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Reducing the risk of vulnerable groups contracting listeriosis

Guidance for health and social care organisations

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Working with

Hospital Caterers Association – Catering for Health Care

NACC
National Association of Care Catering

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Revision history

Revision number	Date	Purpose of revision	Revised by
1	2026	Updates required: • clarify existing policy • transferred to new guidance template • update to legislative references and link addresses throughout the document • updates to legal status of the Guidance • section on Registration added • section on Incidents added • section on Food Safety Culture included • best practice boxes reviewed • types of risky foods updated • incubation period updated • definitions checked and aligned with CODEX General Principles of Food Hygiene Code of Practice • additional resource list added • other minor wording amendments	Food Standards Agency, Food Standards Scotland, National Association of Care Catering and Hospital Caterers Association
0	2016	Guidance first published	

Summary

Purpose

To provide guidance on food safety and hygiene practices required within health and social care settings to reduce the risk of listeriosis, a foodborne illness caused by *Listeria monocytogenes*.

Legal status

This document provides guidance on how to comply with regulatory requirements to improve and maintain food hygiene standards and reduce the likelihood of listeriosis in health and social care settings. It also includes recommended best practices to support and reinforce regulatory requirements.

This guidance applies in both Great Britain and Northern Ireland. References to legislation in this document should be read as, references to assimilated EU law as it applies in Great Britain, and to that legislation as it applies directly in Northern Ireland.

Audience

- health and social care organisations which provide food for persons in their care, especially those with increased risk from listeriosis
- retailers and caterers who supply food to and within health and social care organisations
- enforcement officers within local authorities in England and Wales and district councils in Northern Ireland

Throughout this guidance, references to local authorities include District Councils in Northern Ireland, where relevant.

UK countries covered by this guidance

- England
- Wales
- Northern Ireland

In Scotland, equivalent guidance is provided by Food Standards Scotland and can be accessed via their website.

Key words

- hygiene and food safety
- food law, monitoring and controls

Review date

We aim to keep all guidance up to date and undertake regular reviews to ensure guidance remains relevant. The next scheduled review date for this guidance is **October 2027**, when a review of legislative references will be undertaken.

Contact us

We welcome your feedback on this guidance and will consider all feedback when the guidance is next reviewed. Provide any feedback to: foodhygiene.Policy@food.gov.uk

Introduction

Listeriosis is a foodborne illness caused by the bacterium *Listeria monocytogenes* (*L. monocytogenes*). Although listeriosis is rare, it has a high hospitalisation and fatality rate compared to other foodborne illnesses. People in hospital and care settings often have weakened immunity due to acute or chronic health conditions, being older, or pregnant. These factors increase vulnerability to listeriosis, making it critical to control *L. monocytogenes* in health and social care settings that provide food for vulnerable groups.

Food businesses supplying these settings, and those responsible for providing food within them, should take account of the specific legislative requirements relating to *L. monocytogenes.* They should also take account of the requirements of Article 14 of Regulation (EC) No 178/2002, which requires consideration of the sensitivities of the people likely to consume the food.

Health and social care organisations that provide food are legally required to establish and maintain procedures based on Hazard Analysis and Critical Control Point (HACCP) principles. This will enable them to identify and control food safety hazards. The regulatory requirements for food safety and hygiene are set out in Annex A.

Local authorities can provide advice to health and social care organisations on implementing this guidance and ensuring the necessary control measures are in place. Organisations with a primary authority partnership may wish to contact their primary authority for advice on implementing this guidance.

This guidance considers the need to balance wider consumer and patient needs, such as nutrition and food choice, with the potential risk from listeriosis. Therefore, the guidance does not recommend avoidance of certain foods beyond standard Food Standards Agency (FSA) advice, unless there is specific clinical advice to do so to protect certain consumers.

We are grateful to those stakeholders who contributed to this guidance, which is intended to support regulatory compliance and best practice in the food industry.

Legal status of the guidance

Food law in the UK comprises EU legislation and domestic legislation applicable in each UK nation. References in this guidance to EU legislation should be read as references to EU law as it applies in Northern Ireland or to 'assimilated law' as it applies in England and Wales. In Northern Ireland, under the Windsor Framework, EU food law continues to apply. In England and Wales, EU legislation formally referred to as retained EU law was reclassified as assimilated law on 1 January 2024, under the Retained EU Law (Revocation and Reform) Act 2023.

This document provides guidance on the regulatory requirements for compliance with:

General principles and requirements of food law, set out in:

Assimilated Regulation (EC) No 178/2002 for Great Britain

Regulation (EC) No 178/2002 (external website) for Northern Ireland

Food safety and hygiene requirements, set out in:

Assimilated Regulation (EC) No 852/2004 for Great Britain

Regulation (EC) No 852/2004 (external website) for Northern Ireland

Food Safety and Hygiene (England) Regulations 2013

Food Hygiene (Wales) Regulations 2006

Food Hygiene Regulations (Northern Ireland) 2006

The General Food Regulations 2004 (applicable in Wales)

The General Food Regulation (Northern Ireland) 2004

Microbiological criteria for food (mainly applicable to food business operators involved in the production, manufacture and supply of foods to health and social care settings), set out in:

Assimilated Commission Regulation (EC) No 2073/2005 for Great Britain

Commission Regulation (EC) No 2073/2005 (external website) for Northern Ireland

For further details on these regulations, refer to Annex A.

Note: those listed are the main regulations applicable to this guidance, however other legislation may apply. Businesses with specific queries may wish to seek advice from their local authority or primary authority. Following these guidance notes will help you to comply with the law.

All guidance on best practice in this document is identified with a heading of 'Best practice'. You are not required by law to follow best practice guidance. However, any additional measures taken to control *L. monocytogenes* beyond regulatory requirements could provide further assurance of food safety.

Intended audience

This guidance is for all types of health and social care organisations that provide food for vulnerable groups (see 'Risk of listeriosis') by any system of catering, for example:

- NHS trusts
- private hospitals
- nursing homes
- residential care homes
- hospices
- assisted living developments for the elderly
- day centres for the elderly
- day procedure units
- antenatal and neonatal clinics and centres
- community meal provision

This list is intended as a guide and is not exhaustive.

Health and social care organisations can vary significantly in size and nature, from a simple catering operation within a small care home, to complex operations within a large general hospital. This guidance will be relevant for managers and staff that hold responsibility for and/or are involved in food procurement, preparation, distribution and service, across all food pathways (see 'Food pathways'). It is important that food business operators (FBOs) and those with senior management responsibility understand the necessity of implementing *L. monocytogenes* controls and provide sufficient resources to manage *L. monocytogenes* effectively.

Depending on the size and structure of the organisation, *L. monocytogenes* control may include people from several departments, for example:

- caterers
- care home and nursing home managers
- procurement managers and buyers
- dietitians
- nurses
- retail outlets
- domestic services
- infection prevention specialists
- ward managers
- porters
- facilities and estates departments
- patient services
- housekeepers
- risk assessors

This guidance will also be useful for:

- local authority enforcement officers
- procurement partners
- food safety managers
- contract caterers
- on-site retailers (commercial and charitable organisations)
- suppliers of chilled ready-to-eat (RTE) foods to health and social care organisations, including manufacturers and distributors
- facilities performing food or environmental testing

Registration requirements

All food businesses are required within food law to register the business (Article 6, Regulation 852/2004). This requirement applies to health and social care organisations where they have responsibility for food provision as part of their activities. The same requirement applies to third party food businesses that operate within these settings (for example, retail food outlets, vending machines).

Food business operators must register with the local authority where the business is located. A food business is defined as any persons or organisation carrying out activities relating to food at any stage of production, processing, and distribution of food. This includes providing, cooking, storing, handling, preparing or distributing food, whether for profit or not. NHS Trusts and other health and social care providers are advised to ensure that any third-party businesses are registered correctly, where applicable, as part of their duty of care to patients.

If a food business operates in more than one location, each premise is required to be separately registered with the local authority in which they are located.

A new food business (which includes taking over an existing business) is legally required to register before it begins operating. The FBO is responsible for ensuring that the local authority is kept informed with up-to-date details of the food business, including notification of any significant changes in activities or the closure of the establishment.

Purpose of the guidance

This guidance is specific to *L. monocytogenes* control and outlines the measures expected to be in place within health and social care settings to reduce the risk of *L. monocytogenes* in foods. It is intended to complement compliance with general food hygiene requirements. The activities required for effective control of *L. monocytogenes* will vary depending on the product, processes and setting. This guidance is intended as a general guide and is not exhaustive. Health and social care settings, and the food businesses operating within them, are responsible for determining and maintaining measures appropriate for their particular situations and settings which will effectively control *L. monocytogenes*.

Guidance overview

Health and social care organisations, and the food businesses that operate within them, can help to effectively mitigate the risk of listeriosis by implementing and consistently following procedures that support food safety. Developing procedures such as a food safety management system (FSMS) based on HACCP principles is fundamental to establishing and maintaining a safe food environment – and is a regulatory requirement. A well-designed safety system should cover all food safety and hygiene requirements, including the following discussed in this guidance:

- preventing food from becoming contaminated with *L. monocytogenes*
- controlling and limiting the opportunities for growth of *L. monocytogenes*
- training staff on safe food procurement, preparation, handling, storage and distribution
- testing of food environments for presence of *L. monocytogenes* (if applicable)
- taking necessary actions when there is reason to believe food is unsafe

Risk of listeriosis

Cases of listeriosis in the UK population are relatively low. However, listeriosis can be severe, particularly for vulnerable groups, for whom it has a high hospitalisation and fatality rate compared to other foodborne illnesses. For most people, listeriosis causes no symptoms or mild, flu-like symptoms.

People with weakened immunity due to acute or chronic health conditions, older adults, and pregnant people all have increased vulnerability to listeriosis infection and are more likely to develop invasive listeriosis. Invasive listeriosis is very serious and can result in conditions such as bacteraemia, septicaemia, meningitis and, in pregnant people, miscarriage and stillbirth.

People with a weakened immune system include cancer patients, patients undergoing immunosuppressive or cytotoxic treatment (leaving them immunocompromised), newborn babies, people with diabetes, alcoholics (including those with alcoholic liver disease) and a variety of other conditions.

Listeria in the environment

L. monocytogenes is widespread in the environment, found in vegetation, raw foods, soil, and water. Once introduced, this bacterium is known to remain in food processing environments due to the cells' ability to adhere together, firmly attach to surfaces, and create biofilms, which are not usually visible. Bacteria within biofilms are much more difficult to remove once established in food processing environments as biofilms have a very strong resistance to cleaning and disinfection. During preparation, food that comes into contact with a biofilm can become contaminated.

L. monocytogenes is also persistent in the environment as it can grow at low temperatures (including refrigerator temperatures), is able to grow in low oxygen environments, can survive freezing and is salt tolerant.

Foods of particular risk to vulnerable groups

L. monocytogenes is frequently present in raw foods of both plant and animal origin. However, outbreaks or sporadic cases of listeriosis have mainly been associated with chilled RTE foods and often involve post-process contamination of foods. RTE foods are those which are intended for consumption without the need for further preparation, such as cooking. RTE foods do not undergo a heat treatment or other kill step after production, making them more likely to become contaminated with *L. monocytogenes*. Whether the bacteria can grow depends on the characteristics of the food and how it is stored.

A variety of specific foods have been linked to outbreaks and cases of Listeriosis. The following list includes examples of the types of foods associated with listeriosis outbreaks, sporadic cases of listeriosis or RTE foods sampled for *L. monocytogenes* in microbiological surveys. These lists are not exhaustive.

Types of foods associated with Listeriosis outbreaks

Fish

- Smoked and cured fish, including sushi
- cooked shellfish
- pate

Meat

- Cooked meats and poultry
- Cold, precooked meats such as chicken
- Pâte
- Deli meats, such as salami and cold cuts

Pasteurised and unpasteurised milk and cheese

- soft mould-ripened cheeses, such as Camembert, Brie and blue-veined cheeses
- raw drinking milk (unpasteurised)
- products made from raw milk such as cheese or butter

Prepared foods

- pre-prepared sandwiches and salads
- some cut fruits, including melon slices

Source: Listeria - GOV.UK

There is the potential for chilled RTE foods to present an increased risk to vulnerable groups. Therefore, effective control measures for *L. monocytogenes* must be applied and appropriately managed. Risks can be effectively managed through comprehensive hygiene controls implemented by health and social care providers, as well as by the FBOs that supply them.

Although this guidance deals with listeriosis risks related to chilled RTE foods, certain frozen foods, once defrosted, such as fruit and vegetables or RTE cooked meats, may present a risk because *L. monocytogenes* can survive freezing. It is important that manufacturer's instructions for storage and use are followed, and appropriate controls are in place both for the premises and those supplying the products.

Note, the following foods are outside the scope of this guidance:

- food intended to be cooked and served hot
- frozen food intended to be cooked or reheated from frozen and served hot
- food intended for infants
- food intended for special medical purposes

Food pathways

Health and social care organisations are legally obliged to make sure the food they provide is safe, but there are often many different routes by which vulnerable groups may obtain food and drink.

Health and social care organisations should take into consideration all of the different food pathways under their control, by which chilled RTE foods may reach vulnerable groups within their organisation (see 'Management controls').

Examples of food pathways by which food may be provided to vulnerable groups within health and social care organisations are detailed below:

- Food provided by the main kitchen or central production kitchen to locations such as wards, dining rooms, day units
- On-site restaurants, fast food outlets, coffee shops and on-site retailers, including volunteer organisations
- Food brought in by patients, residents and visitors

- Vending machine
- Other (For example, hospitality and packed lunches)

Control of contamination

The effective management of cross-contamination is an essential food safety control for *L. monocytogenes*.

It is important to prevent *L. monocytogenes* contamination of chilled RTE foods intended for vulnerable groups as growth may lead to bacteria levels harmful to health. Food must be protected from contamination, from delivery of the goods into the organisation through to service of the food to the patient or resident.

Effective controls for personal hygiene, cleaning and disinfection and cross-contamination controls are outlined in this section.

Personal hygiene

Health and social care organisations must have effective procedures in place for personal hygiene, as this will provide a foundation for *L. monocytogenes* controls.

Effective handwashing is extremely important to help prevent harmful bacteria from spreading from peoples' hands, as humans can be carriers of *L. monocytogenes.* It is essential that food handlers ensure good handwashing controls are being carried out frequently, such as when in the kitchen or preparation area, before preparing food, after touching raw food, after handling food waste or emptying a bin, or after cleaning.

To keep food safe, every person working in a food-handling area must maintain a high level of personal hygiene. They must wear clothing that is suitable, clean and, where necessary, protective.

The law requires food businesses to exclude anyone from work if they have an infectious disease and there is any likelihood of them contaminating food directly or

indirectly. Any affected person in a food business who is likely to be handling food must immediately report the illness or symptoms to the person in charge. Further information can be found in the Fitness to work guidance.

Best practice – personal hygiene

Implement a personal hygiene policy and monitor this regularly to ensure staff follow effective personal hygiene practices, such as:

- hair (including facial hair) may directly contaminate food. Choose effective methods of control such as hats, hairnets, tying hair back securely and snoods
- food handlers preparing RTE foods should not travel to their place of work in their protective clothing
- procedures for laundering work clothing and protective clothing, either by the provision of in-house arrangements or providing appropriate instruction for those laundering their own work clothing
- minimise handling of chilled RTE foods prior to service

Cleaning and disinfection

Good construction and maintenance of premises and equipment, as well as effective cleaning and disinfection procedures need to be in place to minimise the risk and remove potential sources of *L. monocytogenes* contamination.

Effective cleaning and disinfection are important for all food pathogens but important activities to be aware of in relation to *L. monocytogenes* are:

- regular cleaning and disinfection should include a two-stage cleaning and disinfection method. Stage 1: general cleaning using a detergent to remove residues from the surface, and stage 2: applying a disinfectant to disinfect the cleaned area. This is important to ensure food contact surfaces are cleaned effectively and to avoid the formation and build-up of biofilms. Biofilms are not

usually visible and, if not removed, biofilms can remain on food contact surfaces and equipment for several years. If food meets a biofilm during food preparation, it can become contaminated. Complex equipment, such as meat slicers, are known to harbour *L.monocytogenes* and therefore require particular attention during cleaning and disinfection to ensure biofilms are removed.

- chemicals known to be effective in destroying *L. monocytogenes* should be used. Chemicals must always be used in accordance with the manufacturer's instructions regarding dilution rates, contact times and rinsing. Disinfection products such as disinfectants and sanitisers will not be effective if used on dirty surfaces, if applied at the incorrect dilution rate, for the insufficient contact time or the incorrect temperature. A professional chemical supplier will be able to provide advice on suitable chemicals and correct usage. Disinfection products should meet the BS EN standards (also known as British Standards) - check product labels for either BS EN 1276 (external website) or BS EN 13697 (external website) codes

- it is important to maintain and repair damaged equipment appropriately to enable effective cleaning to take place, as these areas can create harbourage sites for *L. monocytogenes* where biofilms can form

- keep moisture levels in food areas to a minimum. Repair damaged and poor floor drainage in kitchens, damaged flooring and areas where water can pool can be a reservoir for *L. monocytogenes* biofilms. Drains are one of the most common reservoirs of persistent *L. monocytogenes* and should be inspected and cleaned regularly. Drain cleaning should be carried out separately from the cleaning of food contact surfaces and equipment.

- when using power machinery, such as jet washers and spray-on floor cleaning solutions, spray from cleaning can spread *L. monocytogenes* from floors and drains onto food contact equipment and food. Care must be taken to ensure food contact equipment is not contaminated following this type of cleaning, or

steps must be taken to re-clean and disinfect food contact equipment before food preparation commences

- air handling systems should be well designed and cleaned regularly when food is not being prepared
- avoid accumulation of condensation in refrigerators and blast chillers, as this can create favourable conditions for biofilms, which may be distributed via dripping or moist air blown through the units

Best practice – cleaning and disinfection

- where possible disinfect food contact equipment by heat or by an adequate dishwasher cycle, following the manufacturer's instructions
- use separate cleaning equipment, such as colour coded equipment, for raw and RTE preparation areas to prevent cross-contamination
- undertake cleaning and disinfection procedures when food is not being prepared to avoid harmful substances being consumed
- wear appropriate Personal Protective Equipment (for example, gloves, apron, gown) during cleaning and perform hand hygiene before and after tasks

Cross-contamination

As raw foods can be contaminated with *L. monocytogenes*, health and social care organisations should take appropriate steps to control cross-contamination from raw food directly or indirectly onto RTE foods.

Environmental sources of *L. monocytogenes* like soil mean that raw fruit and salad vegetables may potentially be contaminated with L. *monocytogenes*.

Unless supplied as RTE, fruit and vegetables will need to undergo adequate washing (wash thoroughly by rubbing vigorously in clean running water) and/or processing

(peeling or cooking) prior to consumption. It is important to purchase food from reputable suppliers that can be trusted to supply and handle food safely.

Best practice – washing fruit and vegetables

- rinse fruit and vegetables under cool running water rather than soaking. Soaking can spread contaminants between items
- wash external surfaces before cutting fruit and vegetables to minimise the risk of *L. monocytogenes* on the external surface from being transferred to the flesh of the fruit
- avoid using soap or detergents to wash the fruit and vegetables as they can leave harmful residues
- antimicrobial (food grade) treatment washes can be used to help reduce pathogens in produce wash water. Ensure manufacturer instructions are followed appropriately
- washed fruit and vegetables should be kept separate from unwashed and raw produce to avoid cross-contamination

Best practice – kitchen access

- implement a policy to control who has access to kitchens and pantries and under what circumstances. The policy should include staff, visitors and contractors, be as restrictive as practicable and should limit access when food is being prepared or served
- provide appropriate guidance or supervision on safe handling practices in settings where residents cook their own food as part of a rehabilitation or occupational programme

Control of growth

It is important to minimise growth of *L. monocytogenes* present in chilled RTE foods to prevent *L. monocytogenes* reaching levels likely to be harmful to the health of people with increased vulnerability to listeriosis.

The growth of *L. monocytogenes* can be controlled by applying effective time and temperature controls. These will vary depending on the type of food. This includes appropriate controls on the storage time and temperature of foods at all stages. Controls must be in place from supply and delivery of food and ingredients to the health and social care organisation, through to consumption by patients or residents.

When providing chilled RTE food to vulnerable groups, health and social care organisations should:

- set an appropriate use by date where foods are made on site
- follow manufacturer's instructions for use-by dates, conditions of use, and storage
- maintain the cold chain during food storage and transport
- minimise the time that food spends out of the cold chain (for example, during preparation, delivery and serving)
- ensure chilled RTE foods are stored at appropriate refrigerated temperatures, including in ward fridges, patient snack fridges and other point-of-service refrigeration
- manage opened chilled RTE foods safely, including recording opening dates, minimising time out of refrigeration, adhering to established in-use shelf lives, and discarding products where the opening date cannot be verified

Develop and implement procedures that ensure cold chain equipment is working correctly. For example, check and record fridge and freezer temperatures at set intervals and after rotation of stock. Practical advice on how each of these can be achieved is provided within the cold chain section.

Shelf-life

L. monocytogenes can grow in refrigerated storage. Putting in place controls to limit the shelf life will also limit the opportunity for *L. monocytogenes* to grow to levels more likely to be harmful.

Health and social care organisations must:

- have a HACCP-based FSMS in place to ensure food is stored and used appropriately
- use foods within their use-by date and follow the manufacturer's instructions for storage and use, including any instructions on shelf life after opening
- where products are made on site, ensure the shelf life of the finished product, for example, sandwiches, does not exceed that of any of the ingredients

It is against the law to use or supply food past the manufacturer’s use-by date. The manufacturer's use-by date should not be extended unless this has been agreed and validated by the manufacturer.

Best practice – shelf-life control

- order or purchase as close to the date of consumption as practicable
- take care not to over order foods
- carefully check use-by dates upon delivery or purchase
- organise working practices so that chilled RTE food prepared on site such as sandwiches and salads are used on day of production wherever possible
- a maximum chilled shelf life of day of production plus 2 days should be applied to food prepared on site, unless evidence of shelf-life studies are provided to prove otherwise
- regularly check for expired items and discard immediately

- bought in pre-packed sandwiches for patients or residents, should be consumed as close as possible to the day of purchase
- ensure stock is rotated, for example, using a ‘first in, first out’ principle

Cold chain

Maintaining an effective cold chain is an essential food safety control for L. monocytogenes.

Maintain cold chain

- health and social care organisations should aim to maintain the cold chain and store chilled RTE foods at temperatures below 5°C. Where a manufacturer specifies a lower storage temperature, this instruction should be followed, as storage above the specified temperature may compromise the safety and shelf life of the food.

Minimise time food spends out of cold chain

- it is recognised that there may be unavoidable breaks in the cold chain during preparation and food service. To minimise growth of *L. monocytogenes*, time that RTE chilled food is out of chill storage should be kept as short as possible, and set out within the organisations FSMS principles
- deliveries of chilled RTE food should be placed in refrigerated storage promptly

The ‘4 hour rule’

National rules provide an exemption for certain foods to remain out of temperature control for one period of up to four hours for display and service purposes.

Annex II of Regulation 852/2004 requires food to be kept at temperatures that do not pose a risk to health. Food businesses must therefore ensure that any risks arising

from the display and service of food outside temperature control are appropriately managed.

L. monocytogenes can grow rapidly in warm environments. Given the increased risk to vulnerable groups, it is best practice to apply stricter time and temperature controls and to dispose of chilled RTE foods that have been held out of chilled storage beyond those times.

Best practice – cold chain

- maintain the cold chain of chilled RTE food at 5°C or below from delivery through to service, to allow a margin of error below the legal standard (8°C)
- use chilled display cabinets where RTE foods requiring chill control are presented for sale at retail outlets such as restaurants, shops and cafes. Having doors on the chilled display cabinets can help to maintain the cold temperatures
- pre-chill equipment used for keeping foods cold, such as display cabinets, chilled trolleys and similar equipment
- set maximum times that food can spend out of the cold chain, as part of the HACCP-based FSMS (see 'Food safety management systems'), and monitor to check times are not exceeded. Dispose of food outside of the cold chain for longer than set maximum periods.
- make sure that chilled RTE foods are not stored next to or on top of ward trolleys, designed to keep foods hot
- have contingency measures for equipment failure (for example, backup refrigeration, rapid transfer to alternative storage)
- train staff on cold chain importance, handling procedures, and emergency protocols for breakdowns

Practices and facilities for the preparation of chilled RTE foods should be organised so that the time chilled RTE foods spend at room temperature is kept as short as possible, and that food temperatures remain as low as possible.

Best practice – time and temperature controls during food preparation

- prepare food in small batches
- pre-chill ingredients such as canned tuna, mayonnaise and bread
- pre-chill crockery, for example chill plates prior to plating salads or sandwiches
- provide sufficient refrigerators close to preparation areas so that foods can be removed, used and put back promptly
- cold holding wells provided close to preparation areas will enable fillings to remain chilled during preparation
- only remove from refrigeration the amount of ingredients for foods such as salads and sandwiches, being prepared at that time
- refrigerate chilled RTE foods immediately following preparation
- where chilled preparation rooms are in operation it is good practice to apply time controls, as chilled preparation rooms generally operate above 5°C

Equipment specifications

As *L. monocytogenes* can grow at low temperatures, and the rate of growth of *L. monocytogenes* can increase significantly above 5°C (and can double at 8°C compared to 5°C, as predicted by ComBase, a modelling tool that predicts how microorganisms survive and grow in different food-related conditions), it is important that all

equipment designed to keep foods cold or frozen is fit for purpose and can maintain adequate temperatures.

If domestic equipment is used, for example, in ward kitchens, kitchenettes or pantries, the health or social care organisation must ensure that this equipment can maintain temperatures of 8°C or below, and they should aim for 5˚C to allow a margin of error below the legal standard. Temperature monitoring of food should be done by using a calibrated thermometer. It is important that the temperature of the food is measured and not the air temperature of the storage unit. Thermometers built into fridge and freezer units measure the air temperature only.

Distribution to service points

During transfer or transportation of chilled RTE foods within a health or social care organisation, for example from the main kitchen to ward or dining areas, it is best practice for the cold chain to be maintained.

Specialised cold-holding equipment (for example insulated containers, eutectic plates and chilled trolleys) can be used to transfer or transport chilled RTE foods from the main kitchen to the point of service if the chill temperature is likely to be compromised. This will be dependent on the distance the food needs to travel and the nature of the food service.

Best practice – time and temperature controls during distribution to service points

- maintain the cold chain at 5°C or below
- where possible, containers and equipment used for transportation of food should be pre-chilled to below 5°C
- remove chilled RTE food from refrigerated storage and place into transportation equipment promptly, and as close to the transportation time as possible
- transport chilled RTE food as soon as possible after loading into equipment

- hold chilled RTE foods transported to the service point in chilled equipment at 5°C or less or transfer to appropriate refrigeration at the ward or pantry

Service to patients or residents

Organise the service of chilled RTE foods to patients or residents, for example in wards, wings and dining areas, so that the time food spends at room temperature is minimised.

Effective inter-disciplinary working practices between departments are important as 'non-catering' staff, for example, nurses, care staff, housekeepers are often those with responsibility for time and temperature controls at the point of service to the patient or resident. All staff who are responsible for storage, preparation and/or service of foods must be trained on food safety elements relevant to their roles; This includes non-catering staff.

Best practice – time and temperature controls during food service to the patient or resident

- keep chilled RTE foods in chilled storage until they are ready to be served
- ensure chilled RTE foods are eaten as soon as possible after serving
- keep service times as short as possible
- chilled RTE foods should not be left at room temperature if the patient or resident is not available or ready at mealtime. The food should be labelled with the patient or resident's name and refrigerated.
- dispose of chilled RTE food held out of chilled storage during service at the end of mealtimes
- patients or residents should be discouraged from storing chilled RTE food at their bedside or in beside cabinets for consumption later

- protected mealtimes are recommended to avoid interruptions during mealtimes and to allow staff to concentrate on food service

- ensure ice-cream, frozen flavoured mousses and other frozen desserts which are intended to be served frozen are kept frozen and not defrost before service. Ice-cream or mousses that have defrosted must be thrown away. Do not re-use or re-freeze

- when using oral supplements (sip-feeds) make sure the manufacturer's instructions are followed for use and storage, once opened

Best practice – 'go home' packs or packed meals

If foods are provided for vulnerable individuals, within a go-home pack or packed meal for patients going off-site, assess the risks and consider:

- replacing certain RTE foods with alternatives that do not need to be kept chilled
- if chilled RTE foods, for example sandwiches, are used, provide appropriate advice on consuming these foods within a specific time frame
- use cool bags, chill packs and similar equipment to keep chilled foods cold

Temperature monitoring

Effective monitoring procedures for chilled RTE foods should be carried out to ensure appropriate chill temperatures are being maintained, and the units are working correctly.

Clear responsibilities for temperature monitoring and corrective actions should be allocated to all food handlers, particularly where responsibilities may be split between the health or social care organisation and a contractor. Effective monitoring must be

carried out at prescribed times, including weekends, evenings and holiday periods, such as bank holidays.

Best practice – temperature monitoring

- data loggers can be useful for more complex operations to validate the cold chain

Corrective actions

Clear procedures are required when temperatures are found to be above critical limits and corrective actions must be carried out. The FBO is responsible for deciding what corrective actions are appropriate. It is important that all staff, including temporary staff, and supervisors, have clear instruction on corrective action procedures.

Temperature and time controls for other processes

Effective temperature and time controls and monitoring during other stages of the food operations is also required to control *L. monocytogenes*.

These should be reflected in the FSMS, for example:

- thawing under chilled conditions – to control growth of any *L. monocytogenes* that may be present
- thorough cooking, reheating or regeneration at 75ºC for at least 30 seconds, or equivalent, – to destroy *L. monocytogenes* that may be present in food
- hot holding at 63°C or above – to control growth of any surviving bacteria or *L. monocytogenes* introduced post cooking
- rapid cooling or blast chilling – to control growth of any surviving bacteria or *L. monocytogenes* introduced post cooking

Management controls

Health and social care organisations serving food are required to have procedures in place to manage food safety, typically in the form of a documented FSMS based on HACCP principles.

In addition to establishing controls, critical limits, monitoring procedures and corrective actions in relation to *L. monocytogenes*, the FSMS should include important procedures for the control of *L. monocytogenes* including:

- procurement and purchasing
- training, instruction and supervision
- management of on-site retailers and caterers, where applicable
- food brought in by patients or visitors
- microbiological testing, where applicable

Advice on the content of these policies is provided in this section.

Food safety management systems

Health and social care organisations should ensure that their food safety management system (FSMS) covers all food pathways under their control, by which chilled RTE foods can reach vulnerable groups. The FSMS needs to be a working document, appropriate to the size and nature of the organisation and reviewed regularly.

Some organisations may be using an alternative FSMS - for example, a residential care home could be using 'Safer food, better business' or 'Safe Catering' but should also take this guidance into consideration.

Note: Safer food, better business and Safe Catering is not suitable for all types of food businesses. Refer to the specific packs for further information.

Best practice – food safety management system

- the roles and responsibilities for all levels of staff and management (including directors, managers and supervisors) in relation to this guidance should be clearly identified and documented. For example, responsibilities of non-catering staff and for on-ward kitchens and food service should be defined
- commitment to food safety is important. The FSMS should identify a person with overall responsibility for food safety across the organisation and demonstrate commitment from the organisation's leadership.
- amendments and updates made to the FSMS should be communicated to all relevant personnel within the organisation

Inter-disciplinary working and food safety culture

In most health and social care organisations, several food pathways exist (see 'Food pathways'), meaning that the control of *L. monocytogenes* is not always confined to the main catering operation, and can include several different departments.

Effective inter-disciplinary working, good communication and a consistent approach by all departments involved will be necessary to provide safe food. However, simply knowing how to produce safe food and planning for it isn't enough. It requires consistent actions and behaviours to ensure the FSMS is put into practice effectively. Food safety culture reflects the mindset and daily behaviours of everyone in the organisation, from leadership to frontline employees.

In March 2021, the EU adopted Regulation (EU) 2021/382. This introduced 'food safety culture' into Regulation (EC) 852/2004 (as Chapter XIa). As this amendment was made post-EU Exit, it does not form part of assimilated Regulation 852/2004 in Great Britain. However, as already stated, due to the Windsor Framework, Regulation (EC) 852/2004 is applicable in Northern Ireland, meaning food safety culture is a legal requirement that must be considered by local authorities when undertaking official controls. While food

safety culture is not a specific legal requirement in England and Wales, applying its principles is considered good practice and can help businesses maintain effective food safety management systems.

Practical ways of achieving a good food safety culture within a business could include:

- staff views on how to improve food hygiene actively sought by management as well as suggestions for improvement and being receptive to these
- staff confidence in reporting food hygiene issues and trust in management to respond positively
- management providing very good communication of food safety matters to staff and ensuring to involve them when resolving issues

Further guidance on the assessment of food safety culture in food businesses is also available in Commission Notice (2022/C 355/01) (external website), which supports the implementation of FSMS, including HACCP-based procedures

Record keeping

FSMS records should be kept for an appropriate length of time. Advice on this can be sought from your local authority. Strong traceability systems help organisations identify where food has come from, where it has gone, and what actions must be taken rapidly during a food safety incident. Clear documentation also supports compliance with food safety law and demonstrates due diligence to enforcement authorities.

The incubation period, that is the period between ingesting *L. monocytogenes* and developing symptoms, ranges from 24 hours to 70 days. Therefore, while most cases are likely to present with symptoms in the first two weeks after eating contaminated food, a few may have a delayed presentation. This means it is sometimes difficult to pinpoint exactly which food caused illness in the case of an incident. Therefore, during suspected or confirmed listeriosis incidents, clear and immediate documentation is critical to support investigations and root cause analysis.

Where health and social care organisations have meal ordering systems in place these records can be useful in assisting investigation of potential cases of illness.

Review

It is important that regular reviews of the FSMS are carried out, particularly when something changes. For example, any change to the environment, equipment or processes used, a change in menu, or following a food safety incident. Note these are examples not an exhaustive list. This guidance should be consulted and relevant parts integrated into the review of the FSMS.

Validation and verification

All measures to control *L. monocytogenes* across all food pathways within your control must be validated to prove they are effective. The continued effectiveness of these measures should then be regularly verified at a pre-determined and documented frequency.

Best practice – verification

Verification methods will depend on the size and nature of the operation and can include (but are not limited to):

- day-to-day supervision
- internal and external audits
- complaint and incident monitoring
- patient, resident or customer feedback
- temperature monitoring
- microbiological testing (see 'Microbiological testing')

Procurement and purchasing

It is important for health and social care organisations to have a clear policy in place and to adhere to their inhouse procedures for the procurement and purchase of chilled RTE foods, to minimise the risk of buying food products or ingredients that are potentially contaminated with *L. monocytogenes*.

The policy should include minimum food safety criteria that any suppliers used need to meet to supply the health and social care organisation.

General

Those responsible for purchase of chilled RTE foods intended for vulnerable groups in health and social care organisations must consider food safety during procurement and purchase to ensure that chilled RTE foods intended for vulnerable groups are safe to eat.

Best practice – procurement

- part of the procurement policy should ensure that suppliers are registered or approved, as appropriate, with the competent authority. Health and social care organisations should verify this when considering a new supplier
- the supplier should be able to provide details of the competent authority where they are registered or approved, as well as their most recent food hygiene inspection and food hygiene rating, if applicable. Where a food hygiene rating is not applicable, suppliers should be asked to provide the latest inspection report from their local authority
- use suppliers that have been appropriately assessed and where the health or social care organisation has confidence in their suppliers' ability to provide safe food
- use new suppliers only when food safety has been assessed and found to be satisfactory (see Annex C)

- put a contingency plan in place so that alternative suppliers, who have been adequately assessed for food safety, can be used at short notice
- supplier assessments for chilled RTE foods need to adequately address each stage in the supply chain and may need to be extended more than one step back. The links in the distribution chain should be considered, for example if food is manufactured by one company and distributed by another, both companies should be assessed to ensure appropriate systems and measures are in place to manage food safety
- assurances for appropriate assessment of suppliers for food safety should extend to food purchased by all on-site retailers and contract caterers (see 'Management of on-site retailers and caterers')

Traceability

It is a legal requirement for food businesses to keep a record of where they sourced food from, and to whom they supplied it.

For products of animal origin, there are additional requirements to record information including an accurate description of the food, the quantity, the batch number and the date of dispatch. This information should be kept in a way that allows food to be traced quickly and accurately to see where a food product originated from in the event of a food safety incident or recall.

Methods of supplier assessment

The method by which health and social care organisations purchase food varies considerably and usually depends on the size and nature of the operation. For example, purchasing may be undertaken via a purchasing organisation, an in-house purchasing department, or direct from suppliers.

Purchases are sometimes sourced directly from supermarkets or smaller retailers, particularly for those organisations with small numbers of patients or residents, or where specialist foods, for example, ‘free from’ foods, are required. Where chilled or

frozen foods are being purchased, the appropriate method of their transport back to the organisation needs to comply with temperature control regulations.

All organisations should have nominated suppliers who have been assessed for food safety and found to be satisfactory.

The method of assessment will vary depending on the methods used to procure and purchase food and the size and nature of the health and social care organisation, with consideration including:

- the nature and number of vulnerable patients or residents
- the nature of the food purchased

A reference guide for methods to assess the food safety of suppliers is provided in Annex C.

Best practice – supplier assessment

- depending on the supplier and the food products they supply, check the food safety of suppliers by undertaking unannounced visits at regular intervals
- consider using suppliers that hold third party certification, where the businesses supplying food will be subject to independent food hygiene audits
- use a supplier's FHRS rating as one factor when assessing supplier suitability, and where applicable, consider suppliers with a rating of 3 or above

Best practice – complaint management

- a procedure should be in place to ensure that complaints relating to suppliers are recorded and reported to the supplier and that a satisfactory investigation is undertaken. Food safety complaints may include, for example, temperatures out of target at delivery, delivery of food outside shelf life, foreign bodies

- if sites are part of a larger organisation or group that purchase from the same supplier, ensure that food safety complaints are coordinated and appropriately investigated, reported and recorded
- monitor trends to enable weaknesses in relation to a supplier to be detected and action taken
- When investigating complaints, consider whether the cause of the issue arose from the supplier or from practices within the health and social care setting

Specifications

Some health or social care and purchasing organisations use documented product specifications to clearly describe the quality and food safety standards expected for products. For example, specifications for chilled ready-to-eat foods supplied to vulnerable patients may include requirements for shelf life, temperature control, ingredient restrictions and supplier assurance measures, as outlined in the British Sandwich Association NHS Patient Feeding Guideline.

Incoming products should be monitored to ensure specifications are met. Suppliers should be required to demonstrate compliance with specifications, for example, provide copies of microbiological testing results. If products supplied are out of specification, corrective action should be taken.

Microbiological testing may also be used to evaluate supplier performance in meeting specifications (see 'Microbiological testing' and Annex D).

Best practice – specifications

Include minimum standards for supplier assessment. The following are examples and are not intended to be exhaustive:

- shelf life

- temperature control – including during transportation and for delivery of product
- microbiological criteria in relation to *L. monocytogenes*
- packaging integrity, including protection from damage, contamination and tampering

Training

Regulation (EC) 852/2004 on the hygiene of foodstuffs requires that food handlers are supervised and instructed and/or trained in food hygiene matters appropriate to their work activities. In practice, this includes ensuring that staff are aware of any specific control, monitoring and corrective action measures to either eliminate or reduce the risk of *L. monocytogenes* to an acceptable level.

An appropriate level of training and instruction for the control of *L. monocytogenes* should be provided to all staff involved with *L. monocytogenes* control to vulnerable groups across all food pathways. This will include temporary staff (such as casual, agency, voluntary staff and students). It is useful to ensure that staff, such as those in maintenance who work on air handling units and condensers, are also made aware of risks.

It is important to consider non-catering staff, for example, nurses, care staff and housekeepers, as they can often have a critical role to play in the control of *L. monocytogenes*. They are often those with responsibility for time and temperature controls at the point of service to the patient or resident.

Best practice – training and instruction

- competent food handlers are an integral part of an organisation's food safety culture. If those handling food understand the potential harm caused by *L.*

monocytogenes and how hazards may arise in relation to their work activity, they are more likely to follow safe procedures

- supervisory and management staff, including those responsible for meal service, may require a higher level of food safety training than those under their supervision
- the training should be appropriate to the individual job role and activity, covering awareness and specific procedures to be put in place specifically to control *L. monocytogenes*
- posters and leaflets can serve as useful reminders

Management of on-site retailers and caterers

Many larger health and social care organisations have food outlets on site. These may be commercial or charitable organisations. Such outlets may sell chilled RTE foods like pre-packed sandwiches and salads, which may be bought by or given to vulnerable patients or residents by their visitors.

The health or social care organisation should have procedures in place to help ensure that on-site retailers and caterers have suitable controls in place to reduce the risk of *L. monocytogenes*.

Best practice – agreements

It is best practice for contracts and lease agreements with on-site retailers and contract caterers to include food safety requirements in relation to *L. monocytogenes*, such as:

- appropriate procurement procedures in place for chilled RTE foods (see 'Procurement and purchasing')

- a comprehensive documented FSMS based on HACCP principles
- the need for appropriate training and instruction and supervision of staff

Monitoring

The health or social care organisations should have procedures in place for monitoring standards of the on-site retailers and caterers to ensure suitable controls are in place.

Best practice – monitoring

It is advised to monitor and have available:

- audits by a competent person
- copies of local authority inspection reports provided to a nominated person within the health or social care organisation
- serious or recurring food safety related complaints notified to the health or social care organisation
- copies of sampling results including *L. monocytogenes* analysis, where applicable
- review of ongoing complaints

Food brought in by patients or visitors

Patients or residents and their visitors may wish to bring in food for patients or residents from home or other places. Organisations should have a policy in place to manage this appropriately and provide advice on bringing in food for vulnerable patients or residents. These foods could be a risk if they have been prepared, handled, transported and/or stored inappropriately, which could present an increased risk for certain vulnerable groups. The policy should be documented and the information

made available to vulnerable patients or residents and their visitors, explaining the risks attached to bringing in RTE foods that require refrigeration. If personal food is stored, clear procedures should be established in relation to date labelling of food and how that food should be stored. There should be clear authority and responsibility given to staff that should regularly check stored foods and dispose of foods that are past the use-by date, or unlabelled foods.

Best practice – personal and gift food

- it is advised that chilled RTE food brought in by patients or visitors is labelled with the patient or resident's name and
- the date (and time) when food is brought into the facility and placed in refrigerated storage
- only bring chilled food where there is appropriate storage. If there is no chilled storage available, ensure the food is consumed within a short time frame
- Where gift or donated foods are accepted, encourage items that can be stored safely, such as foods with a best-before date that do not require refrigeration.

Personal refrigerators

Within some health and social care organisations, patients or residents have refrigerators solely for their own personal use, for example, at their bedside or within kitchenettes.

Best practice – personal refrigerators

Health and social care organisations should take reasonable steps to ensure that food stored does not present a health risk. For example:

- provide food safety information to residents and visitors

- carry out temperature and date checks and discard food where use by has expired in consultation with the patient or resident

Microbiological testing

A comprehensive FSMS based on HACCP principles should mean food is safe. The safety of food cannot be guaranteed by carrying out microbiological testing and the focus should be on effective controls being in place. However microbiological testing and swabbing the environment is a useful tool to validate and verify that the FSMS is effective to control *L. monocytogenes*.

Microbiological testing tools can include both food samples and environmental swabs. Food sampling can help verify that food being purchased or produced is meeting required specification and microbiological standards and can also validate the FSMS is effective in controlling *L. monocytogenes*. Whereas Environmental swabs can help to verify that cleaning and disinfection procedures are effective.

Regulation (EC) No 2073/2005 requires food business operators producing RTE foods that may present a risk from *Listeria monocytogenes* to undertake environmental sampling of processing areas and equipment as part of their sampling programme. Environmental swabs can be sent to a laboratory to specifically test for *Listeria*. Rapid methods, such as protein swabs and rapid testing kits, can also be useful to verify general cleaning and disinfection regimes.

An organisation should take into consideration several factors when deciding whether microbiological testing is appropriate:

- size of organisation – number of sites or beds
- vulnerable groups – nature and number of vulnerable patients or residents
- extent and nature of food prepared and purchased
- sampling and testing carried out by suppliers

It is not expected that sampling and microbiological testing will be appropriate for all settings, for example an individual care home or smaller organisations. Medium and larger organisations providing food for vulnerable groups may wish to consider whether microbiological sampling and testing could provide additional assurances that the necessary controls are effective.

If an organisation decides it is appropriate to undertake sampling, the sampling plan should be proportionate to the risk, size and nature of the organisation and undertaken using a risk-based approach. Advice for sampling plans is provided in Annex D.

Co-ordination of sampling programmes

Where sampling is undertaken to check the microbiological standard of supplied products, to avoid duplication or omission, a coordinated approach to sampling is recommended. An example of where this might be useful is where several sites or health and social care organisations are supplied with the same product from a common supplier.

Food safety incidents

If there is reason to believe that food which is being procured, prepared, or distributed within health and social care settings may be harmful to health or does not meet legal requirements, the local authority must be notified.

The health or social care organisation should consider what action is needed and work with the local authority who will advise of any further action. In determining an appropriate response to an incident, the FBO must consider the relevant legislative requirements relating to Listeria monocytogenes. They must also consider Article 14 of Regulation (EC) No 178/2002, which requires consideration of the specific health sensitivities of the groups likely to consume the food.

If you believe food you have supplied is either harmful to health, unfit for people to eat or does not meet legal requirements, you must comply with Article 19 of Regulation (EC) No. 178/2002 and:

- immediately withdraw or recall the food from the market
- tell your competent authority (local authority or port health authority), which will advise you of any further action you might need to take

If you believe unsafe food has reached consumers, tell the FSA incidents team. A recall notice may need to be issued.

Traceability requirements are set out in Article 18 of Regulation (EC) No. 178/2002. Food business operators (FBOs) must be able to identify the suppliers they receive food from and the customers they supply food to.

Annex A: List of key legislation

Legislation relevant to this guidance includes:

General principles and requirements of food law, set out in:

Assimilated Regulation (EC) No 178/2002 for Great Britain, and

Regulation (EC) No 178/2002 (external website) for Northern Ireland, principally:

- Article 14 'Food safety requirements', including:
    - food shall not be placed on the market if it is unsafe, meaning it is injurious to health or unfit for human consumption
    - in determining whether food is unsafe, regard should be had to the particular health sensitivities of a specific category of consumers, where the food is intended for those consumers
- Article 17 'Responsibilities', including:
    - FBOs must ensure that food meets the legal requirement at all stages of production, processing and distribution, and must check that the requirements are met
- Article 18 'Traceability', including:
    - the traceability of food and any substance intended to be added to food, shall be established at all stages of production, processing and distribution
    - FBOs shall be able to identify any person that supplied them with food or ingredients, and have in place systems and procedures to provide this information to the competent authorities when requested
- Article 19 'Responsibilities for food: food business operators', including:

- if a FBO believes a food they handled is unsafe, they must immediately withdraw it from the market and notify the competent authorities. If the product reached consumers, they must provide accurate information and carry out a recall if needed to protect public health
- retailers and distributors must withdraw unsafe products within the scope of their activities and help ensure food safety by sharing traceability information and cooperating with producers, manufacturers, and the authorities
- FBOs must immediately inform the competent authorities if they believe a food they placed on the market may be injurious to human health, explain what actions they have taken, and must not discourage anyone from cooperating with the authorities
- all FBOs must cooperate with competent authorities on action taken to prevent or reduce risks from foods they supply

Food safety and hygiene requirements, set out in:

Assimilated Regulation (EC) No 852/2004 for Great Britain, and

Regulation (EC) No 852/2004 (external website) for Northern Ireland, principally:

- Article 4 ‘General and specific hygiene requirements’
- Article 5 ‘Hazard analysis and critical control points’
- Article 6 ‘Official controls, registration and approval’
- Annex II ‘General hygiene requirements for all food business operators’, including Chapter XII ‘Training’

Food Safety and Hygiene (England) Regulations 2013, Food Hygiene (Wales) Regulations 2006, and Food Hygiene Regulations (Northern Ireland) 2006, including:

a. Schedule 4 ‘Temperature control requirements’

Microbiological criteria for food (mainly applicable to FBOs involved in the production, manufacture and supply of foods including those supplying to health and social care settings), set out in:

Assimilated Regulation (EC) No 2073/2005 for Great Britain, and

Commission Regulation (EC) No 2073/2005 (external website) for Northern Ireland, principally:

- Article 3 ‘General requirements’
- Article 4 ‘Testing against criteria’
- Article 5 ‘Specific rules for testing and sampling’
- Article 7 ‘Unsatisfactory results’
- Annex I ‘Microbiological criteria for foodstuffs’, Chapter 1, Row 1.2: RTE foods able to support the growth of *L. monocytogenes* (other than those intended for infants and for special medical purposes), must comply with the following criteria:

(a) not exceed 100cfu/g during their shelf life when placed on the market; or

(b) if this cannot be demonstrated, be absent in 25g before the food has left the immediate control of the FBO

* From 1 July 2026 an amendment to Criterion 1.2b applies in the EU and other jurisdictions applying EU law (including Northern Ireland), which further applies the limit of not detected in 25g to products during their shelf life.

Annex B: Glossary of definitions

The following definitions are specific to this guidance:

Bacteraemia – the presence of bacteria in the bloodstream

Best before date – a food product label date used by the manufacturer to indicate the date before which the food will be at highest quality

Biofilm – a complex matrix composed of microorganisms which stick together and create a self-produced protective matrix making the microorganisms more difficult to get rid of

Calibration - the adjustment and standardisation of the accuracy of measuring and test instruments, usually carried out by comparison to a certified reference or standard

CFU – colony forming units

Cold chain – a food supply chain which uses refrigeration or freezing to preserve perishable foods

Competent authority – the government authority or official body authorised by the government that is responsible for ensuring compliance with food safety requirements and/or for the organisation of official controls including enforcement

Competent person – a person with sufficient training, experience and knowledge to support

Food safety management system (FSMS) – procedures, practices and conditions, including preventative control measures and assurance activities, based on HACCP principles to establish and maintain food safety and hygiene standards

Hazard – a biological, chemical or physical agent in food with the potential to cause an adverse health effect

Hazard Analysis and Critical Control Points (HACCP) – a system that identifies and analyses hazards, and establishes and monitors critical control points to ensure food safety

Immunocompromised – having a weakened immune system caused by certain conditions or medical treatments

Immunosuppressive or cytotoxic treatment – the inhibition of the immune response, usually deliberately by administering drugs to prevent rejection of transplanted organs, but sometimes resulting from disease

Incubation time – the period between infection/ingestion and the first symptoms of illness

ISO – International Standards Organisation

an organisation to meet the requirements of food safety law

Contact time – the period that a disinfectant must remain on a surface to effectively eliminate microorganisms

Contamination – the presence or introduction of a biological, physical or chemical hazard in a food or food environment that may compromise the safety of the food

Control – (noun) the state where correct procedures are being followed and any established criteria are being met; (verb) to take all necessary actions to ensure and maintain compliance with established criteria and procedures

Control measure – any action or activity used to prevent or eliminate a food safety hazard or reduce it to an acceptable level

Corrective action – any action taken when a deviation occurs to re-establish control, segregate and determine the disposition of the affected product, if any, and prevent or minimize reoccurrence of the deviation

Critical control point (CCP) – a step where a control measure or measures can be applied within the HACCP system and is essential to prevent or eliminate a food safety hazard or reduce it to an acceptable level

Critical limit – a criterion, observable or measurable, relating to a control measure at a CCP which separates acceptability from

Meningitis – a serious, sometimes fatal illness in which a viral or bacterial infection inflames the meninges, causing symptoms such as severe headaches, vomiting, stiff neck, and high fever

Monitoring – a pre-arranged programme of checks of critical and/or legal limits to check whether control measures are failing and which determine the need to take corrective actions

Pathogen – A microorganism that may cause illness

Raw foods – raw meat and any raw food that has not been cooked, including fruit and vegetables and any ingredient that is a potential source of L. monocytogenes

Ready-to-eat foods (RTE) – food intended by the producer or manufacturer for direct human consumption without the need for any additional cooking or processing that is effective to eliminate or reduce microorganisms of concern to an acceptable level

Sanitisers – products that combine a disinfectant and a detergent in a single product. For effective disinfection they must be used twice: first to clean and then again to disinfect

Septicaemia – a disease caused by toxic microorganisms in the bloodstream

Shelf life – the period during which a product maintains its microbiological safety and organoleptic qualities under specific storage conditions

unacceptability of the food (for example, storage temperature)

Cross-contamination – the transfer of hazards, for example microorganisms, between foods, , or from surfaces, equipment or personnel onto foods

Detergents – products used for general cleaning to dissolve grease and remove dirt or debris but do not have disinfectant properties

Dilution rate – the ratio of solute (substance to be diluted) to solvent (for example, water) necessary so that when combined the solute concentration is acceptable for purpose (indicated in manufacturers instructions)

Disinfectants – products capable of reducing the levels of specific microorganisms when applied to visibly clean surfaces at the specified dilutions and for the recommended contact time

Foodborne illness – disease caused by microorganisms (or their toxins) which have contaminated food

Food handler – any person who directly handles food or drink (packaged or unpackaged), or equipment, utensils or surfaces that encounter food, and is therefore expected to comply with food hygiene requirements

Supervision – the process of overseeing the performing of tasks and procedures to ensure that they are carried out effectively and that the required standards are met

Suppliers – organisations that provide food to health and social care organisations, including manufacturers, distributors, importers, wholesale and retailers

Use-by date – the required form of date mark for those foods which are highly perishable from a microbiological point of view and which are in consequence likely after a relatively short period to present a risk of food poisoning, and so relates to the safety of the food

Validation – collecting and evaluating scientific and technical evidence to determine whether the HACCP plan, when properly implemented, can control the food hazard to a desired outcome

Verification – checking or confirming that the HACCP–based procedures are achieving the intended effect, meaning food safety hazards are under control. Provides confirmation that the business is doing what it planned to do

Vulnerable groups – patients or residents who are immunocompromised in some way

Annex C: Methods of supplier assessment – quick reference guide

It may be useful for health and social care organisations to review available guidance when undertaking supplier assessments.

Method of assessment	Organisation type	Assessment criteria
Independent third-party certification	Medium and large organisations, for example, national and regional purchasing organisations, care groups, contract caterers and onsite retailers to health and social care organisations.	• independent third-party certification means food suppliers are audited, assessed and certified for food safety by an independent auditing body • the audit and assessment should be carried out against a recognised audit standard, which should include *L. monocytogenes* specific requirements • third party assessments and audits should be carried out by suitably qualified and experienced food safety auditors • preferably the third-party organisations and/or audit standard should be UKAS (UK Accreditation Service) accredited • a system should be in place to ensure that certification is valid for the products supplied and maintained up to date • suppliers that fail their third-party assessment or whose certification lapses should not be used until the

		supplier has been re-assessed and found to be satisfactory

Method of assessment	**Organisation type**	**Assessment criteria**
Requests for information and documentation	Small and medium size organisations where a third-party audit programme is not in place	• check copies of relevant documentation from suppliers, for example: o copy of local authority inspection reports o copy of documentation for approval under Regulation 853/2004, where applicable o FSMS and HACCP plans o copy of food safety certification (where appropriate), such as BRC (British Retail Consortium), SALSA (Safe and Local Supplier Approval) o food hygiene rating, where applicable o sampling plan and sampling results, where applicable • documentation should be assessed by competent personnel to ensure the content is satisfactory • if the findings of the information or documentation request are unsatisfactory or if documentation is not supplied, the supplier should not

		be used until a satisfactory response is provided • documentation should be kept up to date and reassessed at least annually
Questionnaire	Small and medium size organisations where a third-party audit programme is not in place	• a food safety questionnaire may be used to assess whether adequate food safety systems are in place • the response provided by the questionnaire should be assessed by a competent person • questionnaires may be followed up by visits to the supplier premises by the procurement, health or social care organisation • it is advisable that the food safety questionnaire includes specific questions on arrangements to control L. monocytogenes • if the response provided by the questionnaire is unsatisfactory or if the questionnaire is not completed, the supplier should not be used until a satisfactory response is provided • questionnaires should be completed on a regular basis

Method of assessment	**Organisation type**	**Assessment criteria**

Site visits	Small and medium size organisations where a third-party audit programme is not in place	• site visits are often referred to as second party audits • site visits should be undertaken by a competent person in terms of experience and knowledge, preferably with qualifications in food safety to a minimum of Level 4 Award in Food Safety • the results of the visit should be documented • if standards during the site visit are found to be unsatisfactory, the supplier should not be used until satisfactory standards are demonstrated during a re-visit
Risk assessment (Supermarkets or smaller retailers)	Small organisations only	local purchases from supermarkets and smaller retailers for chilled RTE foods should be minimised, particularly where a third-party audit programme or nominated supplier list is in place. Where local purchases are made: • purchase should be limited to reputable retailers that are likely to have comprehensive procedures in place • check the food hygiene rating • during purchase or delivery, basic checks should be carried out for:

		○ dates codes – buy product as close as possible to date of production ○ temperature of chilled cabinet (for example, if a display is provided) ○ cleanliness Appropriate time and temperature controls need to be in place for the transfer of chilled RTE foods. Transport foods promptly, for example, home delivery in a chilled vehicle or by use of cold packs or containers.

Annex D: Advice for sampling plans

Sampling and testing frequency

Health and social care organisations should decide sampling and testing frequencies as part of their FSMS and HACCP procedures. Frequency will depend on:

- size of organisation
- nature and number of vulnerable patients or residents
- nature and extent of food production and its intended use
- the results of previous sampling

Food and surface sampling

Foods targeted for sampling should concentrate on:

- food destined for the most vulnerable patients or residents
- foods that may present particular risks
- food sampled should be representative, that is, characteristic of the batch from which it is sampled
- food at different stages including point of service

Surfaces targeted for swabbing should concentrate on:

- surfaces used in the preparation of chilled RTE foods, like work surfaces and sinks
- food contact equipment used for preparation of chilled RTE foods, such as chopping boards and knife blades

Sampling and swabbing procedures

- food samples and environmental swabs for laboratory examination should be taken using a sampling technique so that the sample or swab is not contaminated by the sampling process, for example hands or dirty sampling equipment
- swabs should not be taken of surfaces directly following cleaning, unless this is to determine the effectiveness of cleaning
- sterile sampling containers should be used
- the samples and swabs should be stored at a temperature and for a time that will not lead to further growth

Laboratory selection and testing methods

Health and social care organisations must have confidence that the laboratory they select to undertake the examination of food for L. *monocytogenes*/*Listeria* spp. is competent. The laboratory should have the appropriate expertise in selecting and applying appropriate analytical methods. Using an accredited laboratory can provide the appropriate assurances.

Microbiological Criteria Regulations (2073/2005) provide reference methods for L. *monocytogenes*:

Analytical reference method EN/ISO 11290-1 for detection

Analytical reference method EN/ISO 11290-2 for enumeration

Methods other than the analytical reference methods can be used, provided alternative methods deliver equivalent results and the methods are validated appropriately.

Performance of analytical methods can vary, and some are more sensitive than others. It is important to check with the laboratory to ensure the correct testing methods are used, so that results are comprehensive and meaningful.

Samples shall be taken from processing areas and equipment used in food production, when such sampling is necessary for ensuring that the criteria are met. In that sampling the ISO standard 18593 shall be used as a reference method.

Corrective actions

Results should be reviewed promptly. If targets are exceeded, corrective action must be taken without delay.

The purpose of corrective action is to:

- determine the causes of the unsatisfactory results
- determine what actions are required to prevent a recurrence
- put in place interim measures to ensure food safety

Corrective actions should ideally be predetermined within the FSMS.

Actions will depend on the levels, extent and nature of the food contaminated, and may include for example:

- contact suppliers
- withdraw or recall batch (if possible)
- contact local authority
- contact third party auditors, where appropriate
- review and where necessary improve:
    - cold chain
    - shelf life
    - cleaning and disinfection
    - personal hygiene

    - cross-contamination

- modifications to FSMS and HACCP
- conduct additional sampling, where appropriate

Corrective actions should be recorded.

Trends in test results should be analysed as they may reveal unacceptable developments and enable the health or social care organisation to take corrective actions.

Additional information

There is a wide range of practical advice and guidance documents relating to sampling that have been produced by some industry sectors.

EU guidelines on sampling the food processing area and equipment for the detection of *Listeria monocytogenes* can be accessed at: EURL Lm Technical Guidance Document on sampling the food processing area and equipment for the detection of Listeria monocytogenes (external website).

Additional advice can be sought from the local authority, food examiner and/or Official Control laboratory.

Annex E: Additional resources

- UK Health Security Agency guidance on examining food, water and environmental samples in healthcare settings (2024)
- UK Health Security Agency guidance for assessing the microbiological safety of ready-to-eat foods (2024)
- Introduction to MyHACCP | MyHACCP
- https://www.chilledfood.org/listeria-guidance-2026-2/
- Guidance Document on Listeria monocytogenes shelf-life studies for ready-to-eat foods, under Regulation (EC) No 2073/2005 of 15 November 2005 on microbiological criteria for foodstuffs (external website)
- Shelf-life guidance 2025 | Food Standards Scotland

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