basic, tangible food requirements form a pre-requisite for a customer-orientation and are simply not good enough at this stage (especially in hospital C). In general, the patients' focus lies on the qualitative aspects of the food as opposed to service aspects.

In the context of the present study, the service attitude of staff as developed by Allison (2003) or Gregoire (1994), when focusing on an American healthcare setting does not form a key issue in providing satisfactory food service experiences for the patients. The assessment of meal service by patients is certainly multidimensional, but in the present study, patients do not appear to evaluate aspects of the personnel delivering the meal separately from their evaluation of the food. This contradicts the findings of Gregoire (1994), but we need to keep in mind the possible difference in the delivery of food quality between US hospitals and in the NHS.

Issues like the wrapping of food, or placed outside of reach of the patient (as developed by Corish and Kennedy, 2000) have not been encountered in this study. Timing of meals as defined by McGlone et al. (1995) and Cortis (1997), does not appear to be a major issue across hospitals under investigation, and does certainly not form a factor as decisive as food quality when considering patient satisfaction. Overall, meal times appear stretched according to the recommendations of the Council of Europe Resolution (2003), even though various patients and staff members mention food is served too early in the evenings (around 5pm). Patients believe in 'quality not quantity', which is currently not the case. Patients who had the opportunity to try various food production systems, think the steam system provides a better meal experience. The trolley system was highly ranked amongst patients by Hartwell and Edwards (2001), but their particular study at the time only focused on a plated system and a cafeteria trolley system. Almost all patients describing negative food experiences come from hospital C. Parents on the paediatric ward consider the current system in place in the hospital is not working well. This is due to the low quality of the food and frequent mistakes that arise on delivery (i.e. not delivering specific orders). Few NHS staffs across hospitals consider patients to be customers. The catering staff on the other hand is absolutely convinced patients are treated as customers, or "even better than that" (hospital B). Catering staff of hospital C did not comment on this issue. The NHS catering staff of hospital E emphasises the importance of providing patients with TLC (tender loving care), as did the catering staff of hospital A. The 'added value' experienced by patients when receiving emotional

support is transferred to their satisfaction judgements, as evoked by Bélanger and Dubé (1996). Where NHS staff (A, E) are the servers of food, there comes across a feeling of ‘added value’ where there are no overwhelming complaints about the food itself (like occurring in hospital C). These elements lead to confirm and complete the observation developed by Ferguson et al. (2001), who stated that staff interpersonal skills form an important dimension leading to patient satisfaction...at least in hospitals where basic characteristics of the food itself is considered satisfactory by patients.

#### **9.2.4.12 Comments on the steam system**

##### **Negative comments on the steam system**

The nursing staff of hospitals that will have the steam system implemented on their wards soon (hospitals C and E) are very apprehensive of it. Hospitals A, B and E consider the steam system has been (or will be in the case of hospital E) imposed on them by their respective Trust, because of financial restrictions related to food operations. However, the NHS staff of hospitals A and B does not wish to go back to the old system that was in operation on their respective wards. Hospital E feels that the current system (plated food produced in the hospital kitchen) to be much better in terms of quality and the ability of the staff to cater for patients’ specific needs. The fact that they can get hold of the kitchen staff if anything odd occurs is an important factor for nursing staff to keep the current system in operation. Hospitals that are already using the steam system (hospitals A and B) are rather disappointed about the gap between the promise and delivery issues. The major issues the nursing staff (hospital A) deals with, relates to the fact components of the dishes can’t be removed from the plate (as it is pre-packed) and the lack of skills of weekend staff in preparing the meals properly. The impossibility to produce decent crispy food (fries) is another inconvenience of the food system pointed out by the NHS staff across hospitals using the steam system.

##### **Positive comments on the steam system**

The nursing staff of hospital A, B and D is very satisfied with the new steam system implemented in their hospital and definitely want to keep this system operating. Key advantages, pointed out by the nursing staff, relate to waste reduction as the food is chosen (almost) immediately before consumption, along with portion sizes and the involvement of various staff groups in the service process (hospital D). Holmes (2007) advocated the implementation of simple actions such as enabling patients to select their food shortly before consumption, something that has become possible with the steam system. This is in line with Cortis (1997) who considers patients are more likely to be enthusiastic about eating meals

they have ordered that day rather than meals ordered in advance. As stated by Edwards and Hartwell (2006), the steam system has addressed major 'traditional' food service concerns in an effective manner. Catering staff thinks the steam system is easy to prepare and satisfies nurses, as food is always available on the wards (hospital A). Choice is another factor leading to satisfaction (hospital B), whilst catering staff from hospital C thinks it to be more hygienic than traditional food systems. Health and Safety aspects applied to the steam system are indeed an improvement as indicated in a study conducted by Edwards et al. (2006). Giving NHS staff the opportunity to try out the steam system during implementation led to a buy-in for the system (hospital D), confirming the observation that product information and trial (tasting) reduces the reluctance of consumers to choose or purchase foods processed by new techniques (Cardello et al., 2007). According to patients who have the opportunity to experience other food systems, the steam system has enhanced the meal experience. This observation contradicts the statement from Lambert-Lagacé et al. (1996), who found that changing food service systems might not necessarily enhance the perceived meal experience. Overall, expectations towards hospital food are very low and where the steam system is implemented patients recognise intrinsic quality as being rather high. According to the assimilation model serving as a framework when considering the role of disconfirmed expectations on the sensory and hedonic aspects of products (Cardello, 2003), this should imply a state of positive disconfirmation whereby perceived acceptability assimilates the lower expectation and decreases the liking of the food received. Even though it is difficult to organise, a longitudinal study focusing on eventual returning patients experiencing the same food service system would be helpful in understanding the eventual applicability of the assimilation model in a healthcare setting.

#### ***9.2.4.13 Comments other production methods***

In hospital E, the plated food is produced by catering staff, brought on the ward level by NHS staff and finally delivered to patients by domestics working under NHS contract, who are paid and under supervision of the private food and service management firm. This particular situation in hospital E illustrates the somewhat complex boundaries of an organisation like the NHS, whereby sometimes there is a special relationship between a contractor and its client organisation (Martin, 2001). A lack of communication and interaction between NHS and catering (kitchen) staff in this particular hospital (E) leads to frequent mistakes in delivering the food ordered to patients. These mistakes in delivery go one step further than the wrong information about desserts and 'soup of the day' due to a lack of

communication between the kitchen and ward, observed in a study conducted by Edwards and Hartwell (2006) and focusing on the steam system.

In the present study, the bulk system (hospital C) was the least popular amongst patients, followed by the plated one (hospital E). Key issues with the cook-chill method, as pointed out by the NHS staff across hospitals, are the texture, the obligation to order 24hrs in advance, poor quality and poor nutritional value. This observation contradicts the findings from Folio et al. (2002), Hartwell et al. (2007) who stated that a significant improvement of satisfaction noted with the trolley system. The present study however, did not investigate nutritional intake across food service systems. The steam system appears to be, today, the best alternative on offer in terms of popularity, immediately after the option of preparing fresh food from scratch in hospital.

### **9.2.5 Conclusion patients: answering the research questions**

#### **1. How do patients in acute NHS hospitals experience food services delivered by a private food and service management firm?**

When looking at the literature on acute NHS hospitals where the food is not contracted out to private food and service management firms, many parallelisms can be drawn with what has been observed in the present study.

Patients have very low expectations towards hospital food, and tend to focus on tangible characteristics of food to make satisfaction judgments when hospitalized for short periods of time (less than one to two weeks time). Interestingly, patients understand and accept (to a certain extent at least) the constraints related to food production methods in large hospitals. Patients tend to be satisfied about food presentation and diversity, but are critical about the basic quality of the food. According to them, the food served on the ward is not good enough to support proper recovery, and quality should be placed above quantity. This is supported by NHS staff in the hospitals where the steam system is not implemented (C and E). Service components like emotional support are, however, transferred to the patients' satisfaction judgments, but only when there are no overwhelming complaints about the food itself. As developed in numerous DoH and NHS related initiatives, enhancing patient-oriented service aspects related to food is the way forward. But the underlying requirement to this strategy must be food that patients and staff consider to be of 'good quality', something that is apparently not yet achieved at

this point in time. Let us not forget here that good food quality is the best predictor of overall satisfaction for patients (Lau and Gregoire, 1998; Hartwell et al., 2006). In this study, patients are more satisfied with the steam system when considering basic food quality. The system has enabled an extended choice menu, and a revised patient ordering procedure that enables more interaction between catering staff and patients in hospitals where the food is delivered by the former. As stated by Edwards and Hartwell (2006), the steam system has addressed major 'traditional' food service concerns in a pretty effective manner. But apart from this positive note above, patients across hospitals today still ask for a wider variety of fresh vegetables and fruits to be served.

Interestingly, this study identified that patients are more satisfied with food services when hospitalized in small hospitals or when in new facilities. Both catering and NHS staff recognize that understanding and fulfilling patients' preferences implies regular interactions between staff groups, and also between staff and patients themselves. Currently, operational tensions between staff groups as observed across the hospitals in this study, as well as issues with the intrinsic quality of the food offered, do not allow patient-oriented food services to be achieved.

**2. Can patient profiles be developed, relating to specific patterns of food acceptability, choice and satisfaction?**

In line with what has been identified in the literature, when considering segmentation approaches based on traditional demographics or socio-economic variables (O'Hara et al., 1997; Lau and Gregoire, 1998), this study couldn't identify typical patient profiles leading to defined satisfaction ratings. But various factors linked to the personal history of the patient, as well as their length of stay on a ward, relate to specific attitudes and behaviours towards food when in hospital. Before exposing these factors by answering research question 3 below, it is essential to specify that patient profiles only apply when patients are satisfied and where basic quality of food is deemed satisfactory.

**3. Can common defining constructs of relationship marketing and consumer food behaviour possibly serve as a foundation to underpin the development of patient-centric approaches to food services in acute NHS hospitals?**

**Involvement** with food can take various forms, even in healthcare. Patient involvement can imply providing information about food to patients, and for the possibility of patients to give feedback that is actually taken into account (using questionnaires or through direct contacts). Patient involvement has improved with the launch of the steam system within several acute NHS hospitals as from 2003, after a status-quo in terms of food production methods and servicing that lasted for several decades. However, even though the PEAT initiatives allowed patients to voice their viewpoints, it is a bridge too far to say they're involved in the design, delivery and development of services on a local level. Even the steam systems' development and implementation throughout the NHS refers to a product-based approach, instead of the outcome of a concerted customer-oriented product development strategy as designed in marketing co-creation networks. When considering patient involvement, the steam system is an improvement as patients feel more in control of the situation.

Patient involvement in food services should ideally be linked to empowerment of the front-line staff serving the food to patients. As noted above, empowerment of these staff groups is currently an issue, and we might say that the logic of the NHS in regards to food services is rather based on disempowerment (Faulkner, 2001b) that lead to patient frustration. Is it relevant to note that across hospitals, patients simply do not consider their comments are taken into account by NHS or catering staff. Patients consider this is due to the inability of these employees to act upon the food service process. Interestingly, NHS staff would like the front-line catering staff to be more involved in the relationship with patients, as they would be the ones be forced into dealing and acting upon patients' complaints.

When considering involvement with food as the need patients might have to know where the food they receive comes from, or has been produced, this study shows patients have little or no interest in receiving this type of information. There are, however, exceptions:

- patients staying for long periods in hospital (more than one to two weeks), would like to take up a more active role in regards to food;
- patients who are very much involved with food in every day life look beyond tangible food characteristics to develop their satisfaction judgement. In line with Candel (2001), patients' involvement with food products in this study is negatively related to their convenience orientation;
- parents or guardians on the paediatric ward collaborating in this study are very much involved in food-related issues concerning their child. This is partly due to the many complaints about the low quality of the food provided in this particular hospital.

When looking at patient **values**, applying the model from Furst et al. (1996) to NHS hospitals has provided significant insights in regards to the patients' food choices. Considering the food choice model developed above (Figure 9.1), various values that emerged from the data were not new findings when considering the literature on consumers' food choices in general. But when the values are contextualised to acute NHS hospitals, then a new meaning of the values emerges, adding relevant dimensions to the literature on consumer food behaviour developed on this particular context. As such, the analysis of the patients values in the present study outlines familiar patterns of value negotiation that largely depend on events in the patients' life course, as well as the influences patients are subject to. As it is the case with the initial study from Furst et al. (1996), the present study illustrates that the role of life course must be considered when conceptualising food choice in acute NHS hospitals. Unfortunately this is, at this stage, not even considered in the hospitals collaborating to this study. The patient's life course, influences and personal food system are intertwined, but key relationships between levels of analysis have been exposed above under paragraph 9.2.2 dedicated to Values. The constructionist approach to food choices as developed in this study has potential implications to influence food choices in acute NHS hospitals, with a focus on healthy eating and increased nutritional intake.

The defining construct of **trust** as a constituent of relationships between patients and catering staff is a real utopia at this point in time. This is simply due to the fact that patients today do not even envisage engaging with catering staff the way they would engage with NHS staff. The underlying reason is the few interactions patients have with catering staff, high catering staff turnover levels, as well as the little credit catering staff are given by patients and NHS staff, even in regards to food issues. Trust is also related to the low degree of involvement patients have in the food process when in hospital.

4. **Is a personalized food service experience focusing on the development of relationships between patients and medical/non-medical staff likely to achieve increased satisfaction levels, eventually leading to a shift of attitude towards hospital food services?**

Developing relationships based on trust and confidence implies a productive two-way communication process between patients and catering staff. But various hospitals in this study do not facilitate contact between patients and catering staff, which impedes patient-oriented food services. As such, it is interesting to note current food service processes in acute NHS hospitals do not use the internal and outsourced resources at hand to focus on patients' requirements. Frequent interactions between

catering staff and patients is a prerequisite to any form of relationship, eventually leading to trust on the long run. Currently, patients even refer to NHS staff in regards to food-related issues. This is due to the fact patients interact more with NHS staff, and give little credit to catering staff capabilities. But patients also avoid bothering NHS staff with food-related issues, considering they work under significant pressure already to comply with medical duties. One might wonder then who patients can refer to, when knowing that interpersonal aspects of food services might have more impact on satisfaction than technical aspects do (Bélanger and Dubé, 1996). Enabling these interactions between patients and catering staff might be helpful. The current lack of (constructive) interaction between patients and catering staff can be extended to interactions with NHS staff, as not sufficient information is exchanged between parties to fulfil the needs and wants of the patients. As such, disintermediation and the facilitation of direct contacts between patients and catering staff might enable greater patient-orientation. However, to make disintermediation efficient, front-line catering staff must be empowered to act on patients' requirements and complaints. This requires redesigning, in depth, back-office processes. This study has highlighted that patients are inclined to address front-line catering staff when the food is delivered by them (hospitals A and D), providing ownership of this particular staff group on the food process. Properly communicating eventual new roles to patients is of paramount importance. Even though patients have preconceived ideas about catering staff duties (generally limited to serving the food) and do not consider the eventuality of communicating more with them, the benefits from emotional support to patients can't be denied. If catering staff receive ownership of the food service process in hospitals (from production to serving the patients), then it is imperative to redesign the role of this staff group.

### 9.3 NHS staff and staff of the food and service management firm

Following the discussion and interpretation of the research findings focusing on the patients in 9.2, this paragraph will look at the output of the separate focus group sessions conducted with the NHS staff and catering staff from the private food and service management firm. The themes developed in this cross-case analysis have emerged from the focus group sessions based on the focus group schedule (Table 4.3). This phase focuses on two research lines of enquiry:

- the way the determinants of consumer-oriented food service experiences identified in phase 1 of the study are perceived and eventually implemented by front-line NHS and catering staff working in each hospital;
- the marketing/HR implementation problems as identified in the literature, relating to issues of cost, departmentalisation, lack of patient involvement, lack of cooperation among staff members and culture.

For convenience of the reader, the research question related to phase 2 is listed below and will be answered at the end of this paragraph:

5. Do private food and service management staff and NHS staff interact in a way that enable the needs and wants of of the patients to be fulfilled?

#### 9.3.1 *Comments related to the NHS staff*

##### 9.3.1.1 *Stress amongst NHS staff: the case of hospital C*

The working environment appears to be utmost stressful on both wards of hospital C, for nursing and catering staff. This is partially due to chronic under-staffing, the move of the paediatric ward to another location within the hospital, and with what the nursing staff perceive to be a generalised stressful ambiance within the NHS. Both the nursing and catering staff in hospital C feel their management is insufficiently involved in the food service process. This leads to stressful situations for staff members, and is experienced by patients as a lack of clearly defined responsibilities in planning and managing

nutritional care. This is in line with the observations from Melchior et al. (2003), but viewed from the perspective of the patients.

### **9.3.1.2 Others**

Only the nursing staff in hospital C was aware of the BHF aims and objectives. This issue raises the question of lack of education about nutrition, as developed by Melchior et al. (2003).

The catering staff across hospitals sometimes feels looked down upon by medical staff (nurses, doctors and consultants). Much has been written about the profession of the dieticians and the way food service management can be taught to this staff category (Gregoire et al., 2006), but there is very little in the literature focusing on training of staff groups actually serving the food to patients.

### **9.3.2 Issues between catering and NHS staff**

Both NHS and catering staff believe understanding the patients' preferences and fulfilling these implies regular interactions on three levels: between NHS staff and the patients, between the nursing and catering staff and finally between the catering staff and the patients. Achieving these interactions largely depends on the type of food production method in use and the staff group who serve the food. There are significant operational tensions between NHS and catering staff across hospitals which can affect the patient experience. This is quite surprising, as the 'U.K. guidelines for hospital catering 1995' already stressed the importance of good inter-disciplinary communications. Key issues are outlined below.

#### **9.3.2.1 NHS staff as trouble-shooters**

Within hospitals C, D and E the nursing staff describe themselves as real trouble-shooters, often rectifying the omissions or mistakes the catering staff make. According to the NHS staff this could be due to a lack of decent supervision and support of the catering staff on ward level (D), or simply because the catering staff do not hand out the food to the patients (hospitals A, C and E). When referring to the importance of service encounters in the literature on relationship marketing and what Normann (1984) called the 'moments of truth', it is surprising to see the catering staff are often not enabled to serve the food to patients. Core values of the private food and service management firm

cannot be transferred to patients in such a situation, which is further complicated by the difference of working culture between NHS and catering staff. The food service processes whereby food is handed out to patients by NHS staff, do not allow catering staff to act as part-time marketers who are supported by the rest of the organisation.

### ***9.3.2.2 Cultural issues and departmentalisation***

Across hospitals, there is a clear difference of culture between the nursing and the catering staff. The nursing staff feel as though they are part of the global structure and institutional culture inherent to the NHS. The catering staff are regarded as outsiders by the nursing staff and are considered to be less educated and having fewer privileges than the nursing staff do. It can be said that, across hospitals, the nursing staff tend to look down on the catering staff. Pratten (2003) mentioned the fact that food service staff appear to be undervalued and paid a low wage, and his observation is confirmed in the present study. Pay for NHS domestics is at or around the minimum wage, but in the present study, catering staff would prefer to be under NHS contract (perceived as being higher and offering a better status). There has been no mention of 'less intelligent' jobs as illustrated by Donelan (2000), but the comments from NHS staff when speaking about catering staff are not that eloquent. When observing how the importance of employee consideration and job satisfaction is emphasised throughout the literature, this raises questions about the current inconsideration towards catering staff.

Even though Engell et al. (1996) noted the influence of staff attitudes on patient intake and patient experience as a whole, this aspect of the service process was not the key focus of this study. Even though Holmes (2007) stressed problems related to under nutrition can be overcome with effective collaboration between healthcare professionals, catering teams and proactive nursing care, this study clearly illustrates we are far off that ideal picture in the 5 hospitals under scrutiny. This is a rather surprising observation, as 26 years ago, Tredger (1982) stressed the feeding of patients has to be considered as a 'team effort' and this has been emphasised in various DOH guidelines ever since, and supported by other stakeholders involved in hospital food services.

The fact that the nursing and catering staff respond to two different managerial structures contributes to the development of the two different working cultures evolving in the same environment. It is difficult to identify a common patient-oriented culture in this situation. But confirming the approach of Gregoire (1994) and Lee-Ross (1999), and even though the catering and NHS staff will approach patient food services from slightly different perspectives, there is no difference between staff groups across hospitals in their willingness to deliver a good (food)service to patients. But in line with Lee-

Ross (1999), significant differences of specific service dimensions between catering and NHS staff delivering the food to patients have been observed across the hospitals under scrutiny. In hospitals where NHS staff deliver the food to patients (A, C, E), nursing staff show more affinity and deference to patients than in hospitals where food is delivered by catering staff. This is deduced from the patients and NHS staff feedback across hospitals (NHS staff often cites TLC as their main focus), but it is necessary to specify specific service dimensions have not been investigated in the present study. But across hospitals, patients are often recognised as being the ultimate 'customer', depending on which definition is given to this term. Catering staff systematically consider patients are customers and need to be treated accordingly (probably due to training in servicing organised by the private food and service management firm), while NHS staff tends to be more realistic and aware of the fact patients form a captive audience with ensuing limitations in terms of customer orientation.

Across hospitals, the fact food was sometimes delivered by NHS staff, never lead to patient dissatisfaction with the service product itself. Contradicting the findings from Gregoire (1994) and Lambert (1996), the findings from the present study do not imply nursing staff needs better training in terms of food servicing. In most cases it is the NHS staff and management that complain about the lack of skills shown by catering staff about patients' dietary habits and ensuing dietary restrictions. Apart from hospital E where the food is not delivered on the wards by catering staff, the other hospitals all emphasise that the catering staff should know more about the types of food that can be served to patients with specific dietary needs. The key issue for the NHS staff is patient safety and thus avoiding having wrong dishes served to some patients. NHS staff do not refer to a shortage of skilled staff stopping them from providing patients with what they deserve (according to Lee-Ross, 1999) in terms of service skills, as it comes down to patient safety and the delivery of adequate dishes.

In short, the food service process in the NHS whereby a private food and service management company is involved currently leads to two distinct top-down organisational structures (NHS and catering staff) merely working together. There appears to be a lack of patient centricity whereby no dialogue is developed across the patient touch points and no personalised treatment of valuable patients is provided (according to Shah et al., 2006). Integrative concepts like CCBP remain a utopia when considering food services in the 5 acute NHS hospitals under scrutiny, which is surprising as customer-centricity is part of the U.K. Government agenda for the public sector.

Confirming the findings of various authors in regards to failures in the application of consumer-centric processes in the NHS, the present study has uncovered cultural issues as developed above (in line with Carr, 1992; Bolton 2002), departmentalisation between catering staff and NHS staff (in line with Askham et al., 2002), and a lack of involvement from the patients. This is a rather surprising

observation, when considering the efforts put in place over the last decade in regards to patient-oriented food services. But it confirms the finding from Holmes (2007) who notes there is little evidence the situation has improved, despite interventions such as the Better Hospital Food Programme (Department of Health (DoH) 2000). It must be emphasised that the BHF program was criticised at an earlier stage already, with the suggestion that the impetus for concern regarding hospital food was political rather than philanthropic (from Hartwell and Brown, 2005; Channel 4, 'Dispatches', 13 May 2004).

### ***9.3.2.3 Co-operation among staff groups***

#### **The need to focus on patients' complaints**

Another difficulty ensuing this lack of cooperation and communication between staff groups relates to the follow-up of patient complaints in regards to food and nutrition services, as outlined from the patients' perspective above (9.2.1.2). The percentage accounts for 25% as a proportion of food-related complaints within the Essence of Care benchmarks (Allison, 2006). According to this author, many complaints do not relate to care, but rather to miscommunication and the poor handling of complaints. With communication between nursing staff and catering staff from a private food and service management firm being rather poor to basic across hospitals under scrutiny, the findings from Allison's (2006) can easily be understood. This observation is in line with Hartwell et al. (2006) who note the patients' inability and difficulty in providing feedback to the catering staff. The fragmentary nature and difficulty of communication between the kitchen and the ward in hospital E is a good illustration of this issue. In hospitals A and E the nursing staff consider it useless to give feedback to catering staff as no corrective actions are taken. Instead, the nursing staff in these hospitals prefers to talk directly to the catering management. The nursing staff in hospital E are unhappy that there is almost no co-operation with the catering staff as they feel completely sealed off from the kitchen area. This is in line with what de Raeve (1994) denounced more than 14 years ago as she stated there could be no mindfulness, beyond technical information, of the particular needs and preferences of those for whom the meals are cooked.

### **Patient-orientation: the need to improve relationships and communication**

Across hospitals, NHS staff emphasised a more patient and customer oriented service thus implying a better relationships with the catering staff must be developed. Melchior et al. (2003) and Toraman et al. (2002) already stressed the lack of co-operation amongst staff groups, as well as Holmes (2007) more recently. The relationship between catering and nursing staff can, overall, be described as rather good but subject to improvement. The nursing staff within hospitals A and C are on speaking terms with the catering staff, which they consider to be generally helpful in satisfying patient requirements.

Both catering and NHS staff emphasise the importance of focusing on patients requirements, as they know patients are their customers. This understanding partly contradicts the findings of Askham et al. (2002) who stated NHS staff are sometimes unaware of the patient being the ultimate customer. Both NHS and catering staff realise the importance of satisfying patients, but the focus of the services provided is not developed accordingly. Interestingly, resembling the relationship between catering and nursing staff, Donelan (2000) stressed the lack of communication between catering staff and dietitians, as:

*'having kitchen staff do what you want done seems to be the main problem...'* (dietitian)

The solution advocated to improve the situation between catering staff and dieticians comes down to sitting down, developing mutual respect and talking together and developing a good relationship between both staff groups. Apart from hospital C, catering staff in other hospitals are happy about the collaboration with nursing staff. Catering staff working on the paediatric ward in hospital C consider the nursing staff are too busy and would like to have more support from this staff group. On the surgical ward in hospital C, the situation is much better with catering and nursing staff going out for dinner together occasionally. The effectiveness of such social events on interpersonal communication was already identified two decades ago by Shapiro (1998) but still appears to be used with excessive parsimony across the hospitals under scrutiny in the present study. Informal integration thus appears to have a strong and significant impact on interpersonal communication amongst members of the catering and NHS staff. This observation is in line with the model of marketing/HR interactions and marketing implementation as developed by Chimhanzi (2004). There are no joint reward systems in place amongst catering and NHS staff, and this does not allow confirming or contradicting the findings of Chimhanzi (2004) who stated that these joint reward systems tend to alleviate conflict levels. Implementation effectiveness is indeed positively influenced by connectedness and communication frequency (see

hospital C in the case of regular staff), and negatively by conflict. In the hospitals under scrutiny in this study, none of the NHS or catering staff are directly involved in the nurses' handover. This suggestion highlighted in the present study as well as in Hartwell et al. (2006) is a simple way of improving communication between staff groups and ultimately patient satisfaction. As catering and NHS staff tend to work rather independently from one another, there is little dependence between both staff groups in hospitals where the entire food process is taken care of by catering staff (hospitals B, D). This contradicts the observation of Barclay (1991) and Anderson and Narus (1990) who conceptualised connectedness in terms of dependence with the effect of lowering dysfunctional conflicts. In other words, dependence between staff groups is no guarantee of better implementation of patient-oriented food service strategies. This study did however, not investigate in full depth the implications of potential dependence between catering and NHS staff. Occasionally there are tensions between catering and foreign nursing staff in hospital A, but the catering staff are of the considered opinion that positive collaboration comes down to personal characteristics of the staff.

### **Factors leading to trust between staff groups: a prerequisite to patient-oriented food services**

Trust is seen as encouraging partners to co-operate, as developed by Anderson and Narus (1990). Amongst the various dimensions of trust as developed in the literature (Egan and Greenley, 1998), safety and credibility are perceived as essential by NHS staff in trusting catering staff enough to allow this staff group to deliver food to patients. NHS staff do not rely heavily on catering staff because of a generalised lack of trust in regards to food-related matters, similar to the attitudes of the patients. Nutritional care should be a multi-disciplinary responsibility that involves various professions, as advocated over the past decades (Tredger, 1982; Lennard-Jones, 1992). The issue of trust from NHS staff towards catering staff is linked to the different educational pathways affecting the various types of healthcare professionals.

### **9.3.3 Operational issues**

#### **9.3.3.1 Language issues**

The nurses in hospitals A and D are critical about the poor language skills of the catering staff. The NHS staff in hospital E are aware of the language issues in hospital D, as both hospitals are located in the same city. Tredger (1982) stressed the language issue with ward orderlies about 26 years ago, and it

was still encountered in the present study. Possible causes are the fact that catering staff are paid minimum wages and no specific nutritional qualifications are required. The early days in hospital D were difficult for the nursing staff, as many catering staff didn't speak proper English. The patient services manager of hospital D knows that this and the language barrier in the early days of the new steam system led to inconsistencies.

### *9.3.3.2 Skills catering staff*

Apart from hospital E where the food is not delivered on the wards by catering staff, the other hospitals all emphasise that the catering staff should know more about the types of food that can be served to patients with specific dietary needs. The key issue for the NHS staff is patient safety and thus avoiding having wrong dishes served to some patients. A lack of basic skills from the weekend staff is emphasised in hospitals A and C. Inadequate education about nutrition among staff groups has recently been cited as a major factor contributing to undernutrition in hospital patients by Holmes (2007), as is confirmed in the present study. It is surprising to note nutritional training for catering staff is still of paramount importance for NHS staff today, despite the numerous initiatives taken in this area by BAPEN, Skills for Care, The Royal College of Physicians, RCN, Council of Europe Alliance, BDA, NICE and the DoH. Even though common induction standards have an expectation that all staff are competent in the work undertaken, a mandatory requirement for all staff involved in food services might be helpful to develop trust and a better collaborative relationship between catering and NHS staff, as well as between catering staff and patients. In line with the difference in perceptions within practice between dietitians and catering staff, described by Donelan (2000), the NHS staff is perceived as clinical whilst the catering staff as a facilities service. Profiling of the acquired catering staff competencies might then be helpful to obtain some recognition in their field of work, instead of relying on the current system, whereby caterers can practice without formal qualification through diverse routes of training (Donelan, 2000). More involvement (and even empowerment) also implies that the catering staff should listen to the patients more and NHS staff feedback. In addition, at the same time do the menus as well as hand out the food to patients (in hospitals A, C and D) so that more interaction is taking place.

From this study, it appears NHS staff are not aware of the educational tools catering staff receive before working on the various wards. Ideally, these different pathways should interact at each contact point with the patients, which is not the case for the time being. It is quite unfortunate that there is no

legislative requirement for staff to attend nutritional training, nor has there been a comprehensive study of which staff should have the same level of training.

Another issue relates to the large variety of educational packages that can be issued by different NHS Trusts. This is due to the fact that in England alone, there are more than 1000 hospitals operating through about 170 Trusts. Any of these Trusts can produce a different educational package. Dealing with this high degree of variability between and within Trusts must be looked at. This situation is further complicated when a private food and service management company develops its own education programmes related to nutrition, without interaction with NHS staff involved in the food service process at various levels of management. Various training tools used by the private company involved in this study have been collected along the data collection process, as well as the tools made available to NHS staff by the Healthcare Commission.

### **9.3.3.3 Staff turnover**

Within hospitals A, C and D, the high turnover of the catering staff forms a major issue in terms of proper patient service. Nurses in hospital D are tired of having to explain basic ward routines over and over again to new catering staff. The collaboration and overall service with non-regular catering staff (hospital C) is considered to be dreadful, while the usual catering staff appear to be very flexible and satisfactory to the NHS staff. The (long-term) relationship with the same catering staff is of paramount importance to the nursing staff. Again the importance of frequent interactions with the same personnel appears to be paramount in developing trust; not only between patients and catering staff, but also between NHS and catering staff. Without trust, the various stakeholders are not encouraged to work together and seek long-term benefits. Increasing staff levels during weekends might, according to the NHS staff from hospital A, lead to improved service towards patients...and less hassle for the medical staff. Trust and frequent interactions motivates the NHS staff to communicate with the catering staff. This willingness to communicate is a key operationalised construct of connectedness, in line with the approach to connectedness as developed by Jaworski and Kohli (1993). To summarise this issue, developing a patient orientation involves the need to decrease the catering staff turnover (hospitals C, D and E) in order to build up set routines and better co-ordination between both staff groups by increasing written and oral communication (as evoqued in hospitals A, C and D). This is, again, in line with issues of connectedness and communication as developed by Chimhanzi (2004).

#### **9.3.3.4    *Contacts catering and NHS staff***

The nurse assistants in hospital A and the nurses from hospital D have good relationships with the catering management who they consider to be helpful. The nurse assistants from hospital C think that becoming more patient-oriented will involve a better relationship between them and the catering management. Within hospital E, the NHS catering staff serving the food to patients respect the professionalism of the kitchen staff (and their knowledge of dietary needs). The NHS catering staff in hospital E however regret to be 'sealed off' from the kitchen area, considering more positive interaction would benefit the patients. When considering the research of Kelliher (1996) on competitive tendering and the ensuing expectations in terms of reforming industrial relations, it appears that even 12 years later the former remains a sensitive issue within acute NHS hospitals, working with private food service management firms. Modifications in Trust status through a policy of decentralised decision making over the past few years have not brought about the reforms in industrial NHS relations which competitive tendering largely failed to achieve (according to Kelliher, 1996). In this regard and in perspective of the PFI initiatives affecting food provision in acute NHS hospitals, Shapiro and Shapiro (2003) rightly argue organisational changes and liberalised funding schemes frustrate the co-operative efforts of those working to provide good healthcare. Catering staff are considered by their NHS counterparts to be what Donelan (2000) called the skilled and manual trades at the bottom of the health-care professions. Contradicting the observation from May and Askham (2005), the catering staff across hospitals in the present study did not consider hotel services as a route into nursing and clinical careers. Finally and as considered by Akhlaghi (1997) the issue between internal and external customers was not evoked by catering nor NHS staff. Both staff groups do understand the patient is the ultimate customer, and no situation has been encountered where the focus has been detracted from patients' requirements.

#### **9.3.3.5    *Issues with catering supervision***

The NHS staff in hospitals A, C, D and E are dissatisfied with the catering management supervision. The nurses from hospital D think that empowering the catering staff would imply decreasing staff rotation, but feel the catering management is absolutely ineffective in achieving this. In hospital A and D, the NHS staff mention that the catering staff have been 'left on their own' during the implementation phase of the new steam system. The nursing staff in C and E would like to be listened to by the catering management, which is not the case currently. In hospital A and C, domestics do not

feel respected by the NHS staff and are unhappy with the fact that the catering management do not support them properly. NHS catering staff in hospital E are rather worried about the high turnover rate within their management. Overall, high rotation levels amongst catering front-line staff and also management, forms an issue affecting patient-oriented food services. This situation tends to create a 'cycle of failure' as described by May and Askham (2005), whereby the private food and service management firm has little or no room for manoeuvring within the sharp NHS budgets allocated to food services. The usefulness of assigning the same catering staff to the same patient care units on a regular basis to improve the consistence of service (Watters et al., 2003), is apparently not implemented across hospitals under scrutiny in the present study. Even though senior management support is a prerequisite for successful strategy implementation as identified in the literature, there appears to be a significant shortage of support across hospitals collaborating to this study.

#### ***9.3.3.6 Understaffing***

The nurse assistants of the surgical ward in hospital C consider that the catering firm is short staffed, impeding proper food delivery. The NHS staff in hospital C cannot understand why voluntary people cannot be brought onto the wards to assist the patients during lunch. Within hospital C (and particularly the paediatric ward), the NHS staff also feel under considerable pressure from management.

#### ***9.3.3.7 Validity catering firm's surveys***

The NHS staff in hospitals C and E have doubts about the validity of the surveys conducted on their wards by the catering firm. Across hospitals, satisfaction surveys are collected by the private food and service management firm and form the main source of feedback from patients when considering food services. These surveys certainly do not serve the purposes as outlined by Avis et al. (1995); to inform purchasing decisions, stimulate proposals to restructure service delivery and enable evaluating the effects of policy changes. Surveys are standardised and centralised within the private food and service management firm, but little or no feedback is returned to the hospitals. The (overall) positive outcomes of the satisfaction surveys is rather used as a tool to justify the current state of affairs within the hospitals under scrutiny. The surveys collected across hospitals by the private food and service management firm reflects high satisfaction levels, contrasting the findings from the qualitative research from the present study. This observation raises concerns about interpreting satisfaction measures in NHS hospitals, whereby the traditional high levels recorded suggest patient satisfaction has not been

operationalised as a discriminating measure (Carr-Hill, 1992 in Avis et al., 1995). The observation from Avis et al. (1995) can thus be extended from general surveys looking at a wide range of health services, to food services. The present study has not investigated whether high levels of patient satisfaction from surveys were due to social desirability bias, the wording of some questions or the reluctance patients might have to express a negative opinion. But the present study raises the importance and relevance of conducting qualitative research when considering patients criteria for making judgements about their satisfaction with the food service on offer.

#### **9.3.3.8 *Protected meal times***

The protected meals time policy tends to be respected on non-acute wards with long stay patients, similar to the paediatric ward in hospital C. It seems to be an issue in hospitals A, D and on the surgical ward in hospital C. Catering staff in hospital E regret protected meal times are not respected by the medical staff. It is surprising to note protected meal times still form an issue in most cases under scrutiny in this study, as protected meal times were introduced as part of the Better Hospital Food Programme (DoH, 2001) to guarantee no medical tasks would be undertaken during meals. The issue of protected meal times not being respected is supported by the latest survey on the issue conducted by the Royal College of Nursing, whereby nurses tend to complain about coinciding drug rounds and meal times (Royal College of Nursing, 2008).

#### **9.3.3.9 *Who should deliver food to patients: catering or NHS staff?***

##### **Catering Staff**

The catering staff in hospital D currently serves the food to patients and the nursing staff are happy with this procedure. It gives the nursing staff more time to focus on medical duties, an observation in line with Edwards and Hartwell (2006). This observation is also in line with various authors who noted food service duties come second to nursing duties because of the increasing pressure and ill-defined health care goals in the NHS (Wood, 1998; Edwards and Nash, 1999; Kowanko et al., 1999). Some nurses in hospitals A and C (essentially the surgical ward) are willing to hand over the food delivery to catering staff, but clearly stress better (catering) supervision is required, in order to avoid having the wrong food served to patients with specific dietary requirements. Good or better supervision and improved training by the catering management is of paramount importance to the NHS staff in considering delegating more duties to the catering staff. Even though this issue was stressed by Cortis

(1997) more than 10 years ago and Watters et al. (2003), there appear no well defined systems are put in place to make catering staff aware of the specific needs and requirements of individuals, and they are not expected to ask patients if they need assistance or why they have not eaten a meal. This observation contradicts the Nutrition Guidelines for Hospital Catering (DoH, 1995) who state there must be a locally agreed policy for keeping written records of the proportion of a meal eaten by a patient, as well as a system for reporting that information to the nurse responsible for the patient's care.

The catering staff in hospital C would prefer to continue having the NHS staff serving out the food to patients, while catering staff in all other hospitals consider ward hostesses/catering staff should complete this duty. This finding contradicts the outcome of research recently undertaken by the Royal College of Nursing, stating that nursing staff are worried when food is handed out to patients by an outside agency. Nurses consider staff that are not a member of the nursing team are on a tight timeline of 35 minutes, not allowing nursing staff to see whether the patient has eaten or drunk. Coupled with this are the issues around the number of nurses on the ward and people have reported there are far less registered nurses on the ward than there were 3-5 years ago (Westminster Food & Nutrition Forum Keynote Seminar, Food in Hospitals and other care settings-a fresh approach, 4<sup>th</sup> June 2008). Few people would argue that in theory, the serving of the food to patients and collection of plates can be carried out satisfactorily by other personnel rather than the nursing staff, but in practice the situation is much more complicated.

### **NHS Staff**

The nurse assistants of the paediatric ward in hospital C and E (NHS staff under private contract) are reluctant in handing over food delivery duties to the catering staff. Safety appears to be the key issue, as the NHS staff fear wrong dishes may be delivered to patients with specific dietary requirements. From the point of view of NHS staff, the skills of the catering staff are clearly questionable. The nursing staff also consider that the interaction they have with the patients is valuable, enhancing the patient experience they have whilst staying on the ward. This confirms the approach from Folio et al. (2002) who consider the one on one aspect of patient contact between the catering staff and the patient may enhance satisfaction. The catering staff in hospital C would prefer to continue having the NHS staff serving out the food to patients, while catering staff in all other hospitals think ward hostesses should complete this duty.

Barton et al. (2000), supported by Holmes (2007), advocates a number of strategies to be implemented by nursing staff in order to reduce food wastage and enhance consumption. These strategies include nutritional screening, documentation of food intake, improved quality of food provision, offering

nutrient dense snacks, improved food service, and assisting patients with service (Barton et al., 2000). It is not the aim of this study to actually redesign in detail food service processes within the NHS, but the author questions how these tasks might be attributed between staff groups in the case of a private service management firm operating within acute NHS hospitals, especially within the case studies investigated in the present study and where little communication takes place between the various staff groups involved in the food service process. The observation from Sheehan-Smith (2006) in relation to the impeding role of nursing staff in implementing hotel-style room services has not been identified in the present study.

#### ***9.3.3.10 Service levels: week versus W/E***

Apart from hospital B, who did not comment on this issue, all other hospitals mention the service levels of the catering staff are better during the week than at weekends. Weekends are often short staffed, and the weekend staff are described as not properly trained. The role of part-time staff in food service delivery has been questioned in a study by Folio et al. (2002), as the highest rates of tray error occurred at the evening meal when this staff group were operating.

#### ***9.3.3.11 Complaints handling and empowerment of catering staff***

The NHS staff from hospitals A and D feel their food-related complaints are taken into account by the catering staff, whilst the staff from hospitals E and C feel rather frustrated as not much is done about their comments. In these hospitals, complaints to the catering management are deemed useless. The nurse assistants of hospital E consider two different managerial cultures are working alongside each other, but with insufficient interaction (meetings) to voice their complaints. Complaints are generally made over the phone in hospitals A, C and E. But as hospital C sees no improvements, complaints are progressively made in writing. It is interesting to note the Department of Health has put in place NHS complaint procedures (DoH, 2004), but there is no formal procedure in place that define procedures in case of complaints between NHS staff and catering staff from the private food and service management firm.

The overall feeling across hospitals is that complaints must be addressed to the catering management, as the front-line staff are unable to improve the current situation. This is, according to the NHS staff, due to a lack of empowerment of catering staff. This lack of psychological and structural empowerment as defined by Faulker and Laschinger (2008) leads to a lack of organisational trust, less commitment

from both catering and NHS staff and diminished job satisfaction. Overall there appears to be a lack of accountability at ward level from the various staff categories involved in the food production and service process, including critical attitudes towards catering and its staff and an overall failure at ward level to focus on food service. This issue comes down to a diffusion of responsibility for the nutritional care of patients, as initially outlined by Butterworth (1974) more than 30 years ago and further integrated within nine common hospital practices potentially resulting in deterioration of nutritional status as explained by Corish and Kennedy (2000).

When considering the current situation whereby private catering staff and nursing staff collaborate, the latter is accountable for the food service process without having authority as such. This creates a similar situation to the one encountered in the NHS in the sixties when the food was delivered by ward domestics or waitresses. At the time and in the current situation, working relationships between staff groups can easily become strained by putting barriers up between the nurses and feeding of patients.

Catering staff in hospital B consider feedback is read by the catering management, but not much can be changed to the current situation because of financial and structural constraints. The issue of empowering front-line staff is surprising, as it was addressed in January 2002 through the document “Shifting the balance of power in the NHS” as well as by key authors like Lashley (2000). Empowerment of front-line staff (whether it be catering or NHS staff) still appears to be lagging behind, and the cultural change strived for (putting the patient first) is still far off. Four key elements of the document (see 3.4.2.2) are strongly rooted in a typical network and interaction approach through devolution of powers to local NHS organisations, and collaboration between staff and patients in improving the service on offer. But its implementation on ground level through improved interactions between staff and patients still appears to be far off, and is further complicated by the hoped for collaboration from the staff groups supposed to be working together to satisfy patients’ requirements. This is, once again, a surprising observation as the lack of interaction between medical, nursing, and nutrition and dietetic staff was already highlighted by Butterworth (1974) and furthermore by Corish and Kennedy (2000).

### 9.3.4 Summarising the marketing-human resources implementation dyads

With insight of the data analysis completed above, it is possible to start answering research question 5 by completing the overview of customer-centric service delivery implementation dyads within the NHS as initially developed in Table 3.11. Various variables have been added in bold & italic and reflect a contextualised overview of key factors not enabling proper implementation of patient-centric food services in the situation whereby a private food and service management company operates within acute NHS hospitals. The variables in italic add to the current body of knowledge, when considering implementation dyads in the NHS where food services are outsourced.

**Table 9.2 Marketing implementation dyads contextualised to the NHS**

Observed barriers in UK manufacturing and service sectors (2002)	Marketing/HR implementation dyads Human-related factors	Customer-centric service delivery implementation dyads in the NHS & private food service mgt. firm
<p><b>Operational:</b> staff: lack off and turnover lack of enthusiasm amongst non-marketers poor involvement of functions and teams</p>	<p>inadequate training poor integration marketing/HR function</p>	<p>lack of patient involvement departmentalization  lack of cooperation among staff groups, need for a multidisciplinary teams <i>high turnover rate from the private food service mgt. firm</i> <i>lack of empowerment of front-line catering staff to resolve food-related issues</i></p>
<p><b>Communications</b> inadequate communications inadequate information</p>	<p>lack of functional synergy and communication between marketing and HR</p>	<p>lack of communication between staff groups</p>
<p><b>Managerial</b> individual manager's empire building  lack of understanding of customers</p>	<p>conflict  lack of senior management support</p>	<p><i>line managers and hospital managers not sufficiently involved in dealing with 'on the floor' issues</i></p>
<p>senior managers lacking business skills management's failure to see the whole picture</p>		<p><i>lack of understanding of 'soft factors' from patients by catering management</i></p>
<p><b>Cultural</b> top-down approach to planning resistance to change monopoly market position and forces time to conduct planning activities</p>	<p>low motivation</p>	<p>patient not recognized as a customer culture <i>top-down approach to planning from catering management</i></p>

Under operational terms, the high turnover rate from catering staff forms a major issue for both patients and NHS staff. No relationships can be developed between parties, and this has a significant negative impact on patient satisfaction (especially for long-stay patients) and collaboration with NHS staff. As seen above, catering staff are also considered by both NHS staff and patients not to be empowered to improve the food or take direct action in case major issues occur. In terms of managerial issues, catering line managers and hospital managers are not considered to be sufficiently supportive and involved with their front-line staff. Interviews with the management of the food and service company (board level) also illustrate how the management do not have insights into the soft factors leading to patient satisfaction.

### ***9.3.5 Conclusion staff groups & towards a final model***

Research question 5 is addressed in this section, focusing on the interaction between NHS staff and staff of the private food and service management firm. Addressing this research question provides relevant insights into implementation dyads and facilitators of relevance in the private/public interaction process under scrutiny in this study. These factors will be integrated further in a broad conceptual model concluding chapter 9 (Figure 9.2). This model will integrate the main outcomes from the data analysis of this study, from both patients' and staff perspectives. The model expands on the conceptual model developed as a conclusion to the literature review (Figure 3.12). This section will firstly focus on answering question 5:

5. Do private food and service management staff and NHS staff interact in a way that enables fulfilling the needs and wants of the patients?

#### ***9.3.5.1 The implementation dyads***

It is relevant to answer research question 5 by having the objectives of the 2002 document "Shifting the balance of power in the NHS" in mind. There is a significant gap between the objectives outlined in the document and what has emerged from this study. It seems that private food and service management staff and NHS staff do not currently interact in a way that fulfils the needs and wants of the patients. Adding together the implementation dyads identified in the literature (cultural issues, no patient

involvement, co-operation among all staff, patient not recognized as customer, conflict, departmentalisation), various other elements identified in this study also apply:

Front-line staff are not *empowered* to use their skills and knowledge to develop innovative services. The staff groups, whether NHS or catering staff, have little or no say in how services are delivered and resources are allocated. A *top-down approach to planning* is the rule across hospitals under scrutiny in this study. This is surprising when considering the views of Thompson and Richardson (1996). They support the idea that giving discretion to managers and empowering them is a powerful lever for strategic change. Front line NHS staff consider new catering systems to be imposed by NHS management because of financial constraints, certainly not with patient satisfaction in mind. The insights of catering staff are not valued by NHS staff because of cultural issues which make communication between staff groups difficult. This is complicated further by the fact both NHS and catering staff tend not to feel heard by their management. Catering staff believe their line managers are *not sufficiently involved* with front-line duties. Within hospitals C, D and E, NHS staff even describe themselves as trouble-shooters, rectifying the mistakes or omissions of the catering staff. The lack of empowerment leads to miscommunication between front-line NHS and catering staff and the poor handling of complaints. As defined by Faulker and Laschinger (2008), a lack of psychological and structural empowerment leads to a lack of organisational trust, less commitment from both catering and NHS staff and diminished job satisfaction. Quite interestingly and because of the above, both NHS staff and the patients often prefer addressing the catering management directly instead of the front-line catering staff.

When considering the *employment culture*, it might be of interest to compare eventual differences between NHS practices and what is done by a private food and service management firm operating in the NHS. As developed above, working culture between both staff groups is different and the NHS staff show little respect for, and *look down on catering staff*. Interestingly, the NHS staff often complain about the lack of skills from catering staff, even with regard to food issues. According to the former, security of patients is at stake and catering staff should be properly trained to avoid any mistakes in food delivery. This difference of employment culture is a major cause of communication and co-operation mishaps between catering and NHS staff. Ideally, catering staff across hospitals would prefer to work under NHS status as it is considered to be better in financial terms. The *high turnover rate* within the catering staff (front-line as well as the operational management) across hospitals involved in this study, forms a major cause of concern to NHS staff, and sometimes even for patients. High turnover rates impeach frequent interactions with the same catering staff, an essential element for

NHS staff as it leads to trust. Trust and frequent interactions form a key construct of connectedness (Jarowski and Kohli, 1993). With regard to food provision, they are linked to the safety and credibility levels given by NHS to catering staff. Few interactions imply little credibility and trust, contributing to a negative spiral effect. This in turn leads to interactions between staff groups that are not patient-oriented.

To conclude research question 5 the NHS has not managed to develop networks for care with such an external partner. When looking at the communication issue amongst staff groups in the NHS, it is relevant to draw a parallelism with the literature on relationship marketing (RM) which focus' on networks and interactions. As developed by Gummesson (1994) within the Nordic School of Marketing, the definition of RM does not apply to the context of private food service management companies operating within the NHS. When considering the DoH guidelines that emphasise feeding patients requires a 'team effort' involving all stakeholders, results in this study present a worrying picture. The approach to implementing the strategies developed in the various NHS Plans follow a top-down approach which still suffers proper implementation on ground-floor level. This is complicated by the fact that external providers are involved in the process. When it comes to food services, it seems *patient values (soft factors) are poorly understood*. This is partly due to a lack of qualitative in-depth research into soft components of consumer food behaviour; a gap in the literature this study aimed to fulfil.

#### **9.3.5.2 The implementation facilitators**

The elements facilitating the implementation of patient-oriented strategies in food services have been identified in the literature as: senior management support, joint reward systems and informal integration between various staff groups. In this study, the (lack of) senior management support has been identified in the implementation dyads above. Joint reward systems did not emerge as a key issue in this study (there are no joint reward systems in place amongst catering and NHS staff), but are kept in Figure 9.2 as they constitute a relevant aspect emerging from the literature (Chimhanzi, 2004). Joint reward systems are seen to alleviate conflict levels, while informal integration has a positive impact on interpersonal communication. In this study, informal integration appears to have a strong and significant impact on interpersonal communication amongst members of the catering and NHS staff. This observation is in line with the model of marketing/HR interactions and marketing implementation as developed by Chimhanzi (2004). There is *no direct involment in the nurses' handover* by the

NHS or catering staff. According to Hartwell et al. (2006) this is a simple way of improving communication between staff groups and ultimately patient satisfaction.

When considering the facilitation of patient-oriented foodservice experiences, the need to develop *multidisciplinary teams* is emphasised across hospitals involved in this study. They include the management of a range of issues including the food service management firm, hospital administration, nutritional staff and medical staff. These multidisciplinary teams should not only focus on the patients' nutritional requirements, but should also take into account value systems identified in this study.

### **9.3.5.3**     *The patient meal experience*

The central focus of this study lies on the patient's psycho-social determinants of involvement, values and trust which are developed in Figure 9.12. This study has confirmed and explored the determinants that emerged from the literature review in Figure 3.12. Apart from the psycho-social determinants, positive patient meal experiences also depend on environmental and situational variables, the overall food quality and issues of consumption. All the determinants of positive patient meal experiences have been explored in full detail in this chapter. Key elements will be summarised below, together with a discussion which compares the conceptual model emerging from the literature review (Figure 3.12) and the model concluding the present chapter (Figure 9.2).

When considering the psycho-social determinants inherent to patients in hospital, elements of involvement, patients' values and trust play an essential role in satisfaction and increased nutritional intake:

- A. ***Involvement:*** The existing body of knowledge emphasises that a higher degree of involvement of patients in the food process leads to increased satisfaction. This implies understanding the degree of the patients' involvement with food prior to them being admitted on a ward. In this regard, this study has identified that nothing is being done by NHS hospitals and it offers an instrument to determine the patient's degree of involvement with food before the stay in hospital (Appendix A, interview schedule). This situation is partly due to a lack of constructive interaction and exchange of information between all parties involved (patients, NHS and catering staff from the private food and service management firm). Knowing more about the patients' general degree of food involvement provides clues about the attitudes towards
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institutional food when hospitalised. This eventually enables all stakeholders (food service management firm, nutritional staff, medical staff and the hospital administration) to customise the offering to individual profiles and requirements.

When considering the particularities of the NHS hospital setting, it seems the degree of interactions with catering staff and the reactivity of staff to complaints facilitates patients' involvement with food. Consequently, satisfaction levels are raised when frequent interactions with the food produced/provider are facilitated, and when patients feel their comments are taken into account and acted upon. In hospitals where the steam system is in use, patients' involvement is increased as they are able to choose the food on the day of consumption. According to Bélanger and Dubé (1996), patients feel more in control over the situation which positively influences satisfaction with interpersonal aspects and food services in general.

This study also emphasises the need to review the specification of duties of the private and NHS staff working together in food services. This could lead to the breaking up of heavy resistance within the NHS and the delegation of more tasks to catering staff. It could also reduce the blurring of roles concerning responsibility for nutrition and overall service to patients. There is potential for operational tension unless roles are clearly defined and communicated. Within this study not a single patient received information about the food served, in terms of origin or production methods, and only a few showed an interest in doing so. Unless patients are dissatisfied about the food on offer, it seems they do not require additional information related to food production methods.

- B. **Values:** In this study, the patients' value systems have been analysed using the model developed by Furst et al. (1996). The model, contextualised to food services in acute NHS hospitals, is thoroughly explained in section 9.2.2.4. Broad categories have been kept (life course influences, personal food system and food choice strategies) when comparing with the initial model (Figure 3.6). However, when deconstructing the various variables in this study, a totally new and unique significance emerges.

When considering food choices, this study emphasises the importance of social networks and relationships amongst patients, and between patients and staff groups involved in the food service process. Confirming the findings from Breemhaar et al. (1990), this study shows that elderly patients have a more external locus of control and can be called the 'good hospital

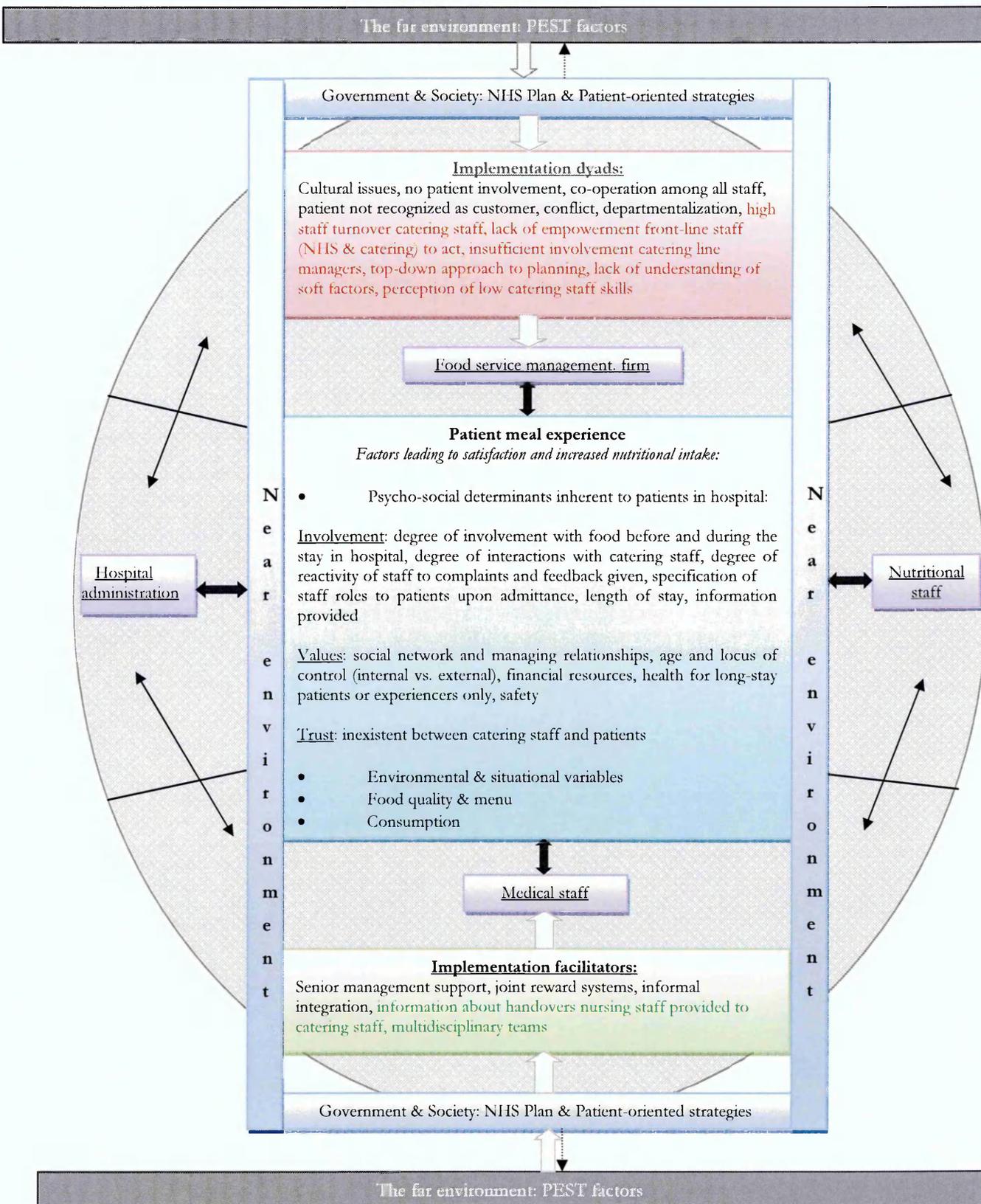
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patient' (Taylor, 1979). Depending on the financial resources and other influences such as the length of stay, this study also analyses how social frameworks and the overall medical condition of patients actually influence their food choices.

- C. ***Trust:*** Investigating how trust towards various stakeholders involved in the food service process can be enhanced, this study focuses on developing an understanding of who patients trust with regards to food when hospitalised in acute NHS hospitals. Interestingly, various dimensions of trust (safety and credibility) are found within NHS staff instead of catering staff. With trust being a key component leading to relationships, this is an element that requires focus. It also requires the need to redesign the service process and enable disintermediation between patients and staff members who actually produce and deliver the food on ward level.

The model (Figure 9.2) integrates all of the above, schematising the interaction between the far, near and internal environment and having the outcome of increased patient satisfaction and nutritional intake as sole purpose. The various 'environments' have been developed in section 3.5 above.

**Figure 9.2 Conceptual model: patient food service experiences in the NHS**



# Chapter ten: Conclusions and the implications for professional practice

## 10.1 Introduction

The last chapter of this study will draw together the threads of the previous chapters. This will enable the author to put the findings into perspective and answer normative questions about policy recommendations and conclusions. This is in accordance with the fifth level of enquiry and analysis as developed in Table 4.8.

First, the initial research objectives will be considered (10.2), before addressing the contributions to knowledge (10.3). Paragraph 10.4 will focus on the implications and contributions for practitioners, while paragraph 10.5 will focus on the limitations of this study. Recommendations for further research will then be suggested in paragraph 10.6. This study will come to a provisional end with paragraph 10.7, which will provide personal reflections of the author on the learning process of this study.

## 10.2 Conclusion: answering the research objectives

Building further on the answers to the research questions developed in chapter 9, the author will make conclusions relating to the initial research objectives (section 1.3) which are listed below:

- A. to provide an overview of food services in acute NHS hospitals, where food services are outsourced to a private food and service management company;
- B. to analyse and assess the body of knowledge from the literature focusing on consumer food behaviour and factors that impede the implementation of patient-oriented strategies;
- C. to identify the patients' core psycho-social determinants leading to satisfactory food service experiences and investigate how these can be facilitated by the various stakeholders involved;
- D. to examine how a major UK food and service management firm aligns its marketing strategy, human resources and competencies with patient-centric policies, which are developed by the NHS Estates and serve as guidelines for the providing contractors (the NHS Trusts);

E. to develop a holistic theoretical model of the requirements of patient-centric experiences and satisfaction with hospital food services.

The first objective (A) of this study was to provide an overview of food services in acute NHS hospitals, where the food services are outsourced to a private food and service management company. A review of the existing literature on the subject provided the tools to achieve this objective in chapter 2. Relevant information emerging from the data has been linked to these secondary sources below.

Over the past decade, much effort has been put into hospital food provision and delivery from all stakeholders involved in the food production and service process. There was the BHF programme in 2001, the ongoing Essence of Care work in nursing, the Council of Europe resolutions, the Hungry to be Heard initiative, the Nutritional Action Plan, the Patient Environmental Action Teams, the initiative of the Protected Mealtimes, the Productive Ward Project (NHS Institute for Innovation and Improvement) and Quality Service on the Ward from the Hospital Catering Association. All these initiatives do not compensate for the fact that malnutrition in hospital was a topical issue back in 1858 and still is today. All these programmes and action plans have helped raise awareness, focusing predominantly on patient feeding and nutritional standards. However, apart from purely nutritional and feeding issues, there is a stringent need to carry out further research into the communication or lack of it between wards, private catering, NHS staff and individual patients. When considering food services in hospitals, all staff who interact with patients should ask themselves how they can benefit the patient. The lack of status afforded to the whole area of hospital food and nutrition has been highlighted in the literature, together with a blurring of roles concerning responsibility for nutrition and overall service to patients. Food provision in hospital deserves to be valued better and receive recognition from the medical world as part of the overall therapeutic process. Food processing techniques in acute NHS hospitals have remained unchanged for several decades, even though no method has been considered to be satisfactory. More recently, new techniques have allowed reducing the usually high wastage levels. This will hopefully lead to cost savings for the NHS, increased nutritional intake for patients and will facilitate the improvement of service-related aspects of food services in acute NHS hospitals. The Care Quality Commission which will shortly act as an integrative regulator might very well enable a return to basic values to stimulate good eating. The new toolkit called 'releasing time to care' provides a way to work from a bottom-up approach, introducing ownership at ward level (instead of an institutionalised habit of opening up the umbrella as soon as a food-related problem arises).

The second objective (B) of this study was to analyse and assess the body of knowledge from the literature focusing on relationship marketing, consumer food behaviour and factors that impede the implementation of patient-oriented strategies. The motivation of this research not only lies in the consumer food discipline, but also in the relationship marketing and management discipline. The study is motivated by a central theme which links the three disciplines; customer-centric processes, or what has been called 'patient-oriented strategies' in this study. Throughout this study thinking has been influenced by contributors from various marketing schools, but the overall thesis should be seen in the line of thinking from the Nordic School in service marketing and management. This particular school is characterised by a network approach to relationship marketing and a rather inductive, theory generating manner of conducting research. Consumerism in public policy and healthcare has become a topical issue today, where the role of patients has shifted from dependence towards a certain degree of ownership and involvement in the care provided. When considering the way this is actually implemented across NHS hospitals (and especially when considering the complex nature of food service operations in this context), the author found the network and interaction approach to be extremely helpful. This approach emphasises how patient-oriented approaches are intertwined with various business areas and require changes in business processes and organisational culture. Even though the quality significance of the whole meal experience has been recognised in the literature, its implementation appears to suffer from various dyads. These do not allow the NHS to implement a food service approach which is in accordance with so-called 'soft' factors leading to patient satisfaction. Major impediments are identified as significant cultural issues, departmentalisation, lack of involvement from patients, lack of co-operation amongst all staff groups and a failure by all stakeholders to recognise the patient as the real 'customer'. Looking at value systems inherent to food choices in the existing literature on consumer food behaviour provided the tools to approach these 'soft' factors, and place it within a holistic conceptual model (3.12) proper to a healthcare setting and linking up the three disciplines considered in this study.

The third objective (C) of this study was to identify the patients' core psycho-social determinants leading to satisfactory food service experiences and investigate how these can be facilitated by the various stakeholders involved. Patient satisfaction within hospital food service is multifactorial and difficult to assess. Until now, no consensus has been found as to which variable is the most significant. Apart from the quality of the food itself, patient satisfaction and perceptions of the food service are closely interwoven with social, physical and emotional aspects of the environment (Dubé et al., 1994). Focusing on significant psychological and social factors in the literature on consumer food behaviour

and comparing these to determinants of relationship marketing, the author has (among other elements) identified values, involvement and trust as potential factors that can underpin the development of relationship marketing leading to customer-centric food service experiences.

Existing frameworks investigating patient **values** towards food choices (Furst et al., 1996) have been used in this study. As such, value systems of patients admitted in acute NHS hospitals have been thoroughly analyzed. The literature on marketing addresses the need to understand patients' values, but without providing adequate tools to achieve this objective. It is therefore relevant to combine the marketing and consumer food behaviour disciplines, even though the value systems identified consider food choices instead of satisfaction as an outcome. In order to overcome this, the 'finality' of food choices in acute NHS hospitals has been conceptualized within a broad interdisciplinary perspective centered on the patient's value systems. This study has focused on various aspects of underlying psychological meanings of food choices and overall attitude towards food in acute NHS hospitals. This contributes significantly to the existing body of knowledge when considering this particular setting.

**Involvement** has received considerable attention in the literature on consumer food behaviour as well as in the literature on relationship marketing. Being closely related to the concept of empowerment (for both patients as well as front-line staff), the increased involvement of patients in the food service process is likely to enhance satisfaction. This approach to client-centred services is supported further by the NHS Guide (DoH 2000). This emphasises patient control and the right of patients to be involved in the decision-making process. This research aimed to look at various aspects of patients' involvement with food; patient involvement with food before admittance on a ward, and the influence this has on food choices and satisfaction with the food service. The five phases of the 'life cycle of food' as defined by Goody (1982) were used to classify patients as 'traditional' or 'experiencers' in terms of their food behaviour patterns. The research also looked at the degree of involvement with food services required by patients, eventually establishing links with the patient's profile. Various relevant variables have emerged from the research, contributing to the body of knowledge about the concept of involvement in acute NHS hospitals.

**Trust** was identified as a core determinant. This research aimed to investigate how it can be facilitated by the various stakeholders involved in the food service process. As identified in the literature on marketing, trust is a key aspect of relationships as it encourages the various stakeholders to work together and seek long term benefits. Trust is built upon experience, satisfaction and empathy. A high

level of trust is likely to bring a more positive attitude, which in turn is likely to increase the level of customer understanding. The research focused on developing an understanding of who patients trust with regards to food when hospitalised in acute NHS hospitals, where a private food and service management company is in charge of food provision. No particular literature has been identified when looking at trust from the perspective of consumer food behaviour, therefore this study aims to fulfil this gap.

Finally, when considering the facilitation of patient-oriented food service experiences, it is important to recognise that food service operations form a multi-disciplinary activity. They include the management of a range of issues including the food service management firm, hospital administration, nutritional staff and medical staff. The elements facilitating the implementation of patient-oriented strategies in food services have been identified in the literature as senior management support, joint reward systems, informal integration, information about handovers provided by nursing staff to catering staff, and finally the creation of multidisciplinary teams focusing on patients' requirements (not only nutritional, but taking into account value systems identified in this study).

The fourth objective (D) of this study was to examine how a major UK food and service management firm aligns its marketing strategy, human resources and competencies with patient-centric policies developed by the NHS Estates and serves as guidelines for the providing contractors (the NHS Trusts). Despite the numerous initiatives relating to nutritional intake and food services it is difficult to tell the difference between a fashion and what is actually the basis for fundamental change. This study illustrates that there is more of the former than of the latter. It appears the NHS has a kind of bureaucratic capacity to resist change, making it possible for problems to continue for an extended period of time. As confirmed by various stakeholders, this applies to the issue of nutrition within acute NHS hospitals. Aiming for excellence in nutrition and food service is one thing, but the NHS is still trying to get many people involved in the food process even reaching the core standards. Considering that the above applies to the NHS as an organisation, where does a private food and service management firm in charge of food services stand in that picture? When knowing that the negative perception and attitude patients show towards institutional food is predominantly caused by food presentation, variety and physical setting (Hartwell et al., 2006), it is encouraging to see consequent progress has been made by the private food and service management firm in this regard. The introduction of the steam system illustrates this improvement, but only offers a partial solution to a much wider problematic picture inherent to the functioning of the NHS itself. The physical setting

certainly needs to be looked at, but according to budget constraints in the NHS it is unlikely to see any progress in the short term. Achieving patient satisfaction with healthcare catering management is definitely a complex phenomenon that needs to be looked at holistically.

This study illustrates how customisation of service and increased patient involvement with food aspects (whereby staff from the private food and service management firm serves the steam food in comfortable small scale operations or new facilities) also increases patient satisfaction in terms of the interaction they have with the person serving the food. However, because of the NHS upscale in hospital provision (Black, 2008), hospitals are grouping together and smaller ones are closing. Larger hospitals are being built which is likely to lead to a smaller degree of customisation and decreased satisfaction levels. Another constraint is the likelihood that budgets allocated to patient meal services in the NHS are unlikely to increase in the near future. As a result of this, it is imperative to develop food service systems and processes that optimise nutritional intake and lead to patient satisfaction in a cost-effective manner. It is therefore important to review the food service and delivery process to achieve patient satisfaction when collaborating with private food and service management firms. However, as identified in this study, the processes and the interaction between NHS and catering staff is made complicated by a lack of empowerment of front-line staff (both NHS and catering staff), a different employment culture and a high employee turnover rate within the private food and service management firm. These elements do not achieve patient-oriented services, but add up to the traditional implementation dyads inherent to the NHS (departmentalisation, lack of patient involvement, lack of communication between staff groups and not recognising the patient as being a customer).

With the above in mind, it is difficult to envisage the policy of competitive tendering and the ensuing expectations of reforming industrial relations to achieve its initial goals. Today the former remains a sensitive issue within acute NHS hospitals, which work with private food service management firms. In addition to the competitive tendering policy, through a policy of decentralised decision making, recent modifications in Trust status have not brought about the reforms aimed for in industrial NHS relations. In this regard and in perspective of the PFI initiatives affecting food provision in acute NHS hospitals, Shapiro and Shapiro (2003) rightly argue organisational changes and liberalised funding schemes frustrate the co-operative efforts of those working to provide good healthcare. Together with the development of PFI initiatives which affect food provision in acute NHS hospitals, it would have been better to focus on organisational changes which enable co-operative efforts between NHS and catering

staff to provide good food services. But a prerequisite to the service components remains the product itself: good quality food. Private food and service management firms also suffer from the negative stereotypes linked to hospital food. Over the past decade much effort has been dedicated to improving the intrinsic quality of the food. However, a key focus should also be on the perceived quality of patients and the wider public, using marketing and educational strategies in order to change consumer attitudes. This is not something that can be achieved by a private food and service management firm alone, but needs to be looked at on a governmental level. This study has illustrated how eating is embedded in a network of psychological and cultural mechanisms that are only partly understood, whilst malnutrition is often seen as pathology whereby inadequate diets are assumed to result from inadequate knowledge or income. Simply increasing budgets for food in the NHS is certainly a start to improve the quality of the food itself, but this strategy will not resolve behavioural health problems or achieve patient-oriented food services in the short term. Much needs to be done in terms of the physical and social eating environment, with a willingness to combine health and sensorial, psychological and social pleasures into hospital meals (Bélanger and Dubé, 1996).

Finally, the last objective (E) of this research was to develop a holistic theoretical model of the requirements of patient-centric experiences and satisfaction with hospital food services. Before fulfilling this last objective, various models were developed along the way. This study has contributed to the construction of a multidimensional model of food choice behaviour (Figure 3.9), contextualized to acute NHS hospitals. Key components of this model were then integrated in a broader model that includes the HR and marketing strategy implementation dyads (Figure 3.12), concluding the literature review. Based on the data collected and analysed in this study, a holistic theoretical model of the requirements of patient-centric experiences and satisfaction with hospital food services was developed (Figure 9.2), concluding chapter 9. In further research, the dimensions addressed in this study could be tested out. This study, according to the work of Rappoport and Peters (1988a), aims to be a significant movement away from rather abstract food item preference studies, and more towards the investigation of phenomenologically meaningful food cognition processes. This implies a move toward the analysis and specification of food information processing as a substantive cognitive activity rooted in biological needs and psychosocial meanings. Even though food choices in hospitals are constrained by nature, it is relevant to see which factors influence food choice strategies as a whole. The models developed in this study aim to contribute to such an understanding.

### 10.3 Contribution to knowledge

The most important contributions of this study to the existing body of knowledge are briefly considered below:

- The **contextualization** of various factors affecting food services in healthcare to a set of acute NHS hospitals, whereby a major private food and service management firm operates, constitutes a contribution in itself. Various implementation dyads of patient-oriented food services proper to these PFI initiatives have emerged in this study. These relate to high staff turnover rates, a lack of empowerment of front-line staff (both NHS and catering) and a top-down approach to planning from the catering management (see Table 9.2). These contribute to having two different managerial cultures working alongside each other. As encountered in the literature this study confirms broad implementation dyads when considering consumer-centric processes: cultural issues (Carr, 1992; Bolton, 2002), departmentalisation between catering staff and NHS staff (Askham et al., 2002), and a lack of involvement from the patients.
- Going beyond traditional boundaries, this study searches **across disciplines** to understand and identify relevant determinants that might contribute further to the development of patient-oriented food services in acute NHS hospitals. Organised theoretical frameworks were produced to identify most relevant factors affecting the complex process of patient's food behaviour process when in hospital.
- **Patients' value systems** were investigated by building on the work of Furst et al. (1996) and Winter Falk et al. (1996). Value systems proved to be relevant, enabling the author to apprehend patients' food choice systems and further distinguish between short-and long stay patients' approach. Emerging from the pediatric ward (hospital C), the specificities of these patients and their guardian's value systems shed a light on nutritional behavioural aspects that have not been developed in anterior literature. But apart from this specific ward, working on the patients' value systems has provided a relevant contribution when considering the insights gained about how patients manage relationships with all parties involved in the food process. An insight into the patients approach to health and food and their convenience orientation when hospitalised has also been gained.

- The degree of **involvement** prior to (and during) admittance on a ward and the non-existence of trust between catering staff and patients form further contributions to the existing body of knowledge. This study advocates disintermediation between catering staff and patients in order to increase interaction between both parties. This will eventually lead to the basics of trust and emergent relations for specific patient groups (long stay patients predominantly, as well as food experiencers who require a different approach to food service).
- The literature on consumer food behaviour did not provide insights into dimensions of **trust** between patients and food service providers, whether they are from the NHS or a private food and service management company. According to patients, dimensions of safety and credibility are found within NHS staff instead of catering staff. Trust being a key component leading to relationships, this is a key element that requires focus and the need to redesign the service process and enable disintermediation between patients and staff members who actually produce and deliver the food on ward level.
- Contradicting the findings in the literature and proper to additional nutritional intake through social facilitation (Hotaling, 1990; Hartwell and Edwards, 2000; Allison, 2003), this study found that patients do not want to make use of a **separate room** to consume their food. However, there are two exceptions here: long-stay patients and parents on pediatric wards who would prefer to recreate a home-like environment in order to stimulate nutritional intake.
- Food choices with short-stay patients (one week on average) can be summarised as a 'trial and error' process as developed in chapter 9, while long-stay patients develop more complex strategies depending on their value systems. These strategies have been analysed in detail in this study.

## 10.4 Implications and contributions for practitioners

This paragraph discusses the implications of the findings of the present study for three audiences. First, there are implications for NHS practitioners, followed by implications for the private food and service management firm. Briefly addressed, the third has broad implications for the NHS and DoH. The outcome of the answers to the research questions addressed in chapter 9, along with the conclusions from this study enables the author to draw lessons for these practitioners groups. As potential actions undertaken when considering food services in healthcare do involve the three practitioner groups linked into a network of relations, it is difficult to separate specific actions. However, outlined below are broad categories for the convenience of the reader and practitioners.

### *10.4.1 Implications for front-line professional practice in the NHS*

#### **A teamwork approach**

In line with the applications suggested by Watters et al. (2003) which is 5 years ago, the data at hand in the present study stresses the need to develop an effective team approach towards improving patient food service satisfaction. The sharing of food service information between staff groups involved in the food service process however is more than has been achieved. In line with what Chimhanzi (2004) has developed for a non-healthcare context, written communications as well as interpersonal communication would facilitate coordination across NHS and catering staff. Ultimately, this would enhance service levels to patients. A possible solution to stimulate patient-oriented food services is to organise interdisciplinary catering ward rounds attended by dieticians, the modern matron and a representative of the general management for facilities. The United Bristol Healthcare Trust that includes seven hospitals (Williams, 2008) currently implements this approach. Organising informal events between catering and NHS staff is another option that facilitates smooth communication and stimulates flexibility, ultimately benefiting the patients. Nevertheless, there is a link between effective communications and a lower catering staff turnover, as developed below when considering the private food and service management firm.

### **Long stay patients & communication between parties involved in the food service process**

Another key aspect is to facilitate communication surrounding nutritional issues between the patients and its relatives, the dietitian as well as the nursing and catering staff involved in the treatment of specific patients. Food 'experiencers', long-stay patients as well as parents and guardians on pediatric wards develop alternative food choice strategies, without speaking about them to NHS or catering staff. This is partly due to a fatalistic approach towards food services in hospital ('nothing can be improved anyway'), and leads to increased food wastage and inefficiencies in food servicing. Even today, there is still insufficient nutritional screening across acute NHS hospitals. It is difficult to envisage time being dedicated to 'soft' factors like the influence of the patient's (or his relatives) emotional status on his food behavior. Nevertheless, it is critical to envisage adequate follow up of the food service experience of long-stay patients especially. Now, there is no focus on, or person in charge of these aspects.

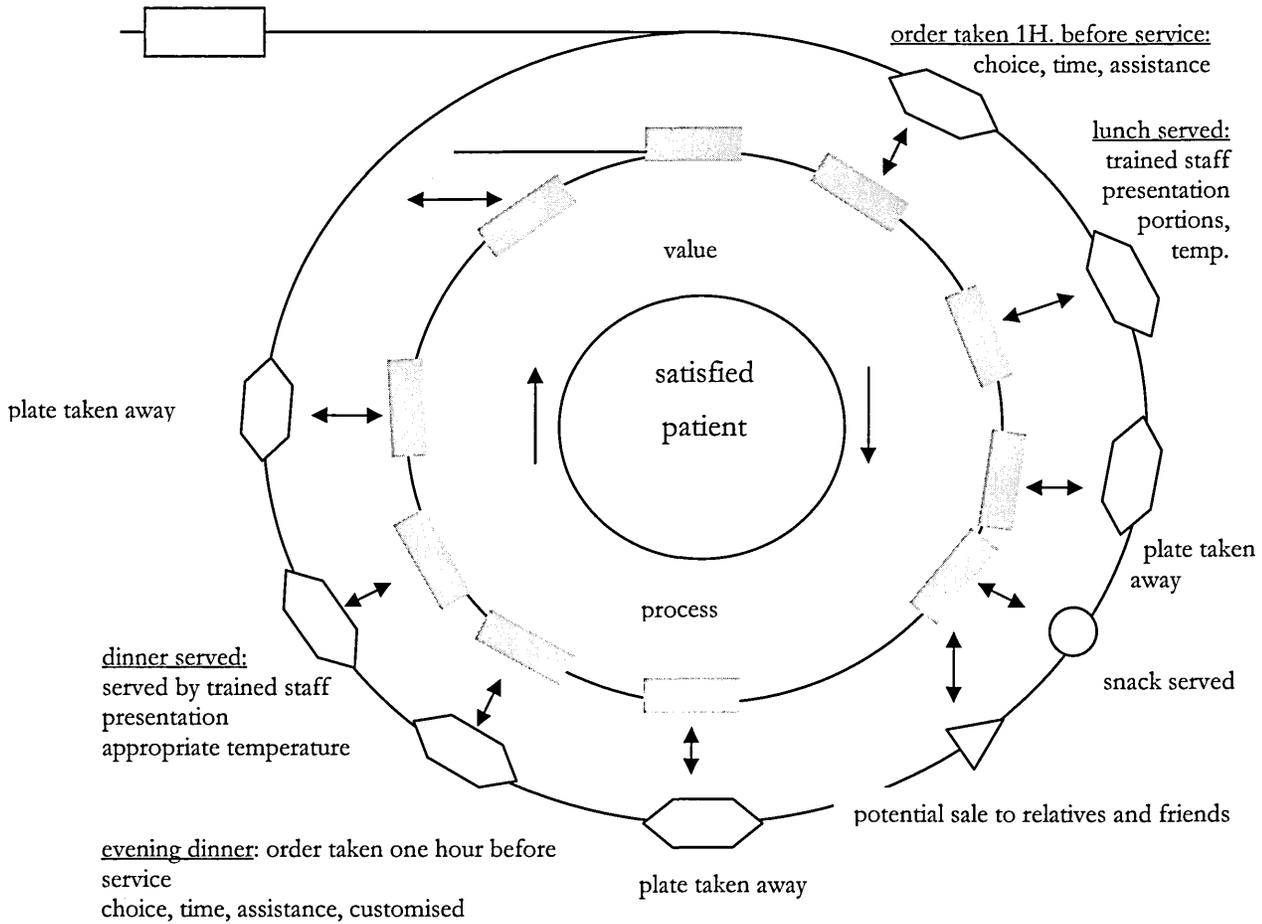
#### ***10.4.2 Implications for the food and service management firm***

##### **The patients' value process**

As developed in the literature review of this study and in accordance with the Nordic School of Marketing, the management of an interaction process is the core of relationship marketing. In this study, when considering patient satisfaction with food services, it appears patients were most satisfied with the steam system when served in small-scale hospitals (like hospital B). Many Trusts are reluctant to allow catering staff to serve the food to patients, but this is a basic requirement to increase the interactions patients have with this staff group. The author has drawn a schematic overview of what could possibly become a value process for patients, thus the serving of the steam food by the catering staff 'steam' food. (Figure 10.1).

**Figure 10.1 The interaction, planned communication and value processes**

Patient admitted on the ward: menu at disposal & explanation about the food services offered (clarity, choice, language, appropriate to the patients needs)



**Legend:**

- mass communication activities 
- direct communication activities 
- public relations activities 
- sales activities 
- episodes in the interaction process, including 

**Requirements for positive patient meal experiences:**

situational variables: time, place, served by, social importance, accountability for system

food: as ordered?, quality, quantity, nutritional, does it match expectations?

consumption: sufficient time, assistance if required, patient protected meal time, monitoring when not consumed (by medical & catering staff)

psycho-social elements: values, trust and involvement

Based on Grönroos (2004)

However, before such a redesign of food delivery processes might take place within the NHS, according to the outcome of this study, the private food and service management firm needs to focus on the following three elements below:

### **Training and communication: repositioning the caterer's job characteristics**

Across hospitals, NHS staff have stressed the need for catering staff to receive more training on diets, also on improving communication with hospital staff in order to reduce potential errors (delivering wrong food to patients). If developed or already existant, these skills need to be communicated clearly to the NHS staff across hospitals. Today, the NHS staff is simply not aware of the efforts conducted by the food and service management firm in respect to training on the subject of diets. Eventually, delegating food-servicing duties to catering staff would indeed give nursing staff more time to focus on medical duties (Wood, 1998; Kowanko et al., 1999; Edwards and Nash, 1999; Edwards and Hartwell, 2006). An additional requirement is to reposition the role of catering staff in the patients (and the broader publics') perception, as currently catering staff's role is perceived to be limited to functional aspects such as preparing and serving the food. This will progressively contribute to modifying the negative perceptions the public has towards hospital food, as acceptance of the food in this study increases with the positive experiences, predominantly provided by the steam system.

### **Selection and working conditions of catering staff**

As mentioned above, the reviewing of roles and specification of duties of the private and NHS staff working together in food services, could lead to the breaking up of heavy resistance within the NHS to delegate more tasks to catering staff. For the food and service management firm, this might imply reviewing the criteria of selection and level of education of their front-line staff. Even though current budgetary constraints within the NHS offer a bleak picture in this respect, it is crucial to increase the budget allocated to food provision within acute NHS hospitals. The investment of part of this increase on the food itself makes sure basic requirements fulfill the need (which was not the case in hospital C and E with the data collected). However, money also needs to be dedicated to improve working conditions and wages of the catering staff, which ultimately can help private food and service management firms to reposition themselves in the field and upgrade the rather negative perception the public has of their staff. Improved working conditions are likely to lead towards a reduction of turnover amongst catering staff. This element is of paramount importance, as 'value' for patients appears to come over time, on the condition that the same catering staff serves the food. But reducing

turnover amongst catering staff is also of paramount importance for the front-line NHS staff working on the wards.

### **Catering staff management: empowerment and supervision**

Across hospitals, catering front-line staff as well as NHS staff asks for a more efficient supervision by the catering management, as they often feel let down by the latter involved in this study. Interestingly, patients currently prefer complaining about the food to the catering managers or NHS staff, because they consider front-line staff is not empowered to change anything anyway. NHS staff across the four hospitals (A, C, D and E) considers themselves as trouble-shooters, rectifying the omissions or mistakes from the catering staff. According to NHS staff, this is due to a lack of proper supervision and support of the catering staff on ward level (D) or because the catering staff does not hand out the food to patients (A, C, E). Giving ownership of the whole food service process to front-line catering staff also implies greater responsibility, but provides the opportunity to deal more promptly with patient complaints.

### **Buy-in of the steam system**

NHS staff shows significant resistance to the implementation of the steam system in their hospitals, even though the hospitals where the system is in use do not wish to go back to traditional food processing methods (cook chill or plated in the case of this study). Section 9.2.4.12 provides comments on the steam system. But it is clear that buy-in by front-line NHS staff is absolutely needed before implementation of the system in a hospital. Providing NHS staff the opportunity to try out the system during implementation facilitates the buy-in of the system by NHS staff.

### **Patient involvement**

Involving patients as well as their parents or guardians in the food process is of vital importance on pediatric wards. Perceived control over a situation positively influences satisfaction judgments (Bélanger and Dubé, 1996) and using tasters or displaying the food on offer to children is likely to increase their nutritional intake as well as satisfaction. However, involvement also implies that the private firm should swiftly react to the complaints of the patients or their relatives', addressed to NHS or front-line catering staff. This entails the development of a strong teamwork approach as developed above. Feedback needs to be acted upon, as currently patients tend to consider providing feedback (verbally or even through surveys) as being useless, because it is not taken into account by NHS or catering staff.

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When considering the issue of involvement, it would be helpful to question the patient about his degree of involvement with food upon admittance on the ward. As emphasised in this study, high involvement strongly influences food choices and it might be helpful for the private food and service management firm to identify these patients at an early stage. This becomes more important when patients highly involved in food must stay for extended periods on a ward, as these patients request to take up a more active role in respect to food.

### **Broad issues relating to the food service**

Across hospitals, patients would like to have a wider variety of fresh vegetables and fruits on offer. Table 9.1 provides an overview of patient suggestions, classified by hospital. The issue of portion sizes and elderly patients emerged across hospitals. Elderly patients are often referred to as being 'good hospital patients' (Taylor, 1979) as they are fearful of complaining and show more gratitude. This study showed the same results. Nevertheless, elderly patients tend to eat lighter in the evenings and portion sizes could be adapted to their needs in hospitals where the food is cook-chilled or plated. Even where the steam system is in place, taking the assumption that patients have sufficient alternatives on offer (e.g. sandwiches), consideration of smaller portions for elderly patients is necessary.

### **10.4.3 Implications for the NHS**

#### **Differentiation**

In line with the report of the Nutrition Summit, in the care of older people in health and social care held in London on March 14<sup>th</sup>, 2007, hospitals and Trusts could link nutritional as well as service standards to gaining business and income. Thus, there is an incentive to make nutrition an important part of care and then service users will opt for treatment at certain hospitals, because of the good reputation inherent to these hospitals. When Trusts do work together with private food and service management firms, it might be helpful for the former to rely on the DoH recommendations about the most efficient food service process. The DoH could specify who should deliver the food to patients and how by providing set guidelines on adequate training of catering staff will lead to an overall recognition of these in the field.

### **Length of stay and the food service proposition**

There is a need to differentiate food provision and servicing between short-stay (less than 7 to 15 days) and long-stay patients in acute NHS hospitals. The food offer could be different in order to avoid menu fatigue, offering alternatives to patients that will otherwise develop food choice strategies involving friends and relatives bringing in food from outside. This applies to hospitals where the food is unsatisfactory, as well as the others where good food offered during the initial phase of the patients' stay on the ward.

### **Hospital size and infrastructure**

Patients from hospital B were overall satisfied with the food services offered and the fact it was a small-scale operation with large rooms played an important role in this respect. Considering the tendency of the DoH to merge hospitals or build larger facilities, the taking into account of good building design, along with the observations of McKenzie (2003) who stressed the importance of good building design concerning patient recovery.

### **Providing separate rooms for consumption on paediatric wards**

As outlined in 10.3 above, parents on the pediatric ward in hospital C would like recreating a home-like environment with their child in order to stimulate nutritional intake. The NHS could facilitate this when considering the development of new hospitals or when refurbishing existing facilities. This in line with Clendenen et al. (1994) and Engell et al. (1996) who note the relationship of the individuals eating meals together has a significant impact on social facilitation of eating.

### **Focus on training in nutrition in the nursing curriculum**

As nurses often interact with patients and sometimes play an active role in patients' food choices, their influence largely depends on their own dietary habits and educational background in this area. An inadequate education about nutrition among staff groups has recently been cited as a major factor contributing to under nutrition in hospital patients by Holmes (2007). A mandatory requirement for all staff involved in food services might be helpful to develop trust and a better collaborative relationship between catering and NHS staff, as well as between catering staff and patients.

## 10.5 Limitations of this study

Leaning on case studies, this study faces limitations on generalization as well as limitations due to the restricted scope of the initial research design. The advantage of using five case studies is the (relatively) advanced level of achievement of detail as well as the freedom the researcher had to make sense of patterns emerging outside the frameworks developed to collect the data. The disadvantage of using case studies is that overview is restricted to analytic generalization (Yin, 2003). Statistical generalization through replication was definitely not the aim of this study and it would require elements from section 9.3 'Implications for professional practice' to be made operational to do so. Given the advanced state of research in the field of marketing and consumer food behavior, we might expect to find questionnaires on profiling and value systems to build on. Unfortunately, developing a detailed instrumentation fell beyond the scope of the present study, due to limitations in time. The data collected in this study was predominantly focusing on patients and front-line staff groups, with little insights gained from governance level in the NHS (apart from the secondary data looked at in chapters two and three). In practice however, in order to apply the recommendations from a study like this one you have to take into account the issues of control. The author is aware of the limitations of the discussion focusing on patients and front-line employees, nevertheless, the insights gained provide useful information to various authority levels within the NHS or the private food and service management firm. The small number of patients and staff interviewed in each case does limit the applicability of this study's findings to other hospitals. Although the identification of the findings are consistent within the current body of knowledge, another limitation of the present study relates to the self-report method of data collection. It would have been preferable to have the data analysed by more than one researcher in order to increase reliability, as a team approach offers numerous advantages (Fonteyn et al., 2008). Again, time and resources available hindered such an approach.

## 10.6 Recommendations for further research

Throughout this study, the author has identified relevant gaps in the literature that link to his own research. Many of these gaps would actually contribute to patient-oriented food services in the NHS, stressing once again the multi-factorial nature of food services in healthcare. Possible lines of research are shown below, with potential research questions:

- Holmes (2007) stressed how nursing staff have an essential role in promoting optimal nutritional care for patients and helping to reduce the incidence of under-nutrition in hospital. Focusing on this aspect in further research and bearing in mind the perspective of collaboration between a private food and service management firm and NHS staff is a route to follow. Could catering staff take up this promotional role when in charge of actually delivering the food to patients? How would patients react to this when considering the current perception towards catering staff in acute NHS hospitals?
- Faulkner and Laschinger (2008) have conducted research on the relationship between structural and psychological empowerment and their effects on hospital nurses' perception of respect. This study was conducted in Canada, although could be replicated in the UK. Further research should not only include the perception of respect from the nurses' perspective within the NHS, but also from the perspective of catering staff from the private food and service management firm working in collaboration with NHS staff on food services. Amongst other factors, structural and psychological empowerment is linked to job satisfaction (Laschinger et al., 2001). So how does (private) catering staff perceive 'respect' from other staff groups in acute NHS hospitals? Does this influence their degree of job satisfaction? The literature offers insights coming from NHS staff towards catering staff, but not the other way round.
- It was not the aim of this study to construct a full-grown developmental theory of food choices in acute NHS hospitals, but future research might focus on studying changing nutritional needs along the life span of patients (with the related changing psychosocial meanings food might have over time). The literature, along with various action plans, currently offers guidelines for nutritional care of the elderly and an overall recognition that different age categories have different nutritional needs, but nothing more than that.

- Among the seven customer groups identified by Pucket (2004) and involved in the food service process is the role of volunteers. It might be interesting to investigate this role and what it might offer in contributing to patient-centric processes. This would be in line with the seventh step suggested in the “Hungry to be heard campaign” launched in 2006, which advocates the use of volunteers where appropriate. Volunteers can take up the role of catering staff or nurses in feeding patients or communicate during lunchtime in order to facilitate nutritional intake. It won’t be the ideal way to improve patient-orientation when considering food services, but within the current context of restricted budgets allocated to food service operations, it might be a valuable route to pursue. Defining the exact role these volunteers might have in the food service process will be crucial, as well as redesigning the managerial implications and attributing volunteers to patients most subjected to malnutrition. Faulkner and Davies (2005) have analysed the role of volunteers as social support in a healthcare setting and provide an interesting framework for analysing social support as an eventual healthcare intervention leading to genuine health benefits. To summarise: further research might look at the supportive role of volunteers and related patient outcomes in food services.
- The factors identified in this study could be integrated in a quantitative study, being added to evaluation tools like the multi-item scale PANAS as used by Bélanger and Dubé (1996). The PANAS scale is a 20 item, standardised, bidimensional scale of positive and negative emotions. Patients values, involvement and degree of trust could be further analysed within a large sample on the basis of demographic, socio-economic and psychographic factors if available. It was not possible to achieve a high degree of reliability in the present study, because of the small sample size of only 31 patient interviewed. Such a more quantitative research would be designed to enhance and validate information gathered in this present study.
- Shapiro and Shapiro (2003) offer an interesting approach in terms of methodology to improve food services within acute NHS hospitals. What the authors call OR (operational research) might be applied to further research on front-line staff, focusing on communication and implementation of recommendations as defined by the DoH. As poor communication and relationship in the NHS have been identified in the literature, further organisation research into this topic should be conducted in the area of hospital food services. The purpose is to improve communication between different staff disciplines (in accordance with the Council of Europe Resolutions, 2003), and ultimately to increase patient satisfaction.

## 10.7 Reflections on the learning process during this study

This study has been a unique opportunity for me, adding numerous skills and competencies to my prior knowledge. Without even realising it, I started this journey with a positivistic mindset towards research. My idea was to use the PhD route to learn about ‘real’ scientific research, based on statistical analysis and causal relationships. Even though the masters degree in social sciences research methods, completed during the first year of the PhD, gave me even more than the basics of these statistical tools, the degree enlarged my horizon to a broad array of alternative ‘scientific’ research methods. Whilst working on a challenging cross-disciplinary literature review leaning on different methodological approaches, I soon left behind my positivistic stance, but still see that it often emerges in the completion of the research design for this study. My willingness to ‘quantify’ my contributions and test these out on a larger scale partly illustrates this, but also aims to reduce the large gap between academic literature and practice in the field. Frequently encountered throughout the data collection of this study is this gap. Adding a qualitatively-sourced contribution of knowledge to an area of healthcare food services that has been leaning on significant quantitative research focusing on nutritional intake proved to be challenging, but illustrates perfectly my own learning process. This led to a research process, whereby I had to verify the answer of the data collection results in order to fulfil the research questions. A key lesson from my journey is that nothing is set in stone and certainly not when considering the complexity of human beings. Conceptualisation is certainly useful here, but apparently, many relevant issues don’t fit into set models. Apart from the academic skills developed along this study, I have evolved as a human being as the journey often looked like climbing steep mountains. The COREC procedures to gain access to the NHS as well as the data reduction phase were steep hurdles. However, when comparing this to the fact that I moved home twice and to different countries with my family during the PhD route whilst combining this with teaching, the latter probably provided the best opportunity to develop my skills to resist stress and manage with emotional situations. Compared to the early days of the PhD route, I have developed ownership on my study and life in general. These two aspects are of significant value and influence for my future as well as for the relatives and colleagues around me. Together with the understanding gained in the fascinating area of consumer food behaviour in healthcare as well as marketing, these aspects make the focus of the past few years more than worthwhile.

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## Appendix A Interview schedule patients developed according to the model of Wengraf (2001)

Research purpose:	Determine which common defining constructs of relationship marketing and consumer food behaviour apply to the development of patient-centric approaches to food services in acute NHS hospitals	
Central research Theory questions (TQ) Interview questions posed to patients		
Involvement. Assumptions: a) increased involvement of patients in food services leads to increased satisfaction levels b) developing relationships between patients and staff members involved in the food service process contributes to better food experiences for patients.		
<p>1. What is the role of patients in acute NHS hospitals, as co-producer of value through communication &amp; interaction (with staff and between patients) in the food process?</p>	<p>TQ1 Does the current communication between suppliers and patients form groundwork for developing trust amongst exchange partners and lead to the development of better solutions? Is connotative meaning created between the catering staff or NHS staff serving the food to patients?</p> <p>TQ2 Is there a relationship dialogue between the various stakeholders involved in the food production and delivery process?</p> <p>TQ3 What is the patients' value-generating process in relation to nutritional behaviour?</p> <p>TQ4 Are some patients more willing to accept a relational contact with a firm, whereas others may want to have a transactional contact?</p>	<p><b>Involvement, communication and interaction</b></p> <p>5a. Do you often discuss issues with the staff serving the food? Or with staff involved in the food process?</p> <p>5b. Would it help for you to talk more with the people serving the food? (or involved in the food service)</p> <p>5c. What would you talk about with that person?</p> <p>6a. Do you think the staff who serves the food gets to know you better over time?</p> <p>6b. Do staff try to comply with your feedback and help you to:</p> <ul style="list-style-type: none"> <li>▫ obtain the food you want</li> <li>▫ consume the food if you ask for it</li> </ul> <p>6c. Do you feel all staff members (food and non-food) focus on your needs in relation to food work together in order to meet these?</p>

<p>2. Does involvement of healthcare customers in the food process increase their level of satisfaction?</p>	<p>TQ5 Will consumers in a relational mode be in an active or passive relational mode?</p> <p>TQ6 Are the patients highly involved with food in their day-to day life?</p> <p>TQ7 Do the patients feel involved with the food production and delivery process in hospital? Is hospital food, as a product category, of low involvement?</p> <p>TQ8 Would patients be more satisfied if involved throughout the life cycle of food?</p> <p>TQ9 How is involvement with certain aspects of food provision related to other involvement aspects?</p> <p><u>Sub question</u> How do patients feel about actually being 'involved' in the food process when in hospital, as their responsibility and possibility to exercise control over the provisioning task is limited?</p>	<p><b><u>Involvement and satisfaction</u></b></p> <p>1a. In your day-to day life, do you prefer eating food products you are used to, or do you like trying out food items with which you are not familiar?</p> <p>1b. While preparing food at home or when you are with friends and relatives, do you like to try out new recipes?.</p> <p>2a. Is the food you receive on the ward important for you, as part of the overall care provided in the hospital?</p> <p>3a. What information (origin, preparation and general) about the hospital food do you currently receive? Whom do you receive this information from?</p> <p>3b. Would you be interested in receiving more information about the way the food you receive on the ward is purchased, prepared and delivered to you?</p>
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**Values.** Assumption: understanding patients' values and sharing these with him will enhance the food service experience.

<p>1. What is the patients' value generating process leading to specific food choices?</p> <p>2. What is the relationship between satisfaction, food intake and food choice?</p> <p>3. What events and experiences over the life course are viewed as shaping food choices and customer satisfaction in a healthcare setting?</p>	<p>TQ1 What is the patients' perceived value from the food services provided in the hospital?</p> <p>TQ2 Is the (potential) relationship developed by the food and service management firm over the period of stay on the ward considered as 'added value' by the consumer?</p> <p>TQ3 Satisfaction</p> <p>Is the food a patient eats the food that provides him-her with the highest degree of satisfaction?</p> <p>TQ4 Ideal food</p> <p>What food do patients consider as being ideal when hospitalised compared to what they would consume outside the hospital?</p> <p>TQ5 Personal factors</p> <p>Does hospitalization change the patients' attitude towards food?</p> <p>TQ6 Resources</p> <p>How do patients experience the resources available when considering food production and consumption?</p> <p>TQ7 Social framework</p> <p>What are the nature of interpersonal relationships, social roles and meanings in hospital?</p>	<p><b>Relation between food choice, food intake and satisfaction</b></p> <p>1a. When choosing items from the menu, do you sometimes choose an item even though you would prefer to pick another one that is listed?</p> <p>1b. If you could would you prefer to buy food from elsewhere or have friends/family bring it?</p> <p>1c. What do you think of the food and the service here - about the whole meal experience?</p> <p><b>Life course events and food choices</b></p> <p>1a. In your day-to day life, what food do you tend to consider as 'ideal' food?</p> <p>1b. Now you have been on the ward for X days, what do you consider as being your 'ideal' food? Did your perception of 'ideal foods' change because of medical reason or because of the surroundings of the ward?</p> <p>3a. Do you think the NHS invests sufficient money in the food provision in this hospital for instance, menus, service, and surroundings where the food is consumed?</p> <p>4a. Do you often have friends and relatives visiting you on the ward?</p> <p>4b. If so, (Q 4a) do you occasionally talk with them about the food you receive?</p>
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<p>4. Does the categorization of food in specific values (health, taste, cost, convenience and relationships) apply to healthcare customers?</p>	<p>TQ8 Food context How do patients experience the healthcare context? Does it influence their level of satisfaction?</p> <p>TQ9 Cost How do patients experience the cost issue when choosing food, as they do not have to pay?</p> <p>TQ10 Health Do patients modify their food choices when hospitalized, in accordance to their medical condition?</p> <p>TQ11 Relationships Do relationships patients develop when in hospital determine their food choices and increase satisfaction levels?</p> <p>TQ12 Children Are values handled by children when in hospital different than the values of adults when determining food choices?</p>	<p>4c. Do your friends and relatives sometimes bring drinks on the ward?</p> <p>5a. Now you consume the food provided on the ward/in the bedroom - but would you prefer to consume lunch and diner on another location in the hospital? Could you tell me where, and why?</p> <p><b><u>Categorisation of food</u></b></p> <p>1a. Do you sometimes buy food from the various commercial outlets in the hospital?</p> <p>2a. Compared to what you would choose to eat in your day-to day life, do you now pick food items that appear to be healthier?</p> <p>3a. Does the comments of medical and non-medical staff influence your food choice?</p> <p>3b. If yes: do you feel happy with these 'new choices'?</p> <p>3c. Do you think you will keep this eating behaviour once you are back at home?</p> <p>4a. Do you think the way the food is presented to you convenient for consumption?</p> <p>5a. In regards to the taste from the menu items, what did you expect from your first meal served on the ward?</p> <p>5b. Is taste important in regards to the food items you pick up from the menu?</p>
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<p>5. Which values do healthcare customers prioritise?</p>	<p>TQ13 Social relationships Do patients place the management of social relationships above other food specific values?</p> <p>TQ14 Value conflicts Does the fact of being in hospital lead to significant value conflicts, re-prioritising values or develop strategies that enable food choices?</p> <p>TQ15 Food choice strategies &amp; satisfaction Do 'new' food choice strategies lead to increased levels of satisfaction?</p> <p>TQ16 Children Whose nutritional needs do children actually accommodate when in hospital: their own, the parent's, or the medical staff requirements?</p>	<p><u>Patient value</u></p> <p>1a. Do you have conversations with the staff serving the food? What are these conversations about: food or non-food issues? What do you think of these conversations?</p> <p>1b. In regards to food issues, do you have one single contact person you can talk with?</p> <p>1c. Would you like to having one single person contacting you with your food issues, and what would be the possible advantage of this?</p>
	<p><u>Sub questions</u></p> <p>Are some patients more willing to accept a relational contact, whereas others may prefer a transactional contact? Will consumers in a relational mode be in an active or passive relational mode?</p> <p>What are the potential benefits of relationship marketing as experienced by patients?</p> <p>What are patients' motives towards food?</p> <p>What are patients' attitudes towards food?</p> <p>What do patients qualify as a 'total food experience'?</p> <p>Do patients use food as a communication tool towards staff, friends and family?</p>	

**Trust & promises.** Assumption: building up relationships between patients and staff involved in the food process whereby trust is central is a key element in the development of positive food service experiences.

<p>1. Is trust a key determinant leading to increased levels of satisfaction for patients?</p>	<p>TQ1 Trustees Who do patients trust in regards to food consumption: nutritionists, doctors, nurses, catering staff or relatives?</p> <p>The same question applies to issues of safety, credibility and honesty in regards to food consumption in a hospital setting. Can we speak of cognitive or affective trust? Does the communication between suppliers and patients form groundwork for developing trust amongst exchange partners?</p> <p>TQ2 Do the patients feel the food service and delivery lives up to the promises made (if any...)?</p> <p>TQ3 Trust and time issues Does trust between patient and staff develop over time?</p> <p>TQ4 Trust and satisfaction Would patients be more satisfied with increased levels of trust towards catering staff producing and serving the food?</p>	<p><b>Trust and satisfaction</b></p> <p>1a. Here are some people involved with the food (show list with the various staff groups to the patient, but without any name attached): the staff serving the food, the nutritionist, the doctor, family and friends. What contacts do you have with these different people?</p> <p>2a. As you have been on the ward for X days now, do you have more contacts with the staff in charge of the food – or with the staff serving the food?</p> <p>3a. Do you consider the food and the food service matches the promises made in this regard?</p> <p>3b. Could you specify which promises have been made in regards to the food served on the ward?</p>
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Profile of the patients

1. Could you tell me your year of birth?
2. From these ethnic categories, where would you place yourself? (provide the patient with a list of various ethnic groups)
3. Do you live with a partner?
4. Do you have any children at home?
5. Did you complete a degree?
6. Together with your partner (where applicable), how much do you earn on an annual bases? (gross income classified in categories and submitted to the patient)
7. Do you actively practice any religion that influences your food purchases?
8. Could you tell me the postcode of the area you live in? How would you describe this area?
9. How would you describe yourself as a person?
10. How long have you been on the ward?
11. How often did you spend journeys in the hospital over the past 10 years?
12. Are you allergic to any specific food, or do you suffer chronically from any problem that does not allow you to consume specific food items?
13. Are you vegetarian, vegetarian or focused on biological food?

General information about the hospital. These questions were not asked to the patients

Name of the hospital: hospital A, B, C, D or E

Ward: Elderly, Surgery, Pediatrics, Medical

Which staff group delivers the food to the customer: NHS Staff, employees from the food & service management firm or other

Food system in use in the hospital: cook-serve, cook-chill, sous-vide, cook-freeze or steam

## Appendix B Interview schedule patients

My name is Michel Altan, doctoral student and associate lecturer from Sheffield Hallam University. My research is concerned with the way you experience the food service within the hospital. I will ask you questions on four broad themes relating to the food service you experience in this hospital. These four categories can be summarised as follows: your involvement in the food process, your values in regards to food, issues of trust in regards to the food served, and finally there will be questions looking at your background and overall profile.

### A. General information about the hospital. These questions will not be asked to the patients

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Name of the hospital:

1. Hospital A (actual names removed in this study for confidentiality issues)
2. Hospital B
3. Hospital E
4. Hospital C

Ward:

1. Elderly
2. Surgery
3. Paediatrics
4. Medical

Which staff group delivers the food to the customer?

1. NHS Staff
2. Catering employees
3. Other: define

Food system in use in the hospital:

1. Cook-Serve
  2. Cook-chill
  3. Sous-vide
  4. Cook-Freeze
  5. Steam
-

## B. Involvement

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### Involvement and satisfaction

- 1a In your day-to day life, do you prefer eating food products you are used to, or do you like trying out food items you are not familiar with?
  
- 1b. While preparing food at home or when you are with friends and relatives, do you like to try out new recipes?
  
- 2a. Is the food you receive on the ward important for you, as part of the overall care provided in the hospital?
  
- 3a. What information (origin, preparation and general) about the hospital food do you currently receive? Who do you receive this information from?
  
- 3b. Would you be interested in receiving more information about the way the food you receive on the ward is purchased, prepared and delivered to you?

### Involvement, communication and interaction

- 5a. Do you often discuss issues with the staff serving the food or with staff involved in the food process?
  
  - 5b. Would you value talking more with the people serving the food? (or involved in the food service)
  
  - 5c. What would you talk about with that person?
-

- 6a. Do you feel the staff serving the food knows you better over time?
- 6b. Does the staff try to comply with your feedback and help you to:
- obtain the food you want
  - consume the food if you ask for it
- 6c. Do you feel all staff members (food and non-food) focus on your needs in relation to food and work together in order to meet these?

**Relation between food choice, food intake and satisfaction**

- 1a. When choosing items from the menu, do you sometimes choose an item even though you would prefer to pick another one that is listed?
- 1b. If you could would you prefer to buy food from elsewhere or have friends/family bring it?
- 1c. What do you think of the food and the service here - about the whole meal experience?

**Life course events and food choices**

- 1a. In your day-to day life, what food do you tend to consider as 'ideal' food?
- 1b. Now you have been on the ward for X days, what do you consider as being your 'ideal' food? Did your perception of 'ideal foods' change because of medical reason or because of the surroundings of the ward?
- 3a. Do you think the NHS invests sufficient money in the food provision in this hospital: menus, service, surroundings where the food is consumed?
- 4a. Do you often have friends and relatives visiting you on the ward?
- 4b. Do you sometimes talk with them about the food you receive?
- 4c. Do your friends and relatives sometimes bring drinks on the ward?
- 5a. Now you consume the food provided on the ward/in the bedroom - but would you prefer to consume lunch and diner on another location in the hospital? Could you tell me where, and why?

### **Categorisation of food**

- 1a. Do you sometimes buy food from the various commercial outlets in the hospital?
- 2a. Compared to what you would choose to eat in your day-to day life, do you now pick food items that appear to be healthier?
- 3a. Does the comments of medical and non-medical staff influence your food choice?
- 3b. If yes: do you feel happy with these 'new choices'?
- 3c. Do you think you will keep this eating behaviour once you are back at home?
- 4a. Do you think the food menu items are presented to you in a convenient way for consumption?
- 5a. In regards to the taste from the menu items, what did you expect from your first meal served on the ward?
- 5b. Is taste important in regards to the food items you pick up from the menu?

### **Patient value**

- 1a. Do you have conversations with the staff serving the food? What are these conversations about: food or non-food issues? What do you think of these conversations?
- 1b. In regards to food issues, do you have one single contact person you can talk with?
- 1c. Would you value having one single contact person coping with food issues, and what would be possible advantages of this?

## D. Trust

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### Trust and satisfaction

- 1a. Here are some people involved with the food (show list with the various staff groups to the patient, but without any name attached): the staff serving the food, the nutritionist, the doctor, family and friends. What contacts do you have with these different people?
- 2a. As you have been on the ward for X days now, do you have more contacts with the staff in charge of the food – or with the staff serving the food?
- 3a. Do you consider the food and the food service matches the promises made in this regard?
- 3b. Could you specify which promises have been made in regards to the food served on the ward?

## E. Patient profile

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2. Could you tell me your year of birth?
  3. From these ethnic categories, where would you place yourself? (provide the patient with a list of various ethnic groups)
  4. Do you live alone or do you live with a partner?
  5. Do you have any children at home?
  6. Did you complete a degree?
  7. Together with your partner (where applicable), how much do you earn on an annual bases? (gross income classified in categories and submitted to the patient)
  8. Do you actively practice any religion that influences your food purchases?
-

9. Could you tell me the postcode of the area you live in? How would you describe this area?
10. How would you describe yourself as a person?
11. When were you admitted on the ward?
12. How often did you spend journeys in the hospital over the past 10 years?
13. Are you allergic to any specific food, or do you suffer chronically from any problem that does not allow you to consume specific food items?
14. Are you vegetarian, vegan or focused on biological food?

## Appendix C      Focus group schedule NHS staff

Michel Altan, Sheffield Hallam University

Mobile: 078 415 07 084

e-mail: [m.altan@shu.ac.uk](mailto:m.altan@shu.ac.uk)

Subject: group discussion

Ward:

Ward Manager:

Study in collaboration with: names of the 5 hospitals

---

My name is Michel Altan, doctoral student and associate lecturer from Sheffield Hallam University. My research is concerned with the way patients experience the food service within four NHS Hospitals.

Today, I would like to discuss with you a few broad themes relating to food services within (name of the hospital). In order to transcribe this discussion for analysis purposes, I would like to record it. All information provided will be handled in confidentiality and is completely anonymous.

Suggested themes for discussion:

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*"There is a consensus that the BHF (Better Hospital Food) targets have been achieved. Now the programme must move towards nutritional outcomes and improvements in food delivery to enhance the patient meal experience. We must move more towards a guest-host relationship with our patients, to give an extra comfort factor that will improve outcomes".*

Graham Walker (England representative of the BHF, 2004)

What does a good 'patient meal experience' mean to you?

---

Are patients currently regarded as customers?

Do you consider the patient is sufficiently involved in the food service process?

Who should be in charge of the food within the Hospital?

- for delivery on the Ward
- for delivery to the patients

How would you describe your cooperation with (name of the food and service management firm)? Is there a difference of working 'culture'?

## Appendix D      Focus group schedule catering staff

Michel Altan, Sheffield Hallam University

Mobile: 078 415 07 084

e-mail: [m.altan@shu.ac.uk](mailto:m.altan@shu.ac.uk)

Subject: group discussion

Ward:

Ward Manager:

Study in collaboration with: names of the 5 Hospitals

---

My name is Michel Altan, doctoral student and associate lecturer from Sheffield Hallam University. My research is concerned with the way patients experience the food service within four NHS hospitals. Today, I would like to discuss with you a few broad themes relating to food services within (name of the hospital). In order to transcribe this discussion for analysis purposes, I would like to record it. All information provided will be handled in confidentiality and is completely anonymous.

Suggested themes for discussion:

---

*"There is a consensus that the BHF (Better Hospital Food) targets have been achieved. Now the programme must move towards nutritional outcomes and improvements in food delivery to enhance the patient meal experience. We must move more towards a guest-host relationship with our patients, to give an extra comfort factor that will improve outcomes".*

Graham Walker (England representative of the BHF, 2004)

What does a good 'patient meal experience' mean to you?

---

Are patients currently regarded as customers?

Do you consider the patient is sufficiently involved in the food service process?

Who should be in charge of the food within the hospital?

- for delivery on the ward
- for delivery to the patients

How would you describe your cooperation with NHS staff? Is there a difference of working 'culture'?

## Appendix E Outline private food and service management firms operating in the NHS

### Presentation of the major private food and service management firms active in the NHS

In the UK, about 25% to 30% of the food provided in acute NHS hospitals is delivered by private food and service management firms. Four major firms are active in this market: Sodexho, Aramark, Avenance (Elior) and Medirest (Compass Group plc). One of these firms contributed to the present study by facilitating access to its facilities across the five hospitals acting each as an individual case study. These companies are briefly presented below, following the table below which introduces the reader to key 2007 figures allowing to compare the four firms:

BALANCE SHEET AND P/L ACCOUNTS ITEMS							
Company Name	Year	Turnover th GBP	Profit (Loss) before Taxation th GBP	Net Tangible Assets (Liab.) th GBP			
<i>Median</i>	LY	376,034	2,887	23,795			
COMPASS GROUP PLC	2007	10,268,000	436,000	1,064,000	1		1
COMPASS CONTRACT SERVICES (U.K.) LIMITED	2007	1,808,718	-81,366	-1,158,927	6		6
SODEXO LIMITED	2007	387,782	14,233	37,113	2		3
ARAMARK LIMITED	2007	364,286	6,461	53,314	3		2
ELIOR UK LIMITED	2007	260,973	-9,001	-17,082	5		5
AVENANCE PLC	2007	204,245	-687	10,476	4		4

BALANCE SHEET AND P/L ACCOUNTS ITEMS							
Company Name	Year	Total Assets th GBP	Shareholders Funds th GBP	Number of Employees			
<i>Median</i>	LY	142,003	24,993	11,590			
COMPASS GROUP PLC	2007	6,432,000	2,148,000	365,630	1		1
COMPASS CONTRACT SERVICES (U.K.) LIMITED	2007	3,219,591	-391,341	54,489	6		2
SODEXO LIMITED	2007	95,895	35,948	11,295	3		4
ARAMARK LIMITED	2007	166,344	14,037	11,885	4		3
ELIOR UK LIMITED	2007	117,661	36,007	9,768	2		5
AVENANCE PLC	2007	50,646	10,354	6,777	5		6

Source: FAME database (<https://fame.bvdep.com/version-20081124>)

### Sodexho

The company is not only active in healthcare, but also operates in corporate services, defence, education and leisure & hospitality. Within healthcare, Sodexho provides food services in hospitals, residential care homes, specialist needs centers and finally to residents in their own homes. As every food and service management firm emphasizes, Sodexho aims to provide well-balanced meals to aid patients' recovery to good health. The focus also lies on delivery components, as the company stresses how it takes into account patients' cultures, allergies and food preferences to ensure they eat enjoyable and well-balanced meals during their stay in hospital. Apart from feeding patients and residents, the firm does provide a range of food services to staff and visitors, operating cafés, restaurants and retail

outlets in various hospital environments. About 6500 Sodexo employees are working in NHS organisations across the UK. Sodexo is the second largest player in terms of turnover, following Compass group Plc.

### **Compass Group Plc.**

Compass Group is the world leader in the provision of catering and support services, with operations in over 90 countries and over 365.000 employees. The company provides food and support services across a number of sectors, and its subsidiary Medirest is the UK's leading provider of hotel services for healthcare. Offering an array of services under the banner of facilities management, the company takes responsibility for the management of all aspects of the services including staffing, purchasing, compliance with health and safety and full budgetary and quality control. Services provided include catering (to patients but also through restaurants, coffee shops and vending machines on site), cleaning and housekeeping, portering and security, reception and switchboard, and grounds maintenance. Medirest delivers its services to the NHS, private hospitals and residential care homes. Currently, Medirest serves 130 UK hospitals and works with the leading chef John Benson to develop new menus. The company's aim is to make the meals served in hospitals closer to a restaurant experience.

### **Aramark**

Aramark Limited is a food service partner to organisations across a range of sectors, including business and industry, judicial, education, healthcare, offshore and defence. The company has over 12,500 employees in the UK, working across various business sectors (business & industry, defence, education, healthcare and offshore). Like Compass Group and Sodexo, Aramark ' services go beyond food and involve grounds maintenance, reception duties, cleaning ect. The company's healthcare division currently operates eleven NHS contracts, serving around 3,120 patients per day and provides retail facilities through Java City coffee outlets.

### **Elior**

Elior and its healthcare subsidiary Avenance are smaller player in this specific institutional market. Avenance is a provider of healthcare catering, hospitality and associated services and operates over 600 catering and refreshment contracts throughout the UK and Ireland. Avenance has around 5.000 employees, and strongly relies on the resources from the parent company to offer products and services.

P	Age group & gender	Length of stay	Food type	Frequency hospital stays	Food product Delivered by	Hospital & ward
1	46 to 60 Male	14 days	traditional	Couple of stays	Steam NHS staff	Hospital A Surgery
2	17 to 30 Male	5 days	traditional	First time	Steam NHS staff	Hospital A Surgery
3	31 to 45 Female	12 days	Experience	First time	Steam NHS staff	Hospital A Surgery
4	17 to 30 Male	6 days	traditional but healthy	First time	Steam NHS staff	Hospital A Surgery
5	61 to 75 Female	15 months	Traditional	Extensive	Steam NHS staff	Hospital A Surgery
6	76+ Female	6 days	Traditional	Extensive	Steam NHS staff	Hospital A General
7	61 to 75 Male	5 days	Traditional	Frequent	Steam NHS staff	Hospital A General
8	61 75 Male	4 days	Traditional	Frequent	Steam Catering staff	Hospital B Surgery
9	76+ Female	2 days	Traditional	One or two stays	Steam Catering staff	Hospital B Surgery
10	61 to 75 Female	2 days	Experience	Extensive	Steam Catering staff	Hospital B Surgery
11	76+ Female	5 days	traditional but healthy	Two stays in same hospital	Steam Catering staff	Hospital B Surgery
12	61 to 75 Male	5 months	Traditional	Frequent	Steam Catering staff	Hospital B Surgery
13	17 to 30 Male	6 days	Experiencer	First time	Cook & chill NHS staff	Hospital C Surgery
14	61 to 75 Female	126 days	Experiencer	First time	Cook & chill NHS staff	Hospital C Surgery
15	61 to 75 Female	8 days	Traditional	Frequent	Cook & chill NHS staff	Hospital C Surgery
16	31 to 45 Male	8 days	Traditional	First time	Cook & chill NHS staff	Hospital C Surgery
17	46 to 60 Male	35 days	Traditional	One or two stays	Cook & chill NHS staff	Hospital C Surgery
18	46 to 60 Male	35 days, 1 week break, 7 days	Traditional	Extensive	Cook & chill NHS staff	Hospital C Surgery
19	6 to 16 Male	1 days	Traditional	Extensive	Cook & chill NHS staff	Hospital C Paediatrics
20	6 to 16 Female	2 days	Parents & child experiences	Frequent	Cook & chill NHS staff	Hospital C Paediatrics
21	6 to 16 Male	1 days	Traditional, mother is a cook	Frequent	Cook & chill NHS staff	Hospital C Paediatrics
22	3 years Female	2 days	Parents experiences, NA child	Frequent	Cook & chill NHS staff	Hospital C Paediatrics

23	46 to 60 Female	29 days	Traditional	First time	Steam Catering staff	Hospital D General
24	61 to 75 Female	10 days	Traditional	One or two stays	Steam Catering staff	Hospital D General
25	61 to 75 Female	7 days	Traditional	One or two stays, same Hospital	Steam Catering staff	Hospital D General
26	17 to 30 Female	11 days	Traditional	One or two stays	Steam Catering staff	Hospital D General
27	31 to 45 Female	3 months	Traditional	First time	Steam Catering staff	Hospital D General
28	76+ Female	42 days	Traditional	First time	kitchen, plated NHS staff under private contract	Hospital E, Rehab
29	61 to 75 Male	42 days	Traditional	First time	kitchen, plated NHS staff under private contract	Hospital E, Rehab
30	46 to 60 Male	90 days	Traditional	Frequent	kitchen, plated NHS staff under private contract	Hospital E, Rehab
31	46 to 60 Male	42 days	Traditional	First time	kitchen, plated NHS staff under private contract	Hospital E, Rehab

### *Summary of patient involvement with food*

Only 4 out of the 31 patients (and 2 parents) can be considered as food ‘experiencers’.

### **Communication and interaction**

#### Importance of hospital food

- All patients agree that hospital food is important for recovery, as it might speed up that particular process;
- Several patients do, however, mention the quality of the food on the ward is not good enough to support proper recovery;
- Food appears to become more important over time for patients, breaking the monotony of their stay in hospital. The fact that food is not a key issue during the first days after admittance on the ward is sometimes due to the lack of appetite after medical intervention. Over time, patients tend to shift from a sole product orientation towards more attention to service and details relating to the food. As the length of stay increases for these patients, their focus shifts from the quality of care to other factors such as food (service) aspects.

#### Information received and interest in receiving information

- Not a single patient received information about the food served in terms of origin or production methods, and only a few showed an interest in doing so;
- Additional information (about food production methods or nutritional characteristics) simply appears not to be a priority for most patients across the various wards under investigation, especially when these patients are satisfied with the food offered;
- When patients are dissatisfied with the food (like it is the case in hospital C), they mention it would be helpful for them to receive information about the alternative menus on offer;
- Most patients consider receiving additional information about the food is not paramount, as they tend to focus on core aspects such as temperature, cleanliness, taste, hygiene and proper service delivery.

## Involvement and satisfaction

### Patient involvement in food issues

- The issue of involving patients (and children) in the food process seems to be paramount on the paediatric ward in hospital C. Patients suggest involving the children much more in the food process by using tasters, or displaying the food on offer. The parents objective in to get their child' appetite going a bit better...and avoid too much waste by giving the patients a chance to experience the food before ordering large portions of it;
- Various patients across the other wards and hospitals also consider they are not enough involved in the food process, as their comments are not taken into account. Patient would like to interact with someone from catering in order to voice their comments, as they now feels catering is simply not interested in receiving feedback;
- Regular surveys would help avoiding huge food waste, providing catering management with the necessary feedback to implement changes the catering (front line) staff are not able to conduct.

### Discussions with catering staff

- At best, the patients refer to the discussions with catering staff as 'small talk'. Generally there is no real communication between patients and catering staff, as most of the patients consider this is not part of the catering staff' job description;
- Across hospitals, many patients interviewed consider it is not the catering staff's duty to interact with patients. This implies therefore that the catering staff are there to present the menu, take the order, prepare and serve the food (in the hospitals where this is not done by the NHS staff), without any additional service components attached;
- The patients explain their relationship with NHS staff is much closer (than with catering staff), as they see this staff group much more often;
- Patients do not want their relationship with the catering staff to change or to discuss issues more in-depth with this staff group. This is essentially due to the fact they don't know the catering staff well enough and prefer to stick to the NHS staff they interact much more with. Keeping a status quo seems appropriate to most patients;
- Patients consider friendly catering staff is all they need, and are relatively satisfied with the friendliness of the catering staff;

- The age, gender or food habits of the patients do not directly influence their views on the relations with the catering staff;
- Two patients stress communication with catering staff is sometimes difficult because of language issues;
- Various patients across 3 hospitals (A,D,E) complain about the fact they never get the opportunity to talk to the catering management to voice their complaints;
- Patients from hospital C consider it useless talking to the catering staff as they are not authorised to improve anything about the food.

#### Discussions with NHS staff

- Patients tend to have discussions with NHS staff much more easily than they do with catering staff. This also applies to food issues. NHS staff is the first contact point for almost any matter, as patients feel they are 'closer' to them because they see them more often. Patients simply feel it is easier to establish contacts with staff they see frequently;
- All patients interviewed gave much more credit to the nursing staff than to the catering staff, even in regards to food issues;
- Various patients consider it shouldn't be the nursing staff' task to deal with food-related issues, as they have enough medical duties on their plate;
- Parents from the paediatric ward avoid food-related discussions with the catering staff in order not to interfere with medical duties. The parents on the paediatric ward (hospital C) are very much involved in the medical aspects of the treatment their child is undergoing. Food only comes second, and the parents are very supportive and understanding towards the medical staff taking care of their child;
- Apart from the parents in hospital C, patients from hospital E also stress the fact that the food shouldn't be served by NHS staff;
- Patients in hospital C mention the nursing staff is simply not empowered to improve the quality of the food, and consider it as useless complaining to them about it.

## Food requests and complaints

- Patients from hospital A and hospital D tend to address catering staff directly. It is relevant to note that, in these two hospitals, the food is brought by catering staff to the patients. This offers more opportunities for the patients to interact with this staff group and voice specific complaints and requests;
- Various patients in hospitals C and E would prefer to interact directly with a catering manager who has the ability to act on the situation, instead of going through NHS or catering staff that (so they consider) is not empowered to do so;
- Various patients across hospitals consider it is not the nursing staff's duty to deal with food complaints;
- In the occurrence of a complaint, patients 23, 26 and 30 would prefer to refer to the nursing staff. This is due to the fact they do not know which manager is in charge of the food on the ward;
- There appears to be no direct link between the food production method and the notion of empowerment;
- Various patients feel sorry for the NHS staff, who sometimes takes the blame for food-related problems they can't do anything about. Three out of the four parents & patients interviewed on the paediatric ward feel sorry the nursing staff has to deal with the food and the problems resulting from the poor quality of what is on offer.

## Overview of patients comments on involvement

		Hospital A	Hospital B	Hospital C	Hospital D	Hospital E
Involvement of the patients with food						
High degree of involvement	3		10	13, 14, guardians 20 and 22		
Communication and interaction						
Importance of hospital food	<p>Food is important for a fast recovery</p> <p>Food becomes more important over time (5, 6): shift from a product towards a service orientation</p> <p>Food is a way to break monotony (6)</p>	<p>Food is important for a fast recovery</p> <p>Food served in this hospital is considered not to be good enough for proper recovery (9)</p>	<p>Food is important for a fast recovery</p> <p>Food served in this hospital is considered not to be good enough for proper recovery (13, 14, 15, 18, 20, 21, 22)</p>	<p>Food is important for a fast recovery</p> <p>Food becomes more important over time (mother 22). Patients sometimes too sick to eat after admittance on ward (24, 26): shift from a product towards a service orientation</p>	<p>Food is important for a fast recovery</p> <p>Food becomes more important over time (30), shift from a product towards a service orientation</p> <p>Food is a way to break monotony (29, 30)</p>	
Information received & interest in receiving information	<p>No information received about food origin &amp; preparation</p> <p>No additional information required, especially as the food is considered to be fine</p> <p>Would like additional information: Patients 2 in case of extended stay, 1 on nutritional values</p>	<p>No information received about food origin &amp; preparation</p> <p>No additional information required, especially as the food is considered to be fine</p> <p>Would like more information (10)</p>	<p>No information received about food origin &amp; preparation</p> <p>Additional information required about alternative menus, as the food is not popular among patients (14, 15, 16, 17, 18)</p> <p>Would like to know where the food comes from (13)</p>	<p>No information received about food origin &amp; preparation</p> <p>No additional information required, especially as the food is considered to be fine</p>	<p>No information received about food origin &amp; preparation</p> <p>No additional information required, especially as the food is considered to be fine</p> <p>Would like to know where the food comes from (26) or just more information (30)</p>	

## Hospital A

## Hospital B

## Hospital C

## Hospital D

## Hospital E

## Involvement and satisfaction

Involvement and satisfaction issues	<p>Children should be involved more by displaying food or using tasters (Parents 19 and 21) to stimulate appetite and reduce wastage</p> <p>Involving patients in regular surveys would help avoiding food waste (15, 18) and improve food service (21)</p>	<p>Discussions described as 'small talk', as talking to patients is not considered to be part of catering staff job description</p> <p>Patients prefers taking to nursing staff, as there are more interactions with this staff group</p>	<p>Discussions described as 'small talk', as talking to patients is not considered to be part of catering staff job description</p> <p>Patients prefers taking to nursing staff, as there are more interactions with this staff group</p> <p>No opportunity to voice complaints to catering mgt. (21,22)</p> <p>Talking to catering staff is useless as they are not empowered to change anything about the food (13,14,15,18,20)</p> <p>More interaction with staff producing food would be helpful (21,22)</p>	<p>Discussions described as 'small talk', as talking to patients is not considered to be part of catering staff job description</p> <p>Patients prefers taking to nursing staff, as there are more interactions with this staff group</p> <p>Catering staff too busy to start discussions with (26)</p> <p>Patient questions the ability of catering staff in dealing with specific food issues (23)</p>	<p>Patient 30 regrets no one from catering (kitchen in this case) comes on the ward. Perceived as no interest in receiving feedback</p> <p>More communication between catering/NHS staff/patients deemed necessary (30)</p>
Discussions with catering staff	<p>Discussions described as 'small talk', as talking to patients is not considered to be part of catering staff job description</p> <p>Patients prefers taking to nursing staff, as there are more interactions with this staff group</p> <p>Nursing staff is more accessible, but long stay patients should interact more with catering staff (4)</p> <p>Catering staff too busy to start discussions with (1, 6,7)</p> <p>Reducing staff turnover would enable developing relations (5)</p> <p>No opportunity to voice complaints to catering mgt. (5)</p> <p>Service level depends on individual factors and overall quality of staff (5)</p>	<p>Discussions described as 'small talk', as talking to patients is not considered to be part of catering staff job description</p> <p>Patients prefers taking to nursing staff, as there are more interactions with this staff group</p>	<p>Discussions described as 'small talk', as talking to patients is not considered to be part of catering staff job description</p> <p>Patients prefers taking to nursing staff, as there are more interactions with this staff group</p> <p>No opportunity to voice complaints to catering mgt. (21,22)</p> <p>Talking to catering staff is useless as they are not empowered to change anything about the food (13,14,15,18,20)</p> <p>More interaction with staff producing food would be helpful (21,22)</p>	<p>Discussions described as 'small talk', as talking to patients is not considered to be part of catering staff job description</p> <p>Patients prefers taking to nursing staff, as there are more interactions with this staff group</p> <p>Catering staff too busy to start discussions with (26)</p> <p>Patient questions the ability of catering staff in dealing with specific food issues (23)</p>	<p>NA</p> <p>No opportunity to voice complaints to catering mgt. (30)...to show they are interested in hearing patient' opinion about food</p> <p>Patient questions the ability of catering staff in dealing with specific food issues (30)</p>

## Hospital A

## Hospital B

## Hospital C

## Hospital D

## Hospital E

## Involvement and satisfaction

Discussions with NHS staff	Patients tend to talk to NHS staff about food-related issues, as they interact more with this staff group	Patients tend to talk to NHS staff about food-related issues, as they interact more with this staff group	Patients tend to talk to NHS staff about food-related issues, as they interact more with this staff group NHS staff shouldn't serve the food, as they have enough medical duties (13,15,16) Food comes second to parents on the Paediatric ward (19,21,22); medical issues first NHS staff under huge pressure, not empowered to improve the food	Patients tend to talk to NHS staff about food-related issues, as they interact more with this staff group	Patients tend to talk to NHS staff about food-related issues, as they interact more with this staff group NHS staff shouldn't serve the food, as they have enough medical duties (29,30,31) NHS staff under huge pressure
Food requests and complaints	Patients tend to address catering staff with their complaints (2,3,4,5) Complaining to NHS staff is useless as they are not empowered to change anything about the food (3,5) Patient feel sorry the NHS staff takes the blame for food-related issues (5)	Both catering and NHS staff are very helpful. No complaints in this hospital	Complaining to catering staff is useless as they are not empowered to change anything about the food (13,14,15,18,20,21) Catering staff rather defensive (22) Would prefer to complain directly to catering management (19,21) NHS staff shouldn't deal with food-related complaints (13,15,16), but focus on their medical duties (19,20,22) Patients feel sorry the NHS staff takes the blame for food-related problems (19,20,22) Alternative menus should be talked about	Patients tend to address catering staff with their complaints (24,25,27) It is the catering staff duty to handle food-related problems Patient would address NHS staff with a complaint, not knowing who the catering manager is (23,26)	Would prefer to complain directly to catering management (19,21) NHS staff shouldn't deal with food-related complaints (29,30,31), having enough medical duties on their plate they should focus on (29,30) Patient would address NHS staff with a complaint, not knowing who the catering manager is (30) Complaining is useless, nothing is done about it on the long run (29) Wrong orders delivered due to lack of communication NHS staff/catering (29,30)

## Comments and issues with the food

### *Summary on comments and issues with the food*

#### **Key issue: food or service?**

- Nursing staff in hospitals A,B,D and E are rather satisfied with the food product itself. Only staff from hospitals D and E mention there are issues in terms of service:
  - Patients in D are not given enough time (by catering staff) to choose from the menu
  - Patients in E do not have the opportunity to interact with catering staff, as it would give them the opportunity to learn about their likes and dislikes
- Decent food appears to be a pre-requisite for a customer focused orientation: nursing staff on both wards of hospital C is very critical about the food itself (cook-chill method) and also mentions the lack of staffing

#### **Specific age groups**

- On the paediatric ward in hospital C, all nursing staff recognises children have specific food patterns that are related to their medical conditions and food habits at home
- The nursing staff tries to push forward healthy food options to the children, but realises the Patients tend to choose for comfort food because of their medical condition and way of living at home
- What nursing staff considers to be 'healthy food' largely depends of the nurses own dietary habits
- Parent of long stay patients/children often bring in food or go down to the hospital restaurant to get food for their child
- The nursing staff in hospital C (surgical ward) mentions the portions given to elderly people are too large, leading to significant waste levels

## Food production method

### Comments on the steam system

#### **Negative comments:**

- The nursing staff of hospitals that will have the steam system implemented on their wards (hospitals C,E) are very apprehensive of it. Hospital E considers the current system (plated food produced in the hospital kitchen) to be much better in terms of quality and the ability of the staff to cater for patients' specific needs. The fact that they can currently get hold of the kitchen staff if any problems occur is an important factor for nursing staff to keep the current system in operation
- Across hospitals, nursing staff considers fresh food produced on site would be the ideal option
- Hospitals that are already using the steam system (hospitals A,B) are rather disappointed about the gap between what was promised and what came out of it. The major issues the nursing staff (hospital A) deals with relate to the fact components of the dishes cannot be removed from the plate (as it is pre-packed), and the lack of skills of weekend staff to prepare the meals properly
- Hospitals A, B and E consider the steam system has been (or will be in the case of hospital E) imposed on them by the Trust because of financial restrictions related to food operations. However, the NHS staff of both hospitals A and B do not wish to go back to the old system that was in operation on their respective wards
- Impossibility to produce decent crispy food (fries)

#### **Positive comments:**

- The nursing staff of hospital D are very satisfied with the new steam system implemented in their hospital, while hospitals A and B are satisfied and definitely want to keep this system operating. Advantages:
  - Waste reduction as the food is chosen (almost) right before consumption
  - Good portion sizes
  - Involvement of various staff groups in the service process (hospital D)

### Comments other production methods

Plated food produced fresh from scratch in the kitchen and brought up/displayed in trolleys is favoured by the nursing staff across hospitals. This 'ideal' system used to be implemented within hospital E, but was abandoned as the size of the hospital became too important. NHS staff are very well aware this food system cannot be implemented in large operations, and accept it. The steam system comes second where already implemented, and the cook-chill method appears to be least popular amongst NHS staff. Key issues with the cook-chill method are the texture, the obligation to order 24 hours in advance, poor quality and poor nutritional value.

### **Availability of chosen food**

The nursing staff of hospital A (both wards) complain about the fact the food chosen by the patients from the menu is not always available on the ward shelves.

Hot food cannot be provided on a 24 hour basis either, as (in the evenings) the catering staff lock the fridges where the food is kept on ward level.

### **Portion sizes**

- Hospital A is satisfied about the portion sizes and the flexibility of the catering staff to deliver double portions when required. The issue appears to be about the willingness of the catering staff to show flexibility when it comes down to portions for patients. Hospital C is rather dissatisfied about the fact the catering staff do not show any flexibility in portioning the food for patients.
- Hospital B considers that the portion sizes have become too small
- There is no clear link between food production method and issues related to portioning

### **Eating in a separate room**

Only nurse assistant of the paediatric ward in hospital C consider having a separate room on the ward would be preferable.

### **Menu fatigue**

Nurse assistants from the paediatric ward in hospital C mention the long term patients on the ward are tired of the food served, and have their relatives bringing in food for them.

Within the surgical ward in this same hospital, the nursing staff also mention that long stay patients become aware of the menu rotation and become bored with the food on offer. The patients try to adapt to the menus by developing specific food choice strategies: switching to Hallal menus which the nursing staff consider to be much better (fresher and larger portion sizes).

Table Schematic representation of comments and issues with food

	Hospital A	Hospital B	Hospital C	Hospital D	Hospital E
Comments and issues with the food					
Key issue: food or service?					
Service is the issue	Satisfied about the food	Satisfied about the food	Dissatisfied about the food	The food is fine but there are problems with the way it is delivered to patients Not enough time given to patients to choose from the menu	As the catering staff do not interact with patients, they cannot learn about their preferences. Lack of communication between catering and patients
Food is the issue	Satisfied about the food	Satisfied about the food	Lack of proper food makes proper service delivery impossible	Satisfied about the food	Food is acceptable/fine
Specific age groups					
Children			Specific food patterns related to medical condition and food habits at home Often, children choose comfort food even though healthy food is put forward Relatives bring in full meals for long stay patients Portions for young patients sometimes too small		
Elderly patients			Portions given to elderly patients are often too large: lack of flexibility in portioning		

	Hospital A	Hospital B	Hospital C	Hospital D	Hospital E
Food production method	<p>Disappointment about the gap between promise &amp; actual delivery of the steam system: pre-packed food, lack of skills of catering staff (during w/e), choice not always available</p> <p>Criticism on food texture: chips</p> <p>Return to old system is not an option for the NHS staff, who are rather satisfied with the steam system</p> <p>Waste reduction as food chosen right before consumption</p> <p>Using microwave is fine</p> <p>Fresh food produced on site would be the best option</p> <p>Good portion sizes</p>	<p>Disappointment about the gap between promise &amp; actual delivery of the steam system</p> <p>New food system is imposed because of financial constraints</p> <p>Return to old system is not an option for the NHS staff, who are rather satisfied with the steam system</p> <p>Using microwave is fine</p> <p>Fresh food produced on site would be the best option</p>	<p>Apprehension with the future implementation of the steam system: lack of space, cost</p> <p>New food system imposed by management because of financial constraints</p> <p>Ordering right before consumption would be more convenient.</p> <p>Currently, wrong dishes often delivered to patients</p> <p>Fresh food produced on site would be the best option</p> <p>Critical towards the current system: texture, 24 hrs, quality &amp; nutritional value</p> <p>Patients prefer ordering from alternative menus or restaurant</p>	<p>Preferable to have patients compose the dishes themselves</p> <p>Nursing staff are very satisfied with the new steam system in place: ability to choose right before consumption, reduced wastage, involvement of various staff groups in the food service</p> <p>Return to old system is not an option for the NHS staff</p> <p>Using microwave is fine</p> <p>Fresh food produced on site would be the best option</p>	<p>Apprehension with the future implementation of the steam system (increased waste levels, weak nutritional value, bad taste, no contacts with kitchen, insufficient skills of catering staff)</p> <p>Food produced on site deemed to be the best alternative possible</p> <p>New food system is imposed because of financial constraints (imposed by the Trust)</p> <p>Canteen food is not good</p> <p>Fresh food produced on site would be the best option</p>
Availability of chosen food	Choice not always available				
Portion sizes	Satisfied about flexibility (e.g. double portions)	Feeling that portions have shrunk over time	No flexibility in portioning	No issue	No issue
Eating in a separate room on the ward	Not an option – no interest	Not an option – no interest	Interesting option for the paediatric ward	Not an option – no interest	Not an option – no interest
Menu fatigue			Long term patients show menu fatigue: switch to alternative menus		

# Appendix I Summary of the focus group sessions with staff from the food and service management firm

Table Overview of focus group sessions food and service management staff

	Hospital A	Hospital B	Hospital C	Hospital D	Hospital E
Patient as a customer	Patients = customers, with a focus on basic needs Staff proud of service provided, loving with patients	Patients should be treated even better than customers		BHF objectives attained Role of the ward housekeepers very positive	BHF objectives attained Tender Loving Care (TLC) Important dedication to patients, focus on the human aspect
Patient involvement	Patients sufficiently involved as they choose the food themselves	Patients often ask information about provenance of food		Creation of information booklets for patients	Creation of information booklets for patients Not enough surveys conducted
Importance of interactions with patients	across hospitals, interaction with patients & other staff groups is considered essential in developing patient focused food services				
	Food not handed out by catering staff, few interactions Experience with patients & other staff groups is important to develop a patient focused food service Duties go beyond delivery of food	Interaction with patients is paramount Fewer patients make interactions even better (small hospital)	Food not handed out by catering staff, few interactions Catering staff regret not having more time to interact, discuss with patients	Catering staff enjoy interacting with patients	Food not handed out by catering staff, few interactions Kitchen staff should be more accessible NHS Catering staff enjoy interacting with patients Experience with patients is important to empathise

	Hospital A	Hospital B	Hospital C	Hospital D	Hospital E
Food issues					
Food or service		Ideally, hot deserts should be offered to patients	Patients can only complain if they order what they do not like		Ideally, patient should receive good, hot food. No service matters considered
Specific age groups			Parents critical about food choice		Elderly patients try not to bother catering staff NHS catering reports to nurses when patients do not eat well
Food production method: steam system receives positive feedback where implemented (hospitals A, B and D), compared to traditional systems. But ideally, plated food produced in house from fresh ingredients is considered to be the best alternative (B and E). Staff realise this is not a realistic option because of the financial constraints inherent to the NHS.					
	Steam: easy to prepare Need to extend menu for long stay patients Staff considered to be well trained to prepare the food Patients from other backgrounds switch directly to specialised menus Nurses are satisfied as food is always available	Happy with the food system in 80% of the cases Patients often complain because of their medical condition Good choice available, leading to patient satisfaction	Steam system implemented on one ward – staff are positive about it (more hygienic)	Very positive about the food system Steam system supposed to rule out wrong food being served to wrong patients	Aware and positive about the food system used in hospital D
Patient as a customer					
	Patients = customers, with a focus on basic needs Staff proud of service provided, loving with patients	Patients should be treated even better than customers		BHF objectives attained Role of the ward housekeepers very positive	BHF objectives attained Tender Loving Care (TLC) Important dedication to patients, focus on the human aspect
Patient involvement					
	Patients sufficiently involved as they choose the food themselves	Patients often ask information about provenance of food		Creation of information booklets for patients	Creation of information booklets for patients Not enough surveys conducted
Importance of interactions with patients: across hospitals, interaction with patients & other staff groups is considered essential in developing patient focused food services					

Patient as a customer (continued)					
	Food not handed out by catering staff, few interactions Experience with patients & other staff groups is important to develop a patient focused food service Duties go beyond delivery of food	Interaction with patients is paramount Fewer patients make interactions even better (small hospital)	Food not handed out by catering staff, few interactions Catering staff regret not having more time to interact, discuss with patients	Catering staff enjoys interacting with patients	Food not handed out by catering staff, few interactions Kitchen staff should be more accessible NHS Catering staff enjoy interacting with patients Experience with patients is important to empathise
Food issues					
Food or service		Ideally, hot deserts should be offered to patients	Patients can only complain if they order what they do not like		Ideally, patient should receive good, hot food. No service matters considered
Specific age groups			Parents critical about food choice		Elderly patients try not to bother catering staff NHS catering reports to nurses when patients do not eat well
Food production method: steam system receives positive feedback where implemented (hospitals A, B and D), compared to traditional systems. But ideally, plated food produced in house from fresh ingredients is considered to be the best alternative (B and E). Staff realise this is not a realistic option because of the financial constraints inherent to the NHS.					
	Steam: easy to prepare Need to extend menu for long stay patients Staff considered to be well trained to prepare the food Patients from other backgrounds switch directly to specialised menus Nurses are satisfied as food is always available	Happy with the food system in 80% of the cases patients often complain because of their medical condition Good choice available, leading to patient satisfaction	Steam system implemented on one ward – staff are positive about it (more hygienic)	Very positive about the food system Steam system supposed to rule out wrong food being served to wrong patients	Aware and positive about the food system used in hospital D

Other food-related matters	Hospital A	Hospital B	Hospital C	Hospital D	Hospital E
<p>NHS Staff collaboration with NHS staff is relatively good across hospitals, and related to a low turnover of catering staff</p>	<p>Portions are too small Menu needs to be developed for long stay patients, otherwise it leads to menu fatigue Good choice Breakfast should be improved Pictures on the menu would be useful</p>	<p>Various patients consider portion sizes are too small Improvements to the food are considered to be difficult, as there is little room to do so</p>	<p>Portions are like adult ones on the paediatric ward, leading to significant wastage Current system of pre-ordering the food is unpopular amongst catering staff</p>	<p>Role of the ward housekeeper strongly appreciated</p>	<p>Staff regret supper boxes have been dropped on Sundays because of cost issues Staff complaints about lack of choice or availability of food Inconsistency in portioning A separate eating room might be an option for some patients Patients quickly become tired with the menu (2 week rotation) Food could be cooked better Need to clean up the trolleys</p>
<p>5. Major issues between staff groups</p>	<p>Tensions between foreign nurses and hostesses Hostesses feel looked down on by some nurses Occasionally cleaning staff serve food to patients Good collaboration due to personal characteristics of staff</p>	<p>Feedback often received by the nursing staff and used by management to improve operations</p>	<p>Difficult working relationship with nursing staff on the paediatric ward Catering staff have been eating out with nursing staff on the surgical ward Nurses do not explain the menus to incoming patients Catering staff do not feel protected (from angry nursing staff) by their management</p>	<p>Stream system supposed to rule out wrong food being served to wrong patients</p>	<p>Good relationship with nursing staff &amp; housekeeper Catering staff still identifies themselves as NHS staff NHS is under strain, leading to low morale and high work pressure Important for catering staff to stay on the same ward, building up trust with staff and patients</p>
					<p>Awareness of the fact wrong food can be served to wrong patients. Catering staff ask nurses if patient is on a special diet Good collaboration due to personal characteristics of staff trust is essential &amp; enables delegation Collaboration considered to be positive with nurses, very difficult with kitchen staff No long term improvement from kitchen staff Catering staff sometimes feel looked down on by medical staff</p>

Hospital A		Hospital B		Hospital C		Hospital D		Hospital E	
Comments on the food and service management firm									
	Domestics do not feel respected by NHS staff, and regret the catering management do not support them properly Catering staff very sensitive to wages / pay	Feedback from patients is taken into account by the catering management Catering staff enjoyed working in the hospital	Catering staff do not feel respected by NHS staff, and regret the catering management do not support them properly	Domestics are fully trained at present and working towards a hostess role Staff turnover has decreased dramatically Language barrier in the early days of the new steam system, leading to inconsistencies	NHS catering staff serving the food respects professionalisation of catering staff (knowledge of specific dietary requirements) Kitchen staff should not run out of stock Contacts with kitchen staff a difficult High staff turnover within catering management				
Operational issues: apart from the catering staff in hospital C, all other hospitals would like to see the ward hostesses hand out the food to patients.									
	Patients tend to complain to hostess	Patient feedback is read by management, but not much can be changed about the current situation (financial & structural constraints)	Nurses generally consult the kitchen if there is a problem with the food Catering staff run down to show parents (on the paediatric ward) she tries to help Catering staff sometimes serve the food on the paediatric ward		Patients tend to complain to hostess, which is followed up by staff liaising with the kitchen Dissatisfied about cooperating with kitchen staff, preferring to manage food issues on their own Protected meal times not respected by medical staff				

## Appendix J Letter of introduction to ward managers across hospitals

Michel Altan  
PhD Student  
Sheffield Hallam University  
(Private address)

Date:  
Ms.

Subject: Request to conduct qualitative research on two distinct wards within (name of the hospital):

Dear...

My name is Michel Altan, doctoral student and associate lecturer from Sheffield Hallam University. My research is concerned with the way patients experience the food service in Acute NHS Hospitals, and how this is facilitated by various staff groups contributing to the food delivery.

My plan is to conduct research within four acute NHS Hospitals. The food and service management firm (name of the firm) is active in each of these four hospitals, and has facilitated access of its facilities to the author. I would like to conduct the research within the four Hospitals below:

(Name hospital A)	Wards: Medical and Paediatrics
(Name hospital C)	Wards: Medical and Paediatrics
(Name hospital D)	Wards: Surgery and Elderly
(Name hospital B)	Wards: Surgery and Elderly

Three patients will be interviewed on each Ward, leading to a total of six interviews within each Hospital. Within each Hospital, the author would also like to conduct a focus group with six NHS Staff members involved in the food service process. It would be important to conduct the focus group with staff members working within the Wards where the research will take place.

The research project received a favourable ethical opinion of the (name of the Research Ethics Committee) in March 2006, subject to minor amendments. The Committee would like to see written approval from the Senior Nurse in each Hospital, allowing myself to conduct the research on the Wards mentioned above.

The formal research and development application has been forwarded to the R&D Office of the Trust in April 2006, and I am currently waiting for provisional approval and issuing of an honorary contract between myself and the Trust.

I would be grateful if you could consider this request and, in accordance with the Research & Development Office, issue a written approval allowing the research project to take place on the Wards under your responsibility. Once I have received your written approval, I will forward it to the (name Research Ethics Committee) in order to receive final approval of the research project.

I have attached an abstract of the research project. This should help to answer any queries you should have at this stage. I would be happy to answer any questions you may have or provide any other details you require.

I look forward with anticipation to your reply and thank you for your cooperation with my research.

Kind regards

Michel Altan

PhD Student

Faculty of Organisation and Management

Sheffield Hallam University

## Introduction

*"There is a consensus that the Better Hospital Food (BHF) targets have been achieved. Now the programme must move towards nutritional outcomes and improvements in food delivery to enhance the patient meal experience. We must move more towards a guest-host relationship with our patients, to give an extra comfort factor that will improve outcomes".*

Graham Walker (England representative of the BHF, 2004)

This research draws upon the above work, and aims to investigate patient meal experiences. Mealtimes should be an enjoyable experience, as they are (along with visiting) often the highlight of the patient's day. The research will explore what really matters to patients with regards to the service provided by the various staff members involved in the food production and service process. This research could be of benefit to the food and service management firm as well as for the other staff groups involved in the patient's food process, in deriving practical recommendations and operational considerations.

Three key components of relations between the patients and staff members involved in the food service process will be explored. The components are:

- a) involvement, whereby the research will investigate if a higher degree of involvement of the patient in the food process would lead to an increase in satisfaction;
- b) values, whereby the values patients hold when choosing food in a hospital will be analysed;
- c) trust, whereby the research aims to understand the extent to which patients trust staff involved in the food process.

Research with patients will be achieved through individual in-depth interviews with a total of six patients from two distinct Wards in the Hospital. Once the position of the patient with regards to food service is better understood, the author will go on to investigate how this can be facilitated by considering various staff categories involved in the patient's food experience. These staff groups include a private food and service management firm (name of the firm) operating in four NHS Hospitals, as well as the medical and non-medical staff involved in the food service process. A focus group will be organised with six NHS Staff involved in the food service process, coming from the two Wards under investigation. Additionally, an in-depth interview will be arranged with the NHS Manager in charge of food provision within the Hospital.

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**In regards to the patients, four specific research questions have been identified.**

These research questions are:

1. what is the role of 'trust, values, beliefs and expectations and involvement' in the conceptual framework of the consumer's food service experience?
2. how do consumers in a healthcare setting experience food services delivered by a private food and service management firm?
3. which core job dimensions can be developed by food and service management firms in regards to their front-line staff in order to allow the implementation of food service experiences in accordance with the psycho-social needs and wants of its consumers?
4. what are the limits between market segmentation, patient acceptability of food and inherent service qualities?

**Rationale of the research:**

Since the NHS Plan in 2001, the NHS has especially aimed to develop a patient-oriented culture whereby the food experience is increasingly becoming part of the treatment. The reasons for conducting the research can be outlined as follows:

a) Research has been conducted on the nutritional value of the food served in hospitals, but currently there is almost no serious knowledge of the patient's internal processes when considering consumption of the food provided in a healthcare setting. The research will focus on patient-oriented food services by investigating how and on which foundations a guest-host relationship can be developed between the patient and the various staff members involved in the food service process. Food in hospitals is not only about fulfilling the physiological requirements of the patients. As such, it is essential to understand the psychological background of patients and see how the food service experience can be enhanced by taking the patient's characteristics into account. The research will contribute to the existing knowledge on nutritional behaviour, and more specifically about the underlying feelings, values and attitudes of patients towards food provided in acute NHS Hospitals.

b) The research will also explore human resources issues by considering the way the patient's requirements might be implemented across the various staff groups.

c) An additional contribution to knowledge relates to the methodology employed. The research will use qualitative methods: in-depth interviews with patients and management, and focus groups with staff groups. This approach is different compared to previous research on food and nutrition in hospitals that strongly relies on questionnaires. The research is based on the use of four distinct acute NHS hospitals, each being considered as an individual case study. This will not only allow using the data from each individual hospital to understand the patient's food service experience in a particular hospital, but it will also allow looking at common patterns between the various hospitals under investigation. It is expected that these patterns will provide indications of what is happening in acute NHS Hospitals and therefore confront managerial issues in regards to food services.

## Appendix K Initial node tree patients, as listed in NVivo

1 Involvement	2 Values
1.1 Involvement, communication and interaction	2.1 Relation food, intake and satisfaction
1.1.1 Day to day life	2.1.1 Preference for non-ward food
1.1.1.1 Take away food – exotic	2.1.1.1 Outside food brought in
1.1.1.2 New recipes	2.1.1.2 Preference for restaurant food
1.1.2 Importance of hospital food	2.2 Life course events & food choices
1.1.3 Information received	2.2.1 Monetary issues
1.1.3.1 Interest in receiving information	2.2.1.1 NHS investment for food
1.2 Involvement and satisfaction	2.2.1.2 Food cost
1.2.1 Discussions with staff	2.2.1.2.1 Food cost ready meals brought in
1.2.1.1 Discussion with employees from the private firm	2.2.1.2.2 Food cost in hospital restaurant and home food
1.2.1.1.1 How patients view catering staff	2.2.2 Ideal food changes due to hospital
1.2.1.2 Discussions with NHS staff	2.2.3 Visits of friends and relatives
1.2.1.3 Willingness to have open discussions	2.2.3.1 Friends bringing in food
1.2.1.4 Interest in discussing food issues	2.2.3.2 Food discussions with friends and relatives
1.2.2 Relationship building	2.2.3.2.1 Relatives trying the hospital food
1.2.2.1 Improving RM, patient suggestions	2.2.3.3 Drinks brought in on the ward
1.2.3 Food requests and complaints	2.2.4 Location of consumption
1.2.3.1 Patients addressing catering staff	2.2.5 Food discussions among patients
1.2.3.2 Patients addressing nursing staff	2.2.5.1 conversation with other patients
1.2.3.3 Communication between private firm and NHS	2.3 Categorisation of food
1.2.3.4 Employees not empowered, role of intermediaries	2.3.1 Convenience
1.2.3.5 Compliance with patient feedback	2.3.2 Influence of staff on food choices
1.2.3.6 Focus of staff on food issues	2.3.2.1 Food advice given
1.2.3.7 Trial and error	2.3.2.2 Are patients influenced by staff?
1.2.3.8 Main issues about the food	2.3.3 Keeping food patterns when back home
	2.3.4 Presentation of food items
	2.3.5 Expectations towards hospital food
	2.3.6 Importance of taste
	2.3.7 Food choice strategies
	2.3.8 Hospital shop purchases
	2.3.8.1 Food bought in hospital shop
	2.3.8.2 Other patient purchases in the hospital
	2.4 Patient values
	2.4.1 Subject of conversations
	2.4.2 Single contact person
	2.4.2.1 Issue of staff rotation
	2.4.2.2 Importance of a single contact person

3	Trust	4	Characteristics of hospital food
3.1	Contacts with people involved in the food service process	4.1	Texture of the food
3.1.1	Contacts with nutritionists	4.2	Quantities of hospital food
3.1.2	Contacts with nurses	4.3	Diversity of the menu
3.2	Lenth of stay and contacts with staff	4.4	General names given to the food
3.3	Food matching promises	4.5	Realising it's catering food in hospital
3.4	Food promises made	4.6	Convenience of the food
		4.6.1	Temperature of the food
		4.7	Repetitiveness of the food items
		4.7.1	Sticking to the same food item
		4.8	Suggestions on food issues
		4.9	Worries production method
		4.10	Availability of food items
		4.11	Comments on the meal experience
		4.11.1	Patient ideal picture
		4.11.2	The steam system
		4.11.3	Traditional food systems
		4.11.4	Comments on the private food and service mgt. firm

## Appendix L Consent form patients

REC Ref:

Date:

Version number:

### Consent Form

#### Towards consumer-centric food service experiences in the NHS

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*Please answer the following questions by circling your responses*

Have you read the information sheet about this study?                      YES                      NO

Have you been able to ask questions about this study?                      YES                      NO

Have you received answers to all your questions?                      YES                      NO

Have you received enough information about this study?                      YES                      NO

Who have you spoken to about this study?                      .....

Do you understand that you are free to withdraw from this study:

▪        At any time?                      YES                      NO

▪        Without giving a reason for with?                      YES                      NO

Do you agree to take part in this study?                      YES                      NO

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Your signature will certify that you have voluntarily decided to take part in this research study having read and understood the information in the sheet for participants. It will also certify that you have had adequate opportunity to discuss the study with an investigator and that all questions have been answered to your satisfaction

Signature of participant:..... Date:.....

Name (block letters):.....

Signature of investigator:..... Date:.....

Please keep your copy of the consent form and the information sheet together.

(name, address, contact number of investigator.)