NHS Health Scotland

Evaluation of the implementation and impact of the Healthcare Retail Standard in Scottish hospitals and other NHS facilities in 2017

Deborah Shipton, NHS Health Scotland

January 2019

This resource may also be made available on request in the following formats:

0131 314 5300

nhs.healthscotland-alternativeformats@nhs.net

Published by NHS Health Scotland

1 South Gyle Crescent
Edinburgh EH12 9EB

NHS Health Scotland is a WHO Collaborating Centre for Health Promotion and Public Health Development.

Contents

Summary

Plain English summary

What is the Healthcare Retail Standard?

The Healthcare Retail Standard (HRS) is part of a vision for the NHS in Scotland to be a national health-promoting health service. As part of this vision the NHS in Scotland aims to make the **healthier** choice the **easier** choice for all those working in, staying in and visiting hospitals and other NHS buildings in Scotland.

The HRS sets out rules that all shops selling food and drink in NHS buildings in Scotland must adhere to. These rules state that half of all food and 70% of all drinks provided in shops must comply with the HRS criteria. Food and drink that complies with this criteria is the type of food and drink that we should be eating more of – i.e. lower in fat, sugar and salt. Food and drink that doesn't comply with the HRS criteria are those that we need to eat less of – such as chocolate, cakes and sugary drinks as well as savoury food high in fat, sugar or salt. The HRS rules also state that only products that comply with the HRS criteria can be promoted in the shop.

An evaluation of the HRS was set up to find out if the shops were adhering to the HRS and if it worked. The evaluation asked six questions:

1. Was the NHS helping shops to comply with the HRS and were shops complying with the HRS?
2. Have there been any important differences in how shops complied with the HRS?
3. Since the HRS was introduced has there been a change in what people are buying?
4. Since the HRS was introduced has there been a change in the cost of the food and drink sold in hospital shops?
5. Since the HRS was introduced has there been a change in where staff, visitors and patients shop because of changes in the price or type of food and drink sold?
6. How did the HRS impact on the profitably of shops in NHS facilities?

The evaluation answered these six questions by looking at the till reports from several shops, asked customers their views, asked shop managers their views, observed the changes made in several shops as a result of the HRS and asked the NHS staff how they supported shops to implement the HRS.

Did the Healthcare Retail Standard work?

Yes, most shops were able to comply with the HRS and it did result in more healthy products being bought. Customers also noticed an increase in healthy products being stocked.

A total of 97% of outlets complied with the rules of the HRS by the end of May 2017. The national teams responsible for supporting shops to comply spent a lot of time getting to know managers and regional managers of the shops, providing information and discussing ways of complying with the HRS.

At first there was a limited range of products available that complied with the criteria. Over time suppliers began to reduce the sugar, fat and salt added to foods, which increased the range of products that complied with the HRS. Some managers and shop staff were more enthusiastic than others about the HRS.

After the HRS was introduced, people were buying more of the products that met the HRS criteria and buying less of the products that did not meet the criteria. The HRS did not appear to affect the cost of food, and didn't appear to drive certain groups (such as those on a low income) away from the shops.

The overall sales of products did fall, at least at the beginning of the implementation of HRS. Managers said this was affecting their profits. However, over time overall sales did start to increase and managers were still keen to continue to operate in NHS buildings in Scotland.

Introducing the HRS was a challenge for the shops and required lots of support. Learning from this process may be applicable to similar initiatives in other places, such as leisure centres, care homes and universities.

What could have been done better?

The team responsible for bringing in the HRS could have done more to tell staff, visitors and patients using the shops about the HRS – for example, why it was being brought in and what changes they would see. This would have helped build support for the HRS from customers and helped the public to see how shops that sell food and drink can make it easier or harder for them to make healthy choices.

Some practices that are not allowed by the HRS – such as promoting products not meeting the criteria – started to be seen in shops several months after the HRS was brought in. More checks need to be done to make sure that all shops continue to comply with the HRS in the longer term. This could involve unofficial checks, such as by NHS staff responsible for ensuring the HRS is compiled with, as well as checks by an auditing body.[1]

[1] Shops will now be audited every 6 months to check they are still complying with the HRS.

Key findings – summary

Q1: Was the HRS implemented as intended?

Yes, all outlets were able to comply with the HRS. Outlets initially found it difficult to source enough HRS compliant products but suppliers reformulated their products in response, resulting in a wider range of HRS compliant products available.

Q2: Were there variations in implementation?

Yes, there was variation across outlets. Some retailers were supportive and committed to achieving compliance. Having a committed retailer was important for demonstrating that the HRS compliance could be achieved and ironing out any issues with the criteria.

Q3: Was there a change in the purchasing behaviour of customers?

Yes, more HRS compliant products and fewer non-compliant products were bought.

Q4: Did the cost of the food and drink change?

The overall cost of food and drink provided didn't change notably as a result of HRS implementation. Before it was introduced, non-compliant products were cheaper than compliant products. In Scotland, over time, the price of non-compliant products rose slightly in contrast to compliant products which stayed the same, such that the price of compliant and non-compliant products were more comparable after the introduction of the HRS. In England, non-compliant products remained notably cheaper than compliant products.

Q5: Did the customer base of the outlets change, particularly those on a low income?

There was no evidence that the implementation of the HRS resulted in change in the customers using the shops – people living on a lower income continued to use the shops.

Q6: What was the impact on the outlet of complying with the HRS?

Overall sales fell immediately after HRS implementation. This was because sales of non-compliant products decreased more than the increase in sales of compliant products. Sales have now started to increase but have not yet reached the pre-HRS levels.

Key findings

Q1: Was the HRS implemented as intended and in a way likely to impact on purchasing behaviour?

High level of compliance with the HRS

The majority of outlets were compliant within a few months of the deadline.

The HRS requires that at least 50% of food lines provided are HRS compliant. Most outlets complied by significantly reducing the number of non-compliant food[2] lines. Outlets did increase the number of compliant food lines but the increase in compliant lines was smaller than the decrease in non-compliant lines.

Successful implementation process

Generally, the implementation process, at a national level and within Health Boards, was sufficient to reach initial compliance.

A similar initiative[3] in NHS Scotland meant that the HRS could align with existing processes within the Health Board. Conversely, the similarity between the HRS and other initiatives in Scotland[3] and England[4] did also provide some confusion.

After several months there was slippage in compliance in several outlets, with some non-compliant product being promoted.

The role of the Health Board lead, who was generally not crucial for the initial implementation, will need to be strengthened to ensure ongoing compliance. Further engagement will be needed with Health Board leads.

[2] Food here refers to all edible products, such as sandwiches and fruit as well as snacks such as crisps and sweets.
[3] The healthyliving award plus - a mandatory standard that catering outlets in NHS Scotland must comply with.
[4] www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19

Limited number of compliant lines available from suppliers

Most outlets struggled to find suppliers with a sufficient range of HRS compliant food lines to increase their HRS compliant range. Most outlets provided packaged rather than fresh products.

No notable increase in the use of promotions on HRS compliant lines

Under the HRS, only compliant products can be promoted. Immediately after the deadline the promotion of non-compliant lines did stop. However, the use of promotions on HRS compliant food[5] did not appear to increase.

[5] This was based on the promotions on fruit and salad only. It is possible that other products were being promoted.

Q2: Was there variation in the implementation and did it have a positive or negative effect on purchasing behaviour?

There was variation in:

- **The level of change required**. For most outlets, significant changes in food lines were needed to enable 50% of food lines to be HRS compliant. For all the national providers the restrictions on the use of promotions of non-compliant food and drink lines marked a significant change from their usual practice. However, all outlets eventually complied with the HRS. The timeliness of achieving compliance was not related to the extent of changes required. The timeliness was more related to the outlets support for the HRS, in that the more supportive retailers generally achieved compliance earlier than those less supportive of the HRS.
- **Support from outlets.** Some retailers were more supportive of the HRS, began the changes needed to comply with the HRS earlier and, in many cases, surpassed the minimum requirements of the HRS. The engaged retailers worked effectively with the national implementation team and informed the overall implementation.
- **Predicted impact of HRS on sales.** Some outlet managers were very negative about the impact the HRS would have on sales, and job security. After implementation, most managers were pleasantly surprised how smooth the implementation had been.

Q3: Was there a change in the purchasing behaviour of customers?

Yes. In Scotland, the total amount of sales of HRS compliant lines increased markedly after the HRS implementation deadline.

In Scotland, the sales of non-compliant lines also decreased markedly. The decrease in the sales of non-compliant lines was much larger than the increase in sales of compliant lines.

It was not possible to determine if the provision criteria or the promotion criteria of the HRS, or a combination of the two, was responsible for the change in purchasing behaviour. Retail managers felt that both had an impact on customer purchasing behaviour.

Change in shopping patterns was incremental. Although people started buying healthier products, the findings from the survey of customers leaving outlets suggest that people still buy within categories. For example, people aren't swapping from chocolate bars to fruit. There was also no evidence of a notable shift to the provision of fresh produce.

Q4: Did the cost of the food and drink change?

There was no evidence of a major change in overall cost of food and drink because of the HRS.[6]

Before the HRS was introduced, non-compliant products were notably cheaper than compliant products. In Scotland, over time the price of non-compliant products rose slightly in contrast to compliant products which stayed the same. The result was that after the introduction of the HRS the price of compliant and non-compliant products were comparable. This may be because the HRS drove the need for more HRS compliant products of a comparable price.

In England non-compliant products remained notably cheaper than compliant products.

There was no change in the customers' attitudes to whether the shops offered value for money before and after the HRS was introduced, suggesting customers didn't feel any noticeable cost change.

[6] This section draws on the following sources: Data were available from (1) the survey of customers exiting retail outlets in NHS Scotland facilities; (2) till reports of the average costs of a unit of compliant and non-compliant food and drink lines; and (3) an observational study of the average costs of a range of products in 13 static outlets before and after the HRS implementation deadline.

Q5: Did customers change where they shopped as a result of price changes and or stock changes?

The evaluation explored if the HRS affected the types of customers who used the hospital shops, specifically in relation to people's income.

There was no evidence that the implementation of the HRS resulted in differences in the type of customer using the hospital outlets.[7]

There was a mixed response to the HRS by customers. Some people reported that more 'healthy' food was available while some retail managers received complaints from customers that they could no longer find a particular product. Although the outlets did need to make significant changes to comply with the HRS, customers didn't report noticing large changes in the outlets.

Interestingly, although the outlets did provide more healthy options there was no change in the numbers of customers reporting that the outlet catered for their needs. This suggests that the majority of customers using these outlets are not currently looking for more healthy products.

[7] We were not able to say if the numbers of customers using the outlets changed.

Q6: What was the impact of complying with the HRS on the outlets, including economic sustainability?

Overall sales fell immediately after the implementation because the fall in non-compliant sales was larger than the increase in compliant sales. Given the large reductions in the range of non-compliant products available in outlets, without a similar increase in the compliant product range, it is perhaps not surprising that sales were affected in the way that they were.

Over time, sales and profits did begin to increase but sales have not returned to that in the pre-HRS period.[8]

The HRS was introduced to NHS Boards and outlets 17 months before the deadline. Managers reported that this long lead in time allowed them to experiment with different products lines to more effectively comply with the HRS.

Retail managers of national retailers reported that their company continued to be interested in expanding into the Scottish NHS market, suggesting that outlets in NHS facilities remain commercially attractive.

[8] Approximately 18 months after the HRS implementation deadline.

Learning for other settings

This sections draws on the findings of all the study components to identify lessons that can inform the implementation of similar initiatives in other settings.

Summary

1. Bold measures, like the HRS, can be successfully implemented.
2. Key players need **time** to successfully implement the changes, and the implementation team will need **resources** to adequately support the key players.
3. Given the ability of the system to self-correct – i.e. resist change and find other means to maintain the status quo – the success of any initiative to improve the diet of Scotland will need to be **part of something bigger** in order to successfully affect change.

Time and resources

A **long lead-in time** between introducing the initiative and the deadline for implementation was needed to allow the outlet to make the changes incrementally, to source new products and to experiment with their product offer.

Reporting and auditing mechanisms also needed time to be set up. Given the reduced public sector spend it will be particularly important to allow the publically funded bodies time to introduce new reporting and compliance mechanisms if the introduction of an initiative is an addition to normal workloads.

Get to know your setting. The Healthy Living Programme team, with their commercial background, were crucial in providing commercially relevant support that the health partners could not. They helped identify what was feasible to implement and where the criteria needed to be relaxed or could be strengthened to ensure it was workable while maintaining nutritionally impact. The structure of the market will also affect the implementation process – with the HRS, three retailers operated 80% of the retail outlets in hospitals which made communicating with retailers more

straightforward than if the sector was made up of a larger number of retailers. In a different setting it will be important to identify if there are a few big players or a large number of independent retailers.

As health policy moves into other spheres – retail, transport, housing, etc. – different **relationships** will need to be established and those implementing health policy will need to become familiar with the cultures in different settings. Developing functional working relationships will take time. Where possible find **allies**. The HRS national implementation team dedicated significant time to building relationships with retailers and obtained the support of a major retailer who supported the ethos of what the HRS is trying to achieve. Having this support was instrumental in demonstrating that the HRS could be implemented.

For initiatives that need to be implemented locally providing **support to local implementers** is resource intensive but crucial. Local implementers could be local retailers or publically funded bodies responsible for ensuring implementation within their area, such as Health Boards or local authorities. What new skills are needed to implement the initiative? What relationships will they need to develop? It will be important to appreciate that every setting is a crowded landscape of processes, initiatives and targets, and that any new piece of work will need to be distinguished from other similar initiatives.

Don’t assume that those responsible for ensuring an initiative is implemented will be supportive of the principles of it. Not all NHS staff were supportive of the HRS.

Part of something bigger

The start of a journey

Scotland, like many other countries, is at the very early stages of shifting the food environment to be more health promoting. The HRS is one of the few non-voluntary national-level interventions focused on the food environment. Implementing the HRS identified the changes that need to take place in the system, and initiated these changes in the hospital setting (**Box 1**).

Box 1: Changes needed in the system to support a more health-promoting commercial food environment

- The production of more healthy food and drink products.
- Increase in the skills, knowledge and confidence of retail managers in dealing with nutritional product information.
- Experimenting with the food and drink offers to maintain sales.
- Acceptance and support from the retail profession that there is a need to improve the commercial food environment.

Other initiatives that follow the HRS will encounter their own resistance but will ultimately benefit from initiatives that have been implemented before them.

What the HRS failed to address was customer support. The implementation process did not raise awareness of the HRS with customers or why it was being introduced. This was a missed opportunity to build support for the HRS and encourage an expectation in the population that the food environment should work for us.

Incremental change

The HRS was successfully implemented. The provision of the food we need to eat less of was reduced and was less visible, and the food we need to eat more of was more available and slightly better promoted. However, only incremental changes in shopping patterns were seen – people tended to still buy within the same food category – they didn't shift from buying a chocolate snack to a fruit snack. This likely

reflects ingrained eating and shopping habits. To achieve the changes in diet that are needed in Scotland, such regulatory changes in the food environment will need to be in conjunction with system change at all levels.

Introduction

The NHS in Scotland developed a vision for a national health-promoting health service – a cultural transformation where every contact is a health improvement opportunity. As part of that, NHS Scotland has been working to make the healthier choice the easier choice for those working in, staying in and visiting its premises.

There are over a hundred[9] hospital facilities in Scotland, housing a number of catering and retail outlets offering food and drink to staff, visitors and patients. From 2012, all catering outlets were required comply with the healthyliving award (HLA) plus (HLA),[10] which provides a minimum requirement for the provision and promotion of food and drink. In 2017, all retail outlets in NHS Scotland facilities were required to comply with the Healthcare Retail Standard (HRS),[11] which also sets a minimum requirement for the provision and promotion of food and drink.

There are 70 shops[12] and 39 trolley[13] services in NHS facilities in Scotland. They are run by a mixture of retailers, including commercial retailers that run several outlets across Scotland, small voluntary-run outlets, NHS-run outlets and a national third sector retailer that operates commercially and provides opportunities for volunteers and returns a contribution of profits to the NHS.

The retail outlet market in NHS facilities is increasingly competitive, with outlets competing for business leases. As part of the lease conditions some retailers are required to operate a ward trolley service. Trolley services contribute to a very small proportion of sales and are generally seen more as a service than having a commercial role.

[9] www.scotlanddirectory.info/category/hospitals.html
[10] www.healthylivingaward.co.uk/index
[11] www.gov.scot/Publications/2016/07/2024
[12] some offering both retail and catering
[13] Some outlets operated a trolley service, in which a trolley was filled with a selection of the food and drink sold in the outlets and wheeled around the wards by an outlet employee or volunteer.

Healthcare Retail Standard

The HRS applies to all static outlets (shops) and trolleys.

To comply with HRS 50% of food items (and 70% of drink items) in the store/trolley must meet the defined criteria for a healthy product. In addition, products also need to meet criteria to be able to be promoted, including as part of meal deals.

The criteria for healthier products was designed around supporting the Scottish Dietary Goals[14] and takes account of the fat, sugar and salt content of products, particularly the food and drink we currently consume too much of.

HRS implementation process

Figure 1 identifies the key stages of the implementation process. In brief,

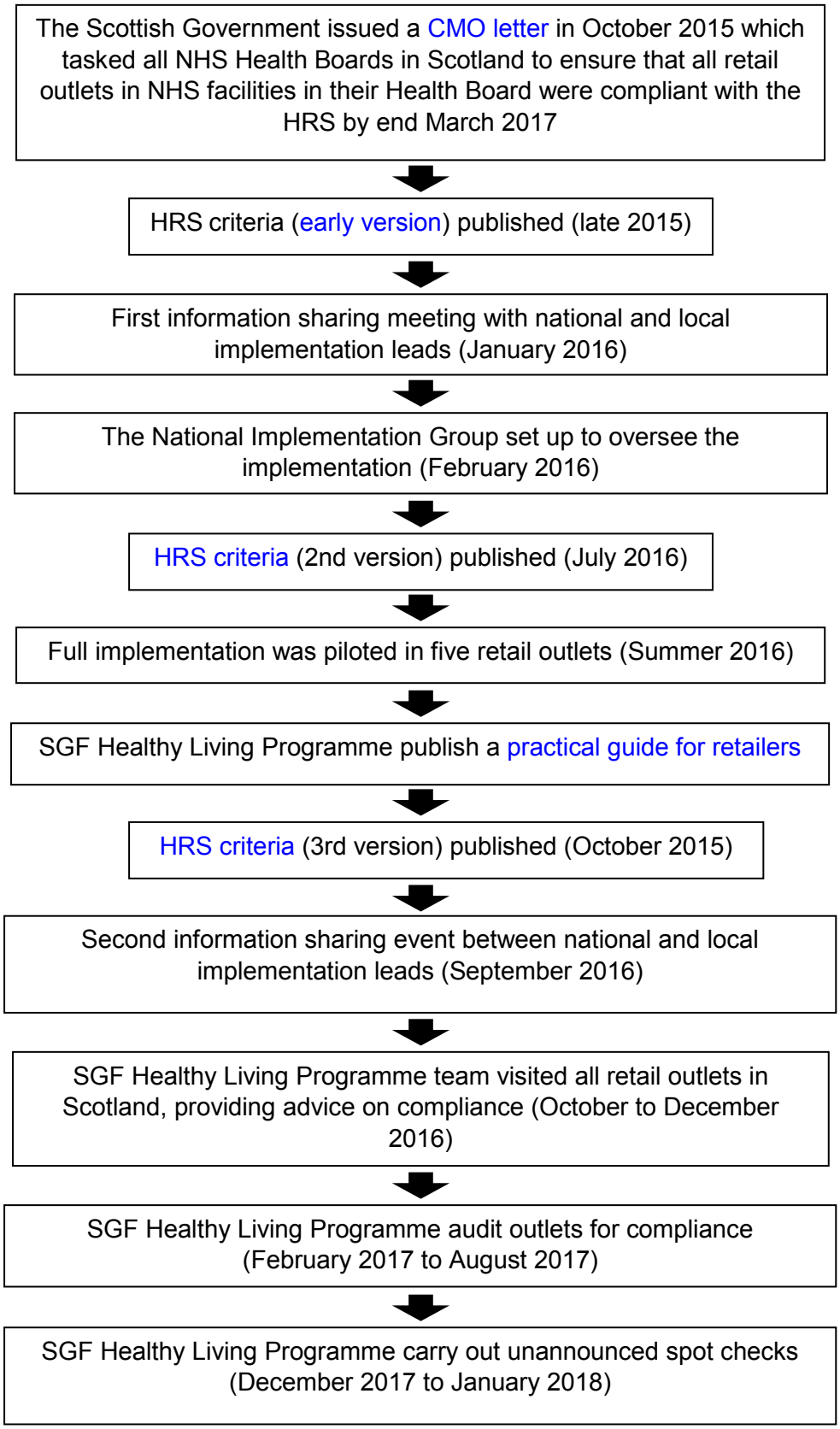
- In late 2015, all Health Boards in Scotland were tasked with implementing the HRS, which meant ensuring that all retail premises were compliant by 31 March 2017.
- The first version of the criteria was published in 2015. Revised versions were published in July and October 2016.
- A series of three information sharing events between national implementation leads[15] and local implementation leads (i.e. NHS Health Board staff) took place between January 2016 and January 2017.
- The Scottish Grocer's Federation (SGF) Healthy Living Programme (HLP) provided support to retail outlets, publishing a guide for retailers and visiting all outlets prior to the assessments.
- Beginning in February 2017, SGF HLP began to audit retail outlets for compliance with the HRS.
- Full implementation was piloted in five retail outlets (Summer 2016).
- Nine months after the implementation deadline, SGF HLP carried out unannounced spot checks in a number of outlets.

[14] https://www.gov.scot/Topics/Health/Healthy-Living/Food-Health/DietaryGoalsScot
[15] National implementation leads included members of the Scottish Government diet policy team and NHS Health Facilities Scotland

The letter from the Chief Medical Officer instructing Health Boards to bring in the HRS stated that the HRS was to be included in the contract of all retail outlets when they were next negotiated. Therefore, although the deadline for compliance was given as 31 March 2017, retailers were not contractually obliged to comply with the HRS until their current contract was due to be renegotiated. However, all retailers did work towards the 31 March 2017 deadline regardless of whether or not the HRS was included in their contract by this date.

The ultimate sanction for a retailer not-complying with the HRS was to have their contract withdrawn.

Figure 1: HRS implementation process



Evaluation objectives

NHS Health Scotland were tasked with evaluating the impact of the HRS. Six evaluation questions were identified (**Figure 2**), exploring both implementation and impact. Additionally, the evaluation was tasked with identifying learning for other settings.

Figure 2: Evaluation questions

Was the HRS implemented successfully?

1. Was the HRS being implemented as intended and in a way likely to impact on purchasing behaviour?
2. Was there variation in the implementation (at outlet and Health Board level) and did it have a positive or negative effect on purchasing behaviour?

Did the HRS have an impact?

3. Was there a change in the purchasing behaviour of customers?
4. Did the cost of food and drink change?
5. Did customers change where they shop as a result of price changes or stock changes?
6. What was the impact of complying with the HRS on the outlets, including economic sustainability?

Learning for other settings

What could be learnt from implementing the HRS for similar initiatives in other setting – e.g. leisure centres, care homes, universities?

An Evaluation Advisory Group was set up to oversee the evaluation, to provide advice, agree and quality assure the methods, monitor the progress and provide overall governance.

The evaluation was made up of four components. Each addressed one or more of the above evaluation questions (**Figure 3**).

Component 1: (a) compliance and (b) purchasing patterns

Conducted by: NHS Health Scotland

(a) Compliance was explored by analysing audit data provided by the SGF HLP.

(b) Purchasing patterns were explored by analysing till report data provided by three national retailers.

Component 2: Customer survey

Conducted by: Institute of Social Marketing (University of Stirling), ScotCen and the University of Dundee.

A survey of customers leaving selected outlets, before and after HRS implementation, was used to explore changes in their reported purchasing patterns and their opinions of the outlet.

Component 3: Retailer changes and views

Conducted by: Institute of Social Marketing (University of Stirling), ScotCen and the University of Dundee.

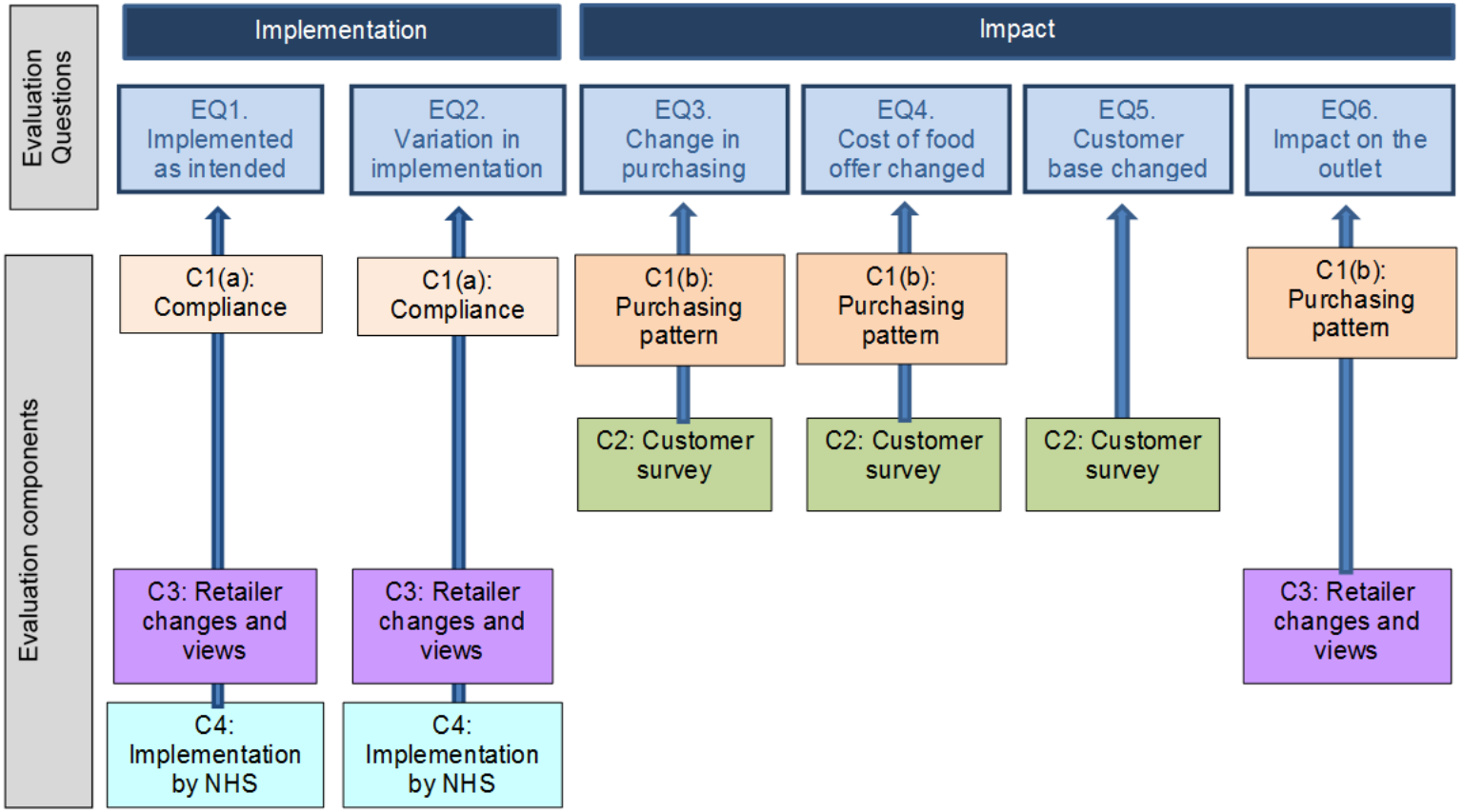
Observations of selected outlets and interviews with retail managers before and after the HRS implementation was used to explore changes in the outlets and retailers' perspective of complying with the HRS.

Component 4: Implementation by NHS

Conducted by: NHS Health Scotland.

Interviews with local and national implementation leads were used to explore the implementation by NHS Health Boards. These were the assessed against a framework of successful implementation.

Figure 3: How the evaluation questions are addressed by each of the study components



Component 1: compliance and purchasing patterns

Purpose

This component contributed to answering the following evaluation questions:

Q1: Was the HRS implemented as intended and in a way likely to impact on purchasing behaviour?

Q2: Was there variation in the implementation (at outlet and Health Board level) and did it have a positive or negative effect on purchasing behaviour?

Q3: Was there a change in the purchasing behaviour of customers?

Q4: Did the cost of a food and drink change?

Q6: What was the impact of complying with the HRS on the outlet, including economic sustainability?

Methods

Compliance data

The Scottish Grocers' Federation Healthy Living Programme (HLP) provided data relating to the first round of audits, which started in February 2017 and continued until all outlets were compliant (November 2017). Data used here were supplied in a Microsoft Excel spreadsheet in May 2017.

The audit process

The HLP was in contact with all retail outlets in NHS Scotland facilities prior to the audit process to provide information, guidance and support, as necessary. Mock assessments were carried out in some outlets to provide feedback on the outlet's progress to compliance. The HLP was also available to respond to additional queries that arose outside of these scheduled visits. The compliance audits were carried out in the two months prior to the implementation deadline. Outlets were advised of the date of the audit. Where the outlet did not reach compliance, the HLP provided feedback and suggestions for the changes needed to reach compliance. Outlets that had failed the initial audit were visited two months later for a repeat audit. Where an outlet had failed the audit because of minor faults a full re-audit was not carried out; instead, the outlet had to send photographic evidence of corrective action to HLP. Audit data was shared with NHS staff responsible for HRS implementation. This corrective practice mirrored similar activity for the healthyliving award.

In December 2017 and January 2018, the HLP team carried out unannounced spot checks on 24 outlets in the central belt, Aberdeen and Inverness, including outlets run by the large multi-retailers and some independently run outlets. During these spot checks compliance with the both promotion criteria and the provision criteria[16] was assessed. These spot checks were not intended to be of sufficient depth to audit compliance, but were intended to identify where outlets were clearly not complying with the HRS.

[16] The **provision** criteria states that 50% of the food lines on display (and 70% of drink lines) must comply with the HRS criteria. The **promotion** criteria states that only a subset of those products that are HRS compliant can be promoted, for example through price or quantity discounting, prominent in-store promotion.

Till report data

Data were received from three retail organisations, covering 77% of all outlets and 85% of all trolleys.

Structure of the data

Retailer 1

Time period: The retailer provided a summary of four weeks of data. This covered sales between October 2013 and March 2018 for three of their outlets in Scotland.

There were 58 data points per outlet. Each data point represents sales data from a four-week period.

- Pre transition = 27/10/2013 – 28/09/2015
- Transition = 26/10/15 – 13/02/2017
- Post transition = 13/03/2017 – 12/03/2018.

As a control, data were provided for three of their outlets in the north of England, which were not obliged to comply with the HRS, covering sales between September 2015 and August 2017.

Data: The data provided are detailed in Appendix I. In brief, data were provided on the number of units[17] and the value (in pounds Sterling) of products sold in the outlets, by HRS compliance (HRS criteria[18]).

[17] The unit the product is sold in, e.g. if an apple was sold individually then three individually sold apples would be recorded as three units. If the applies were sold in packs of 6 then one pack of 6 apples would be recorded as one unit.
[18] www.gov.scot/Publications/2016/10/5243

Retailer 2

Time period: data covering four time periods were provided – three time points prior to the implementation deadline and one time point immediately after the deadline:

Pre-implementation:

- February and March 2016
- April and May 2016
- February and March 2017.

Post-implementation:

- April and May 2017.

Data: The number of units and the value (in pounds Sterling) was provided for three product categories (food, drink and snacks) by HRS compliance status. In addition, the number of lines actively stocked across all of their outlets in NHS facilities was provided. This does not represent the products provided in the stores – i.e. cannot be used to asses compliance with the HRS, but does provide a picture of how the compliant and non-compliant lines changed over time.

Retailer 3

Data on the number of lines[19] provided in the outlet, by HRS compliance status, were provided for two outlets operating in NHS Scotland for September 2016, May 2017 and April 2018.

Data on total sales (units) and sales for food and drink separately were provided for three outlets operating in NHS Scotland for the financial year 2016/17 (i.e. before implementation of the HRS) and financial year 2017/18 (i.e. after the implementation of the HRS). Sales data was not available by HRS compliance status.

[19] A product line is a distinct product type, different brands, flavours, sizes would represent different lines. For example, Brand A salted flavoured crisps would be a different product line to Brand A cheese flavoured crisps. Similarly, an apple sold singularly would be a different line to a pack of 6 apples.

Economic impact on outlets

The area managers of the three national retailers operating in NHS Scotland were sent a short questionnaire (Appendix J) asking about the economic impact of the HRS on their business. Responses are reported here for the group as a whole to maintain confidentiality. Some retailers preferred to respond by telephone. Notes were made from these conversations and sent to the retailer to confirm they reflected the conversation. All retailers were sent the relevant chapter presenting their data and provided consent for it to be included.

Analysis

Initial exploration of the data was carried out in Excel 2013. Further data manipulation and descriptive analysis was conducted in SPSS (IBM SPSS Statistics 19).

Using England as a control

When interpreting the differences between England and Scotland it should be noted that as part of the commissioning process in England[20] there is some non-mandatory emphasis on improving the food and drink offers available to staff which may result in some improvements in the food and drink available in hospital outlets in England.

[20] www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19

Findings

This section draws on data from the SGF HLP audit and the supplied till reports.

Q1: Was HRS implemented as intended?

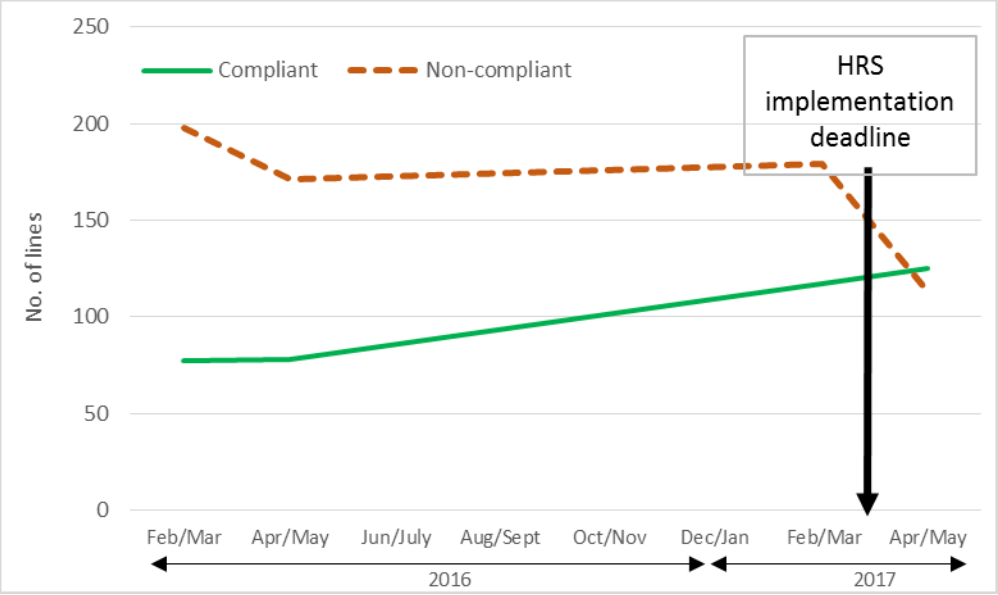
Compliance

A total of 94% of all 109 outlets (shops and trolleys) audited complied with the HRS criteria by May 2017. Six outlets failed to comply, four had successfully complied by June 2017 and the remaining two were compliant by August 2017 and November 2017, respectively.

Change in the food/drink offered

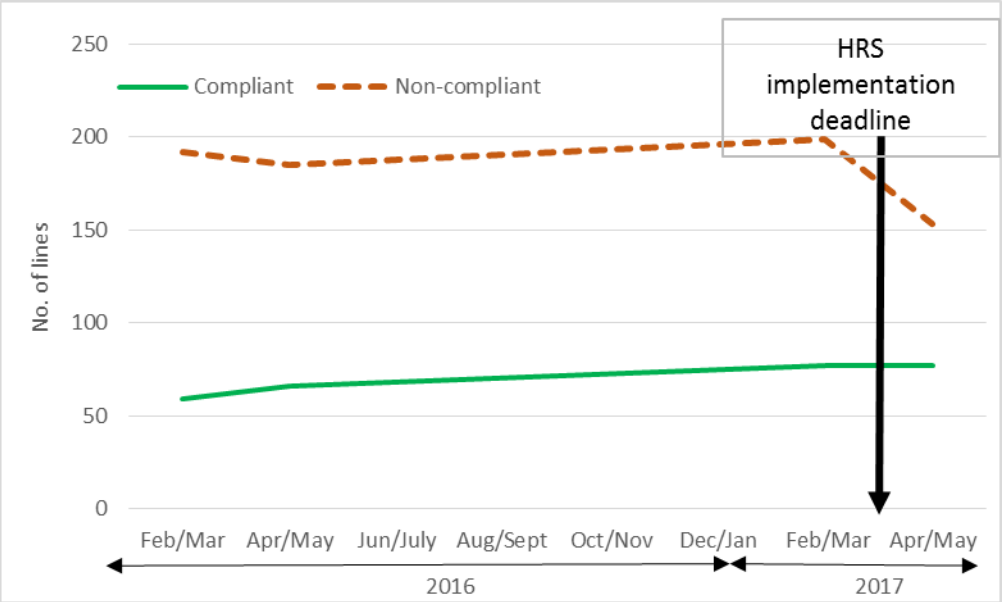
For one of the national suppliers, the number of non-compliant lines, particularly snacks, was significantly reduced to achieve compliance. Although the number of compliant lines did increase, the increase in compliant lines was not proportionate to the decrease in non-compliant lines (Figure 4–6). The result being that there were significantly fewer food and drink lines in the outlet after the HRS was implemented.

Figure 4: Number of compliant and non-compliant **food** lines over time



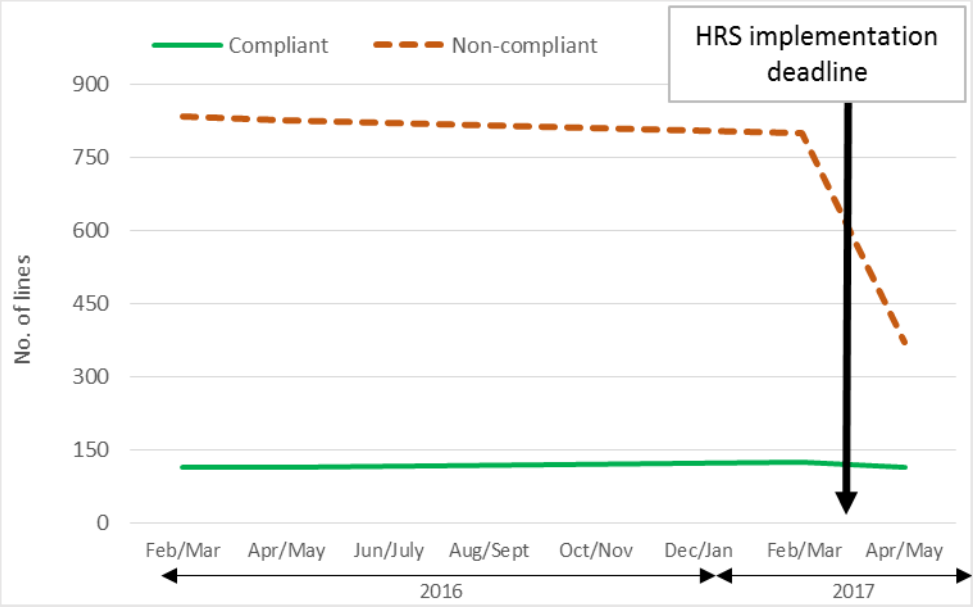
[Source: Retailer 2, based on all their Scottish stores]

Figure 5: Number of compliant and non-compliant **drink** lines over time



[Source: Retailer 2, based on all their Scottish stores]

Figure 6: Number of compliant and non-compliant **snack**[21] lines across time

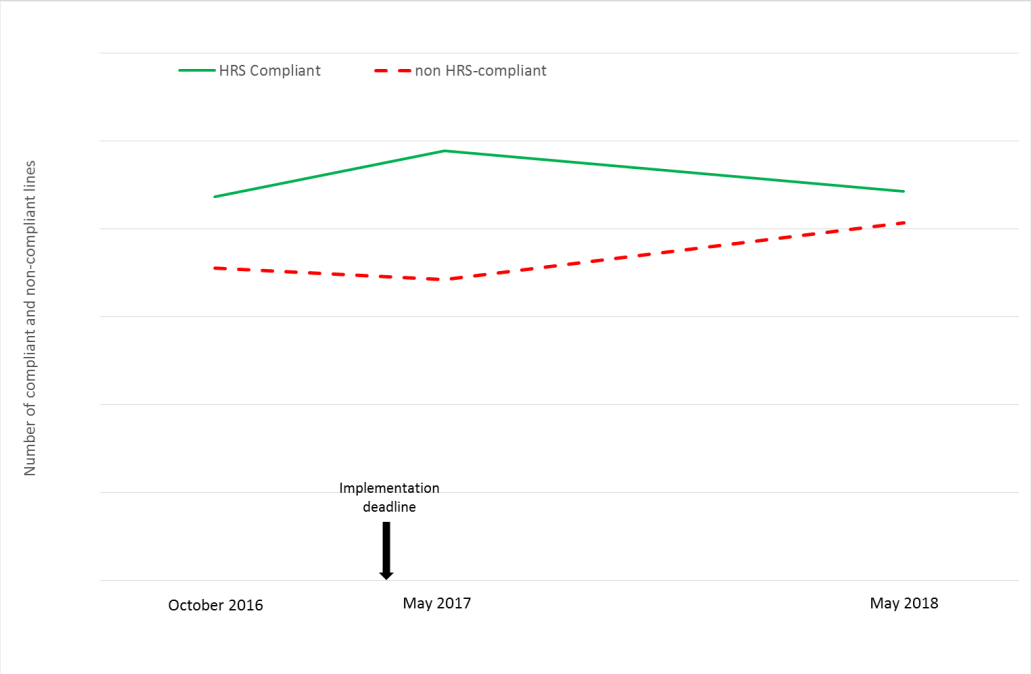


[Source: Retailer 2, based on all their Scottish stores]

For a different national supplier, which was close to achieving compliance for food lines prior to the introduction of the HRS, the change in food lines was less marked (**Figure 7**).

[21] The provider defined the product categories.

Figure 7: Number of compliant and non-compliant **food** lines across time

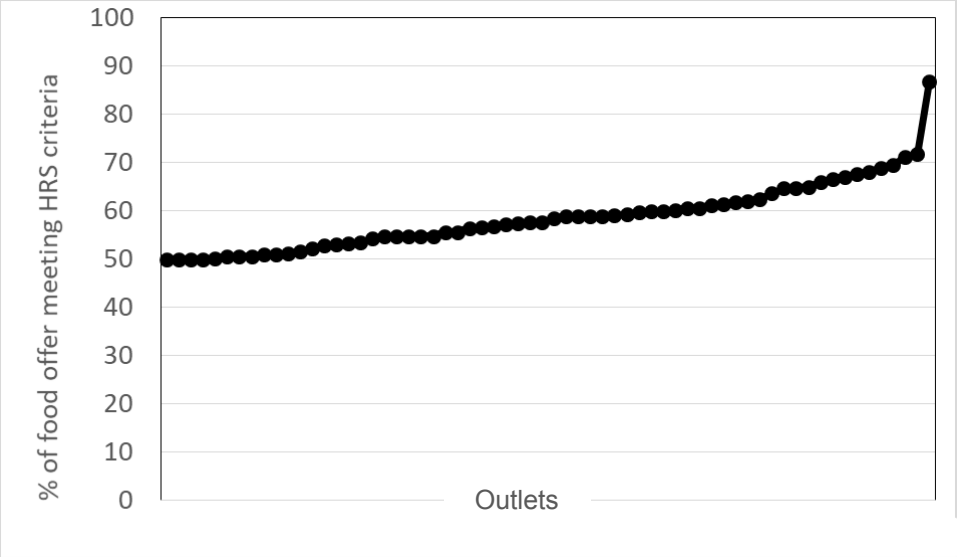


[Retailer 3, based on two outlets]

Q2: Was there variation in implementation?

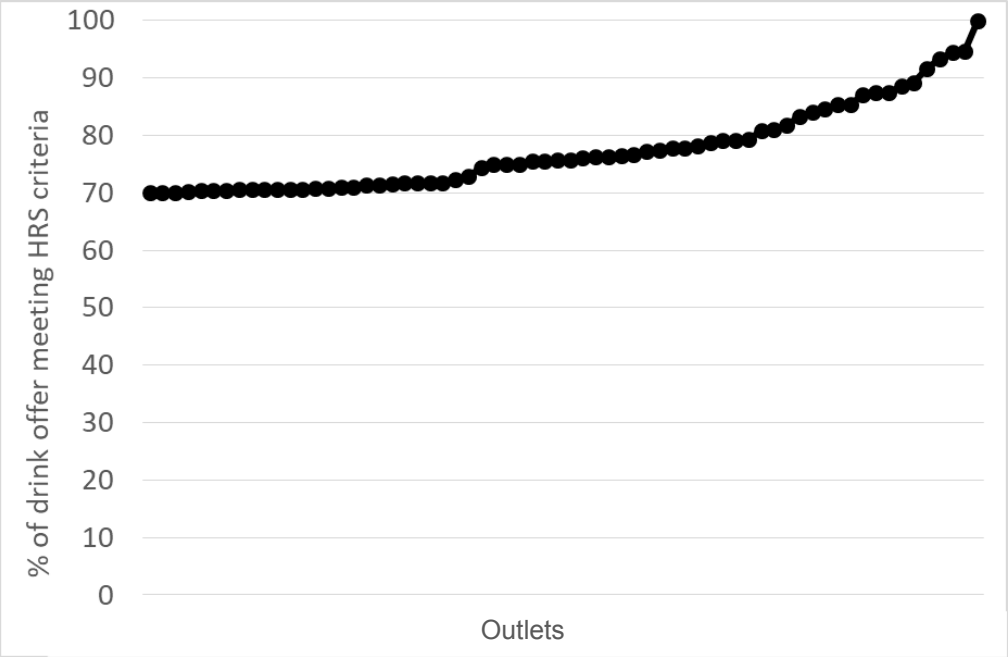
There was variation in the percentage of food and drink offer that met the HRS criteria across the outlets (**Figure 8** and **9**), with some outlets exceeding the minimum requirement of 50% of HRS compliant food and 70% HRS compliant drink.

Figure 8: Variation in percentage of **food** meeting the HRS criteria at the HRS implementation deadline, across all outlets



[Source: HLP audit data]

Figure 9: Variation in the percentage of **drink** meeting the HRS criteria post HRS implementation across all outlets



[Source: HLP audit data].

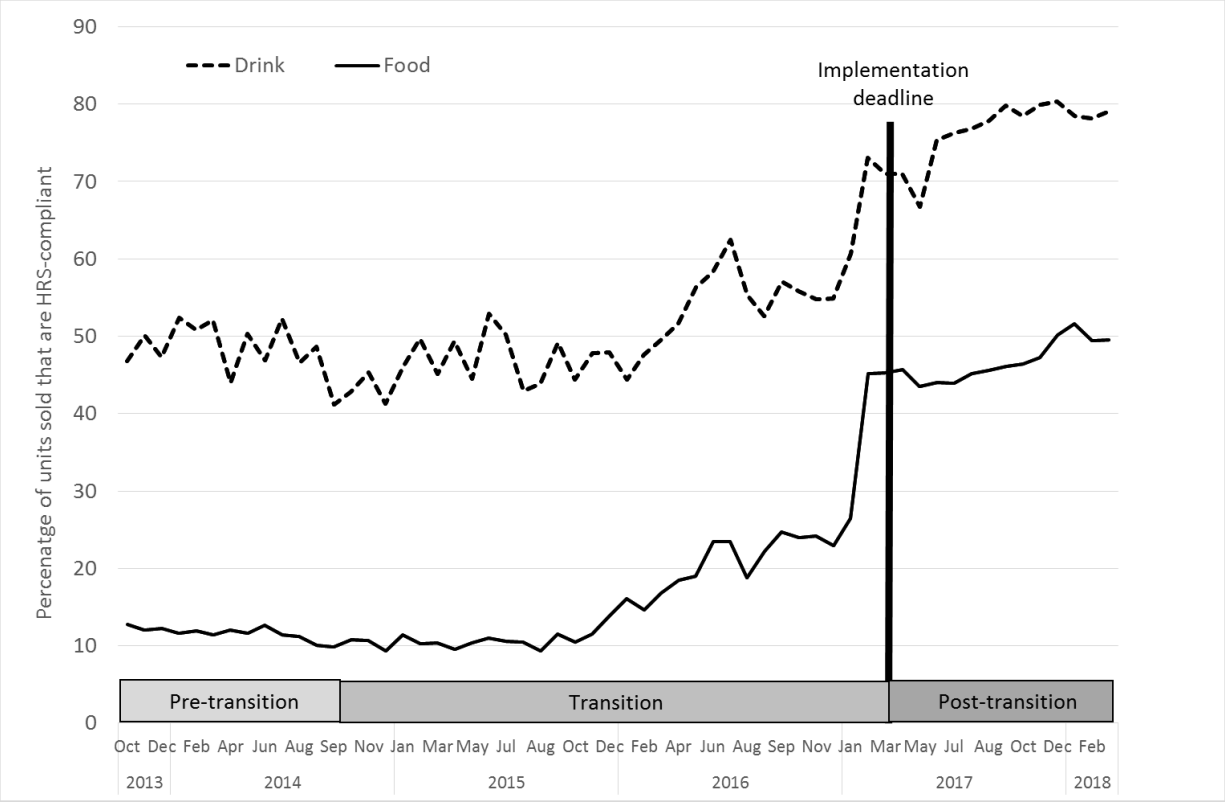
Includes only shops or hybrid outlets that had passed by 31 March 2017. Trolleys are not included. Outlets in NHS Greater Glasgow and Clyde were also required to comply with the Health Boards Food Retail Policy.[22]

[22] www.nhsggc.org.uk/media/235672/food-retail-policy-may-2014.pdf

Q3: Was there a change in the purchasing behaviour?

The introduction of the HRS was associated with an increase in the percentage of the food and drink purchased that met the HRS criteria in Scotland – i.e. of the products purchased a higher proportion were HRS compliant (**Figure 10**). Data from one retailer are presented but reflects the change seen in other retailers.

Figure 10: The percentage of food and drink purchased that met the HRS criteria (**Scotland**)

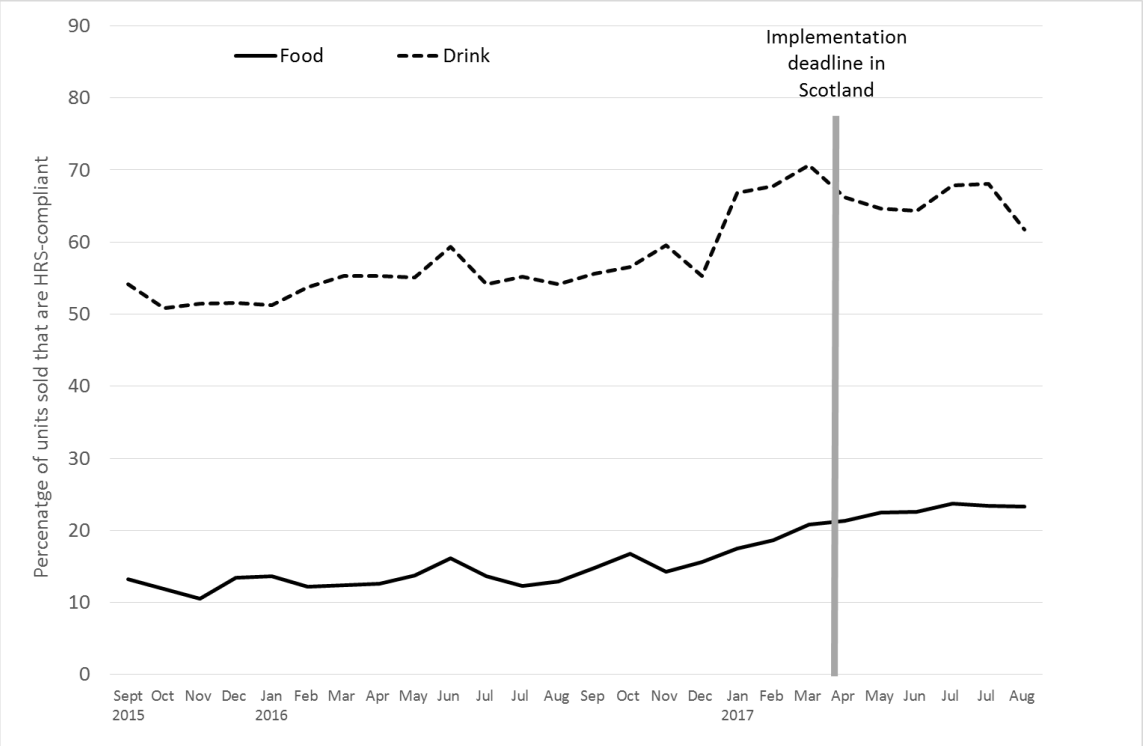


[Retailer 1, data based on 3 outlets]

Comparable data from three hospitals in the north of England, which were not obliged to comply with the HRS, show that from around late 2016 there was a general increase in the percentage of HRS compliant food and drink sold (**Figure 11**). However, the changes are not as marked in Scotland. Consequently, a higher percentage of all sales was HRS compliant in Scotland (approximately 80%) compared to that in outlets in England (between 60–70%). The retailer that supplied this data did make some changes to the products that were promoted in their English stores. This could explain some of these changes in the number of compliant lines

purchased in England. No HRS-related changes to the range of products offered were made in their English stores until early 2018.

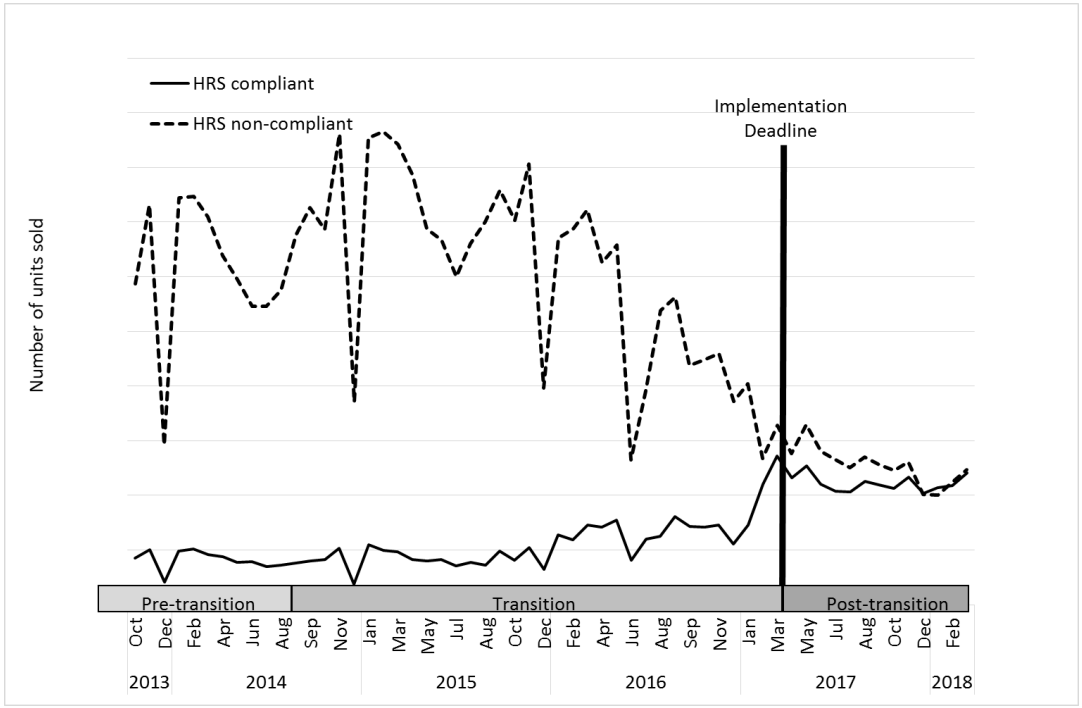
Figure 11: The percentage of food and drink purchased that met the HRS criteria (**England**)



[Retailer 1, data based on 3 outlets]

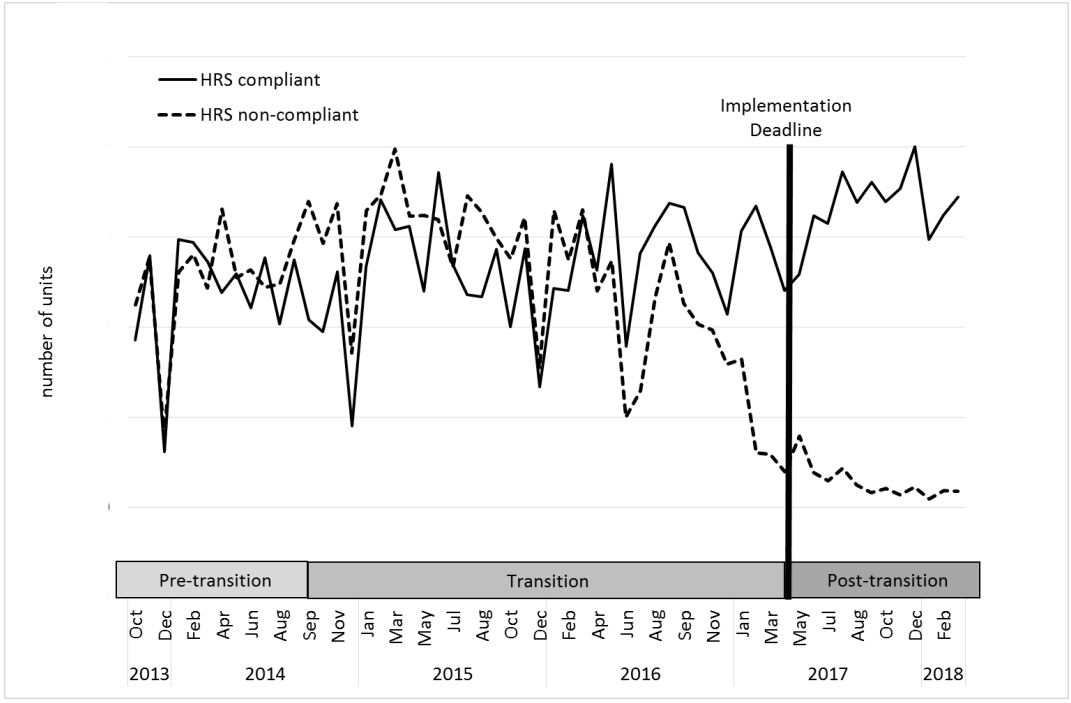
In addition to the increase in the percentage of products purchased that were HRS compliant, the total sales of compliant products also increased. There was also a notable decrease in the purchase of non-compliant products. The increase in compliant products was generally smaller than the decrease in non-compliant products (**Figure 12–13**).

Figure 12: Number of units purchased of compliant and non-compliant **food** (**Scotland**)



[Retailer 1, based on three outlets. The numbers on the y-axis are not shown because of commercial sensitivity.]

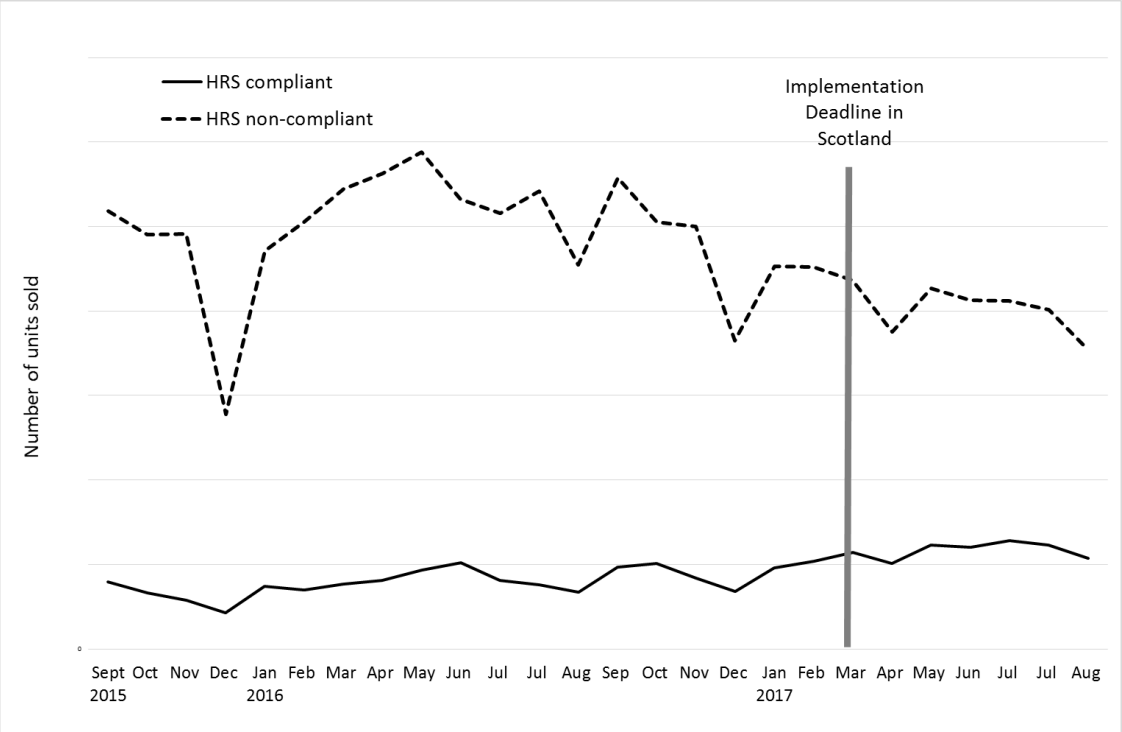
Figure 13: The number of units purchased of compliant and non-compliant **drink** (**Scotland**)



[Retailer 1, based on three outlets. The numbers on the y-axis are not shown because of commercial sensitivity.]

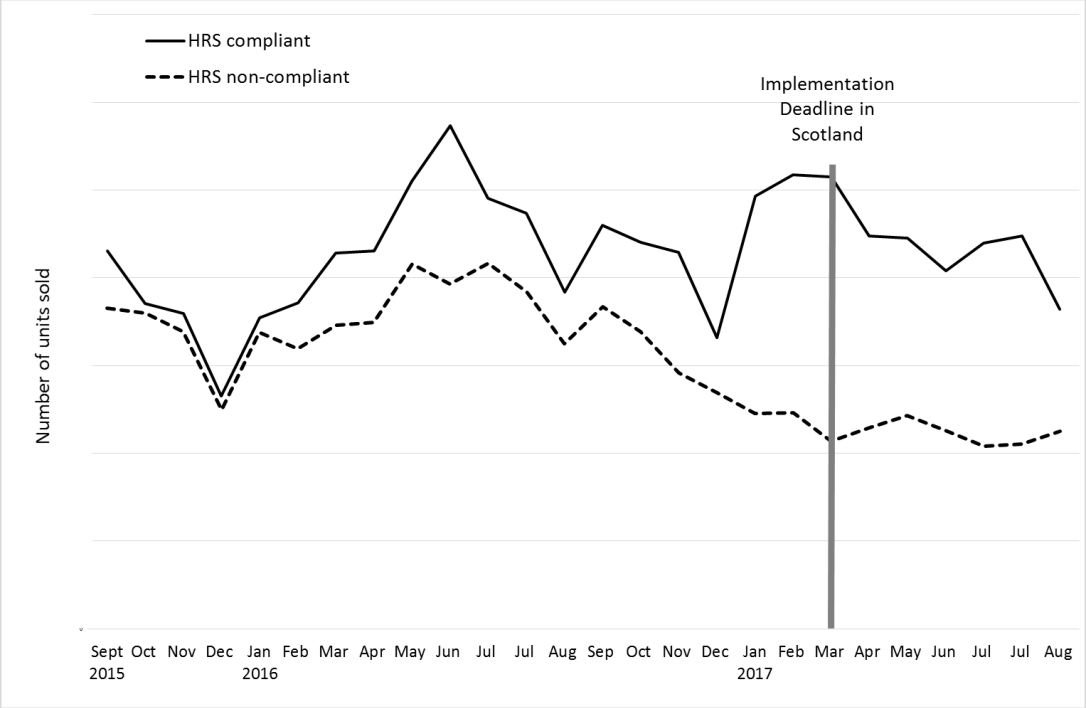
Some very modest changes in the sales of HRS compliant and non-compliant products were also seen in the English outlets (**Figures 14–15**).

Figure 14: The number of units purchased of compliant and non-compliant **food** (**England**)



[Retailer 1, based on three outlets. The numbers on the y-axis are not shown because of commercial sensitivity.]

Figure 15: The number of units purchased of compliant and non-compliant **drink** (**England**)



[Retailer 1, based on three outlets. The numbers on the y-axis are not shown because of commercial sensitivity.]

Q4: Did the cost of food and drink change?

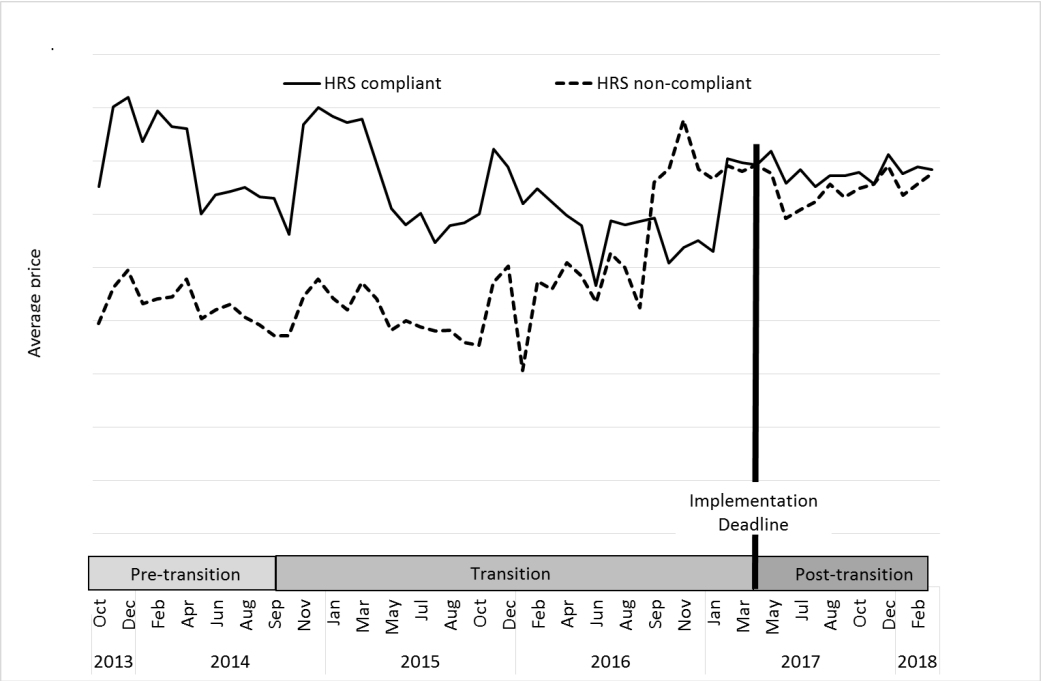
Food

In both Scotland and England the cost of non-compliant food was notably cheaper in 2015 than HRS-compliant food. By the time HRS was implemented in Scotland the cost of HRS and non-compliant food was comparable in Scotland, but in England HRS compliant food was still more expensive per unit than non-compliant food (**Figures 16** and **18**).

Drink

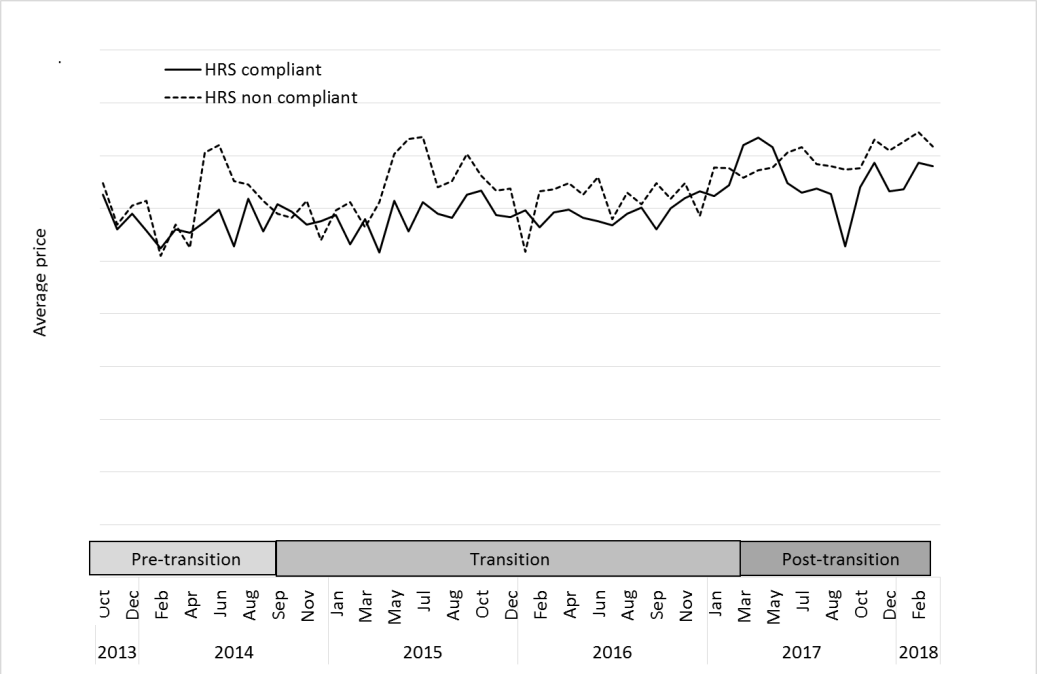
In Scotland the changes in the unit price of HRS compliant and non-compliant drink was similar – i.e. a slow increase in the unit cost throughout the observation period (**Figure 17**). The picture in England was similar, although the data suggest that non-compliant drinks in England tended to become more expensive than compliant drinks over time (**Figure 19**). It should be noted that these observations are based on data from only one retailer.

Figure 16: The unit **price** for compliant and non-compliant **food** over time (**Scotland**)



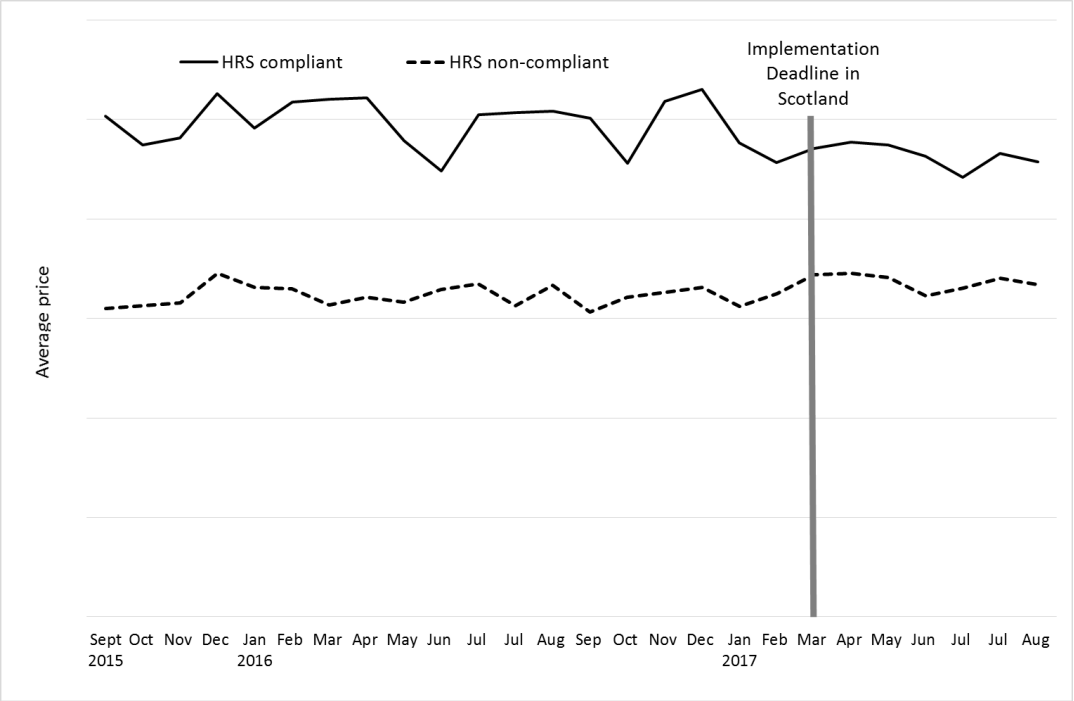
[Retailer 1, based on three outlets. The numbers on the y-axis are not shown because of commercial sensitivity.]

Figure 17: The unit **price** for compliant and non-compliant **drink** over time (**Scotland**)



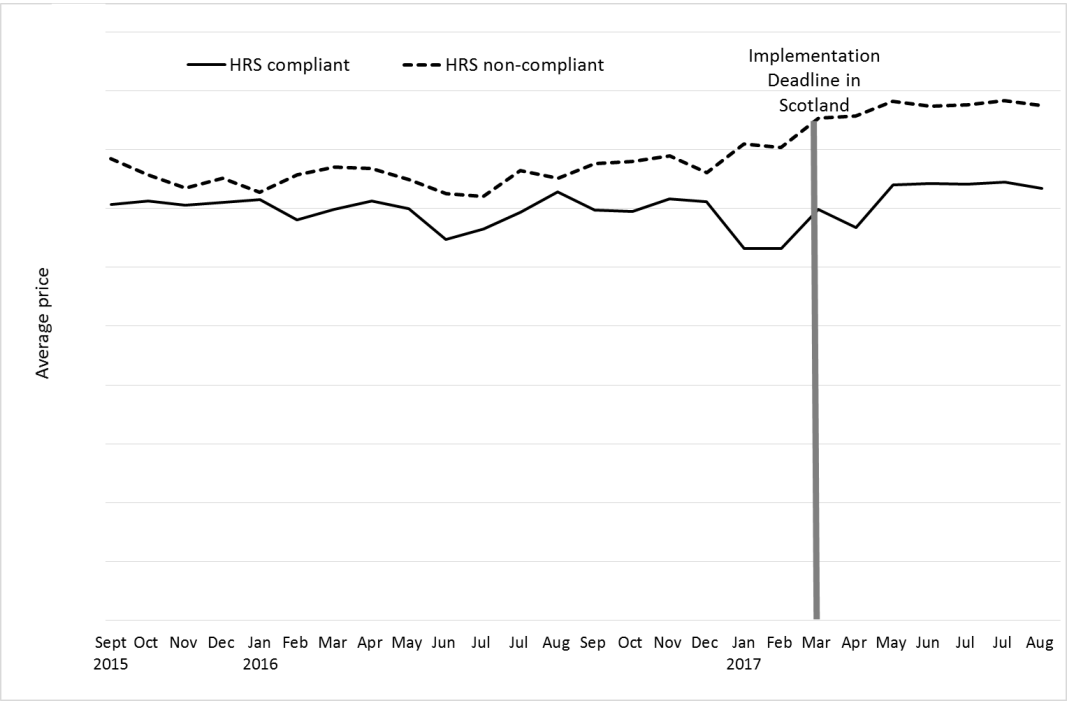
[Retailer 1, based on three outlets. The numbers on the y-axis are not shown because of commercial sensitivity.]

Figure 18: The unit **price** for compliant and non-compliant **food** over time (**England**)



[Retailer 1, based on 3 outlets. The numbers on the y-axis are not shown because of commercial sensitivity.]

Figure 19: The unit **price** for compliant and non-compliant **drink** over time (**England**)



[Retailer 1, based on 3 outlets. The numbers on the y-axis are not shown because of commercial sensitivity.]

Q6: What was the impact of complying with the HRS on the retailers?

The following synthesis is based on responses to questions posed to regional managers of three national retailers via email (covering 11 of the 70 non-trolley outlets) and via telephone (covering three out of 70 non-trolley outlets).

Impact on profits

Regional managers reported that the HRS did have an economic impact, which included the cost of implementing the HRS and the impact of the HRS on sales. The reduction in sales was seen immediately after the implementation of the HRS. Sales did begin to increase several months after implementation, although a year after implementation they had not returned to pre-HRS levels. For one retailer, the range of products provided in comparable hospital outlets in England[23] is approximately 35% higher than in their outlets in hospitals in Scotland. Sales in their Scottish hospital outlets – with a lower product range – are approximately 20% lower than in their hospital outlets in England. This suggests that the range of products available in the outlet does affect sales.

Retailer response

Retailers have responded by monitoring sales, refining products offered and developing new lines that adhere to the HRS criteria. These changes are thought to be responsible for improving sales.

Other impact

Retailers continue to look for opportunities to expand in the NHS Scotland market.

Continued compliance

Spot checks were carried out by the HLP team in December 2017/January 2018. These spot checks suggest that outlets are maintaining compliance with regards to

[23] Taking into account demographics and hospital size (including hospital employees and bed numbers)

the provision of drinks, i.e. 70% of drink lines are compliant with the HRS, but were borderline compliant for the provision of food lines, i.e. less than 50% of food lines were compliant.

Several outlets had introduced promotions of non-HRS compliant products, for example, non-compliant products were displayed at the point of sale (i.e. next to the till), in end of aisle displays, multi-buy discounts (e.g. 2 for £1) or had large price marking.[24] Some meal deals included non-compliant products.

[24] The HRS promotion criteria states that for non-compliant products the price display is not permitted to be above 25% of the surface packaging.

Component 2: customer views

Purpose

This component aimed to contribute to answering the following evaluation questions:

Q4: Did the cost of food and drink change?
Specifically, were there any changes in the amount spent by customers using the outlets?

Q5: Did customers change where they shopped as a result of price changes or stock changes in the hospital outlet?
Specifically:

- Were there any changes in the frequency of customers using the outlets?
- Has there been changes in the customer base associated with the introduction of the HRS?
- What were customers' awareness and views of the changes brought about by the introduction of the HRS?

Methods

ScotCen carried out two waves of customer surveys: the first before HRS implementation (August–September 2016), and the second after implementation (August–September 2017). People leaving selected retail outlets were asked a series of questions (Appendix C) by an interviewer. Verbal consent was obtained.

The topics covered in the customer survey included:

- frequency of visiting the outlet
- reasons for visiting the outlet
- use of nearby shops
- list of products purchased and role of promotions in their purchasing choice
- awareness of, and attitudes to, any changes in stock
- customer characteristics (reason for being in the hospital, gender, age, household income).

The surveys took place outside four retail outlets in two large urban hospital sites. The hospitals are in different Health Boards. The four outlets were run by three different operators (**Table 1**). These locations were chosen to maximise the number of customers interviewed.

Table 1: Retailers operating the outlets in the customer survey

Outlet	Operator
1	Large multiple retailer 1
2 and 3	Large multiple retailer 2
4	Independent operator

A pilot survey was carried out in June–July 2016 to test the questionnaire and the likely response. Ethical review and approval were provided by the University of Dundee Research Ethics Committee.

The customer survey is described in more detail in a journal article.[25]

Analysis plan

Data were analysed descriptively. The study sample was not selected randomly. Outlets in large hospitals were selected to ensure that sufficient numbers of interviews could be conducted. As a result, statistics analysis (e.g. tests to provide a p-value for the statistical significance) could not be carried out on the findings. Annual household income incorporates all sources before tax, including benefits and savings.

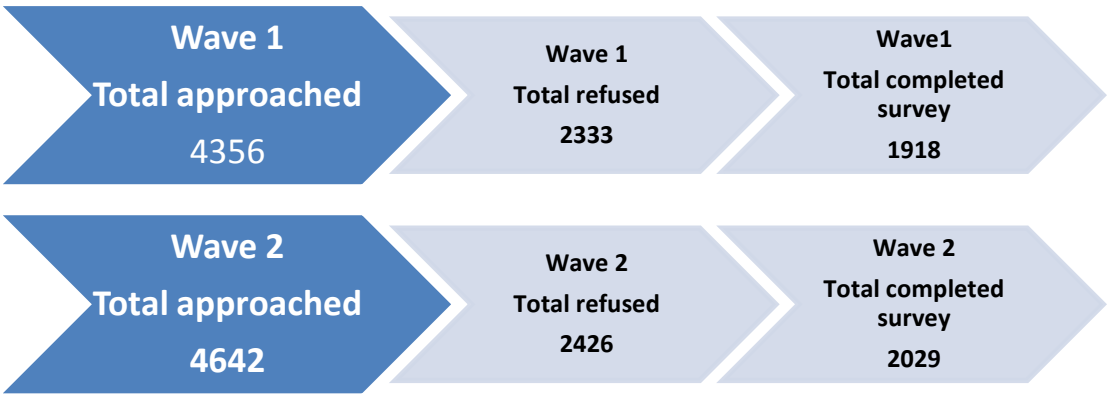
Respondents were asked the amount of money they spent in the shop, with respondents often consulting their receipt. If the respondent was unable to report the actual amount spent they were asked to estimate the amount they spent. Unless otherwise stated, the data on money spent in the outlet was based on the actual rather than estimated spend.

[25] Stead M, Eadie D; McKell J; Sparks L; MacGregor A; Anderson A. Making hospital shops healthier: implementation of an innovative nutrition-based mandatory standard for products and promotions in hospital food retail outlets (submitted 2018 to International Journal of Behavioral Nutrition and Physical Activity).

Findings

Over 4000 outlet customers were approached at each wave, with approximately 2000 taking part at each wave. This represented a 45% response rate.

People approached and taking part in the customer surveys at each wave.



Study sample

The majority of the sample were female, consistent with the majority of hospital staff being female.[26] There was an equal distribution across age and income groups. A total of 40% of the sample were staff, just over 20% were outpatients and just over 20% were visiting or accompanying patients. The remaining 12% were inpatients or there for another reason (**Table 3**).

The majority were frequent users of the outlets and didn't use nearby shops outside the hospital complex.

[26] www.gov.scot/Topics/People/Equality/Equalities/DataGrid/Gender/GenHealth

Description of outlets

Surveys took place outside four outlets, each with slightly different characteristics before the introduction of the HRS (**Table 2**). Outlet 1 was slightly more expensive than the other outlets.[27] It attracted those with a higher income and offered a greater selection of healthier products.[28] This could arguably be reflecting the general commercial trend where outlets that have a more healthy food and drink offer tend to be more expensive.

Table 2: Characteristics of the outlets outside which the customer survey was carried out, wave 1

	Outlet 1	**Outlets 2 & 3**	**Outlet 4**
Income of customers[1], n (%)			
Low (< £25,000)	124 (28)	305 (37)	194 (43)
Medium (£25K to < £45,000)	146 (33)	250 (31)	128 (29)
High (£45,000+)	**170 (39)**	261 (32)	127 (28)
Total	440 (100)	816 (100)	449 (100)
Average customer spend on food and drink, £ (n)[2]	**£5.17** (416)	£2.68 (558)	£2.98 (447)
Offer a wide range of healthy products, n (%)			
Agree/strongly agree	444 **(91)**	523 (68)	311 (70)
Neither agree nor disagree	22 (5)	97 (13)	41 (9)
Disagree/strongly disagree	20 (4)	152 (20)	94 (21)
Total	486	772	446
Purchase of fruit or salad, n (%)	163 **(34)**	32 (4)	40 (8)

[1]N = 213 missing for income including: Refused=85, don't know = 109, Missing = 19.
[2] N = 214 not applicable/don't know.
Bold numbers highlighting differences referred to in the text.

There were no other notable differences in the customers using the different outlets in terms of the age or sex distribution (data not shown).

[27] Based on greater average spend.
[28] Based on customer perceptions and purchase of fruit and salad by outlet and supported by observations - see **Component 3: changes to the outlets and retailer views of the HRS**

Changes associated with the introduction of the HRS

Customer base

There were no notable differences in the survey samples pre and post introduction of the HRS in terms of sex, age distribution, reason for being in the hospital or income (**Table 3**). This suggests that there was little change in the customer base of those that continued to shop at these outlets.

Table 3: Comparison between customers pre and post introduction of the HRS

Characteristic	Pre, N (%)	Post, N	% point difference
Sex			
Female	1337 (70)	1395 (69)	↓ 1
Male	574 (28)	627 (31)	↑ 3
Total	1911[1]	2022[1]	
Age			
16–29	418 (22)	442 (22)	0
30–39	375 (20)	389 (19)	↓ 1
40–49	370 (19)	387 (19)	0
50–59	370 (19)	389 (19)	0
60 and over	379 (20)	418 (21)	↑ 1
Total	1912[2]	2025[3]	
Reason for being in the hospital			
Hospital NHS staff	660 (34)	821 (40)	↑ 6
Hospital non-NHS staff	109 (6)	65 (3)	↓ 3
Out-patient	436 (23)	415 (20)	↓ 3
In-patient	85 (4)	88 (4)	0
Visiting/accompanying patient	485 (23)	555 (27)	↑ 4
Other	143 (8)	84 (4)	↓ 4
Total	1918	2028[4]	
Income			
Low (<£25,000)	623 (37)	622 (35)	↓ 2
Medium (£25K to <£45,000)	524 (31)	526 (30)	↓ 1
High (£45,000+)	558 (33)	628 (35)	↑ 2
Total	1705[5] (100)	1776[6] (100)	

[1] N = 7 missing; [2]N = 4 refused, 2= missing; [3]N = 4 missing (2 = refused, 2 = missing); [4]N = 1 missing; [5] N = 213 missing for income including: refused = 85, don't know = 109, missing =19; [6]N = 253 (10 = missing, 158 = don't know, 85 = refused).

Changes in shopping patterns

There was no notable change in the frequency at which those in the survey sample shopped at the outlets, or the proportion that shopped at nearby shops (i.e. outside of the hospital site) (**Table 4**). This suggests that there was no notable change in the shopping patterns of customers as a result of the introduction of the HRS.

Table 4: Comparison of shopping patterns of customers' pre and post introduction of the HRS

Characteristic	**Pre, N (%)**	**Post, N (%)**	**Percentage point difference**
Frequency of visiting to outlet			
Daily	245 (15)	233 (13)	↓ 2
At least once a week but not daily	707 (42)	832 (47)	↑ 5
Once or twice a month	263 (16)	275 (15)	↓ 1
Less often	460 (28)	451 (25)	↓ 3
Total	1675[1]	1791[2]	
Buy food/drink in shops outside hospital			
Yes	401 (21)	356 (18)	↓ 3
No	1510 (79)	1667 (82)	↑ 3
Total	1911[3]	2023[4]	

[1] N = 243 (16 = missing, 227 = had not visited the outlet previously); [2] N = 238 (1 = missing, 237 = had not visited the outlet previously); [3] N = 7 missing; [4] N = 6 missing.

Changes in the cost of the food/drink offer

There was no notable change in the amount spent pre and post introduction of the HRS. However, the average spend per customer varied significantly across the study population, therefore it is likely that a moderate increase would not be identified among the sample variation (**Table 5**).

Table 5: Average spend on food and drink, pre and post HRS, by outlets

Outlet	**Pre, £ (N)**	**Post, £ (N)**	**Difference**
Outlet 1	£5.17 (416)	£5.08 (498)	↓ £0.09
Outlets 2 and 3	£2.68 (558)	£2.38 (465)	↓ £0.30
Outlet 4	£2.98 (447)	£3.20 (578)	↑ £0.28
Total	**£3.51 (1423)**	**£3.56 (1541)**	**↑ £0.05**

Does not include estimated spend. Standard deviation for the pre average spend is 3.53 and for the post average spend is 2.99.

The change in spend pre and post introduction of the HRS did not vary by household income group (**Table 6**).

Table 6: Average spend on food and drink, pre and post the introduction of the HRS, by household income

Outlet	**Pre, £ (N)**	**Post, £ (N)**	**Difference**
Low (<£25,000)	£3.50 (452)	£3.43 (456)	↓ £0.07
Medium (£25K to < £45,000)	£3.39 (387)	£3.45 (413)	↑ £0.06
High (£45,000+)	£3.64 (432)	£3.67 (490)	↑ £0.03

Does not include estimated spend.

Changes in the food purchased

Customers were specifically asked about the purchase of four food items – crisps, chocolate, fruit and salad (**Table 7**).

Table 7: Purchase of certain food categories pre and post introduction of the HRS

Products bought	Pre, N (%)	Post, N (%)	Percentage point difference
Crisps	374 (20)	401 (20)	0
Chocolate	208 (11)	186 (10)	↓ 1
Fruit	133 (7)	153 (8)	↑ 1
Salad	102 (6)	126 (6)	0
Meal deal	103 (6)	28 (1)	↓ 5
Total	1836	1966	

Before the HRS was introduced around a third of study participants bought crisps or chocolate and only a small proportion (13%) bought fruit or salad.

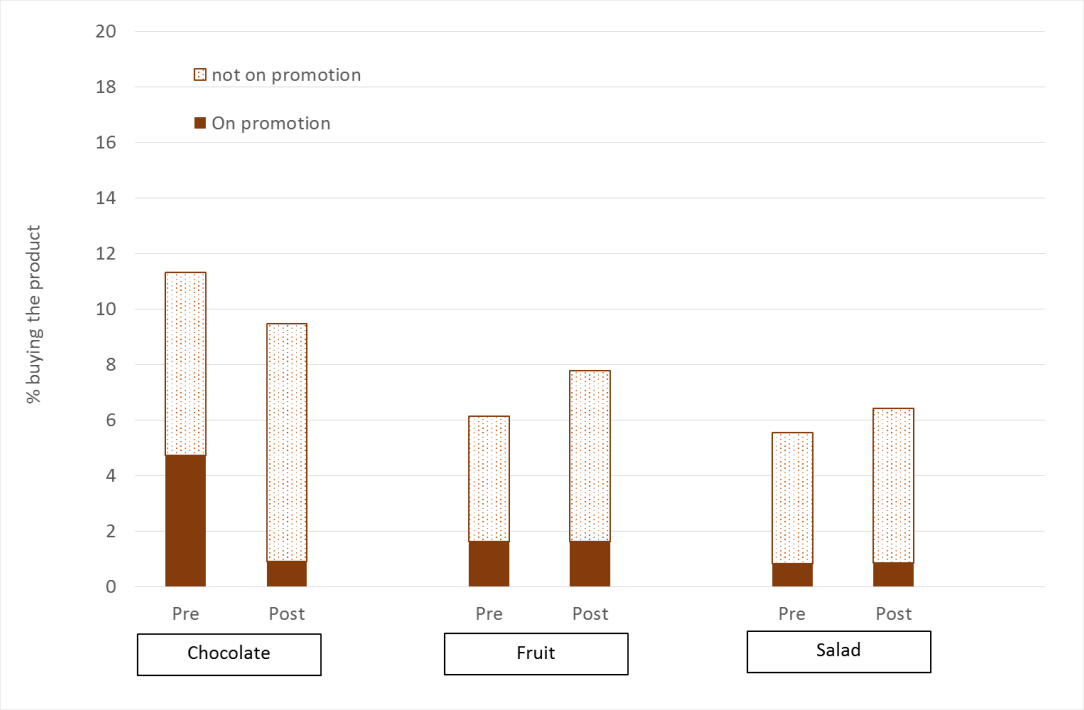
The percentage of people buying fruit or salad did not increase notably after the introduction of the HRS. Data from other components of this evaluation identified that the HRS did not generally result in the provision of markedly more fresh produce. Outlets largely reduced the number of non-compliant products rather than markedly increased the number of HRS compliant products. This may explain the lack of increase in purchase of fresh produce seen here.

There was only a marginal decrease in the percentage of people buying chocolate after the introduction of the HRS (**Table 7**). Other evaluation components identified that purchase of non-compliant products did decrease notably after the introduction of the HRS. One plausible explanation for the lack of change in the purchase of chocolate seen in this component, given the general decrease in purchase of non-compliant products, is that customers may have been more likely to purchase HRS compliant products if they were available in the same food category but not to switch food categories altogether. For example, someone intending to buy a chocolate bar may be less likely to switch to a piece of fruit but someone intending to buy a sandwich might buy an HRS compliant sandwich rather than a non-compliant sandwich.

This question did not distinguish between compliant and non-compliant crisps, therefore information on crisps is of limited value.[29]

Although the amount of chocolate that was bought did not appear to change greatly, the amount that was bought **on promotion** reduced substantially after the introduction of the HRS (**Figure 20**). Before the HRS, 42% of chocolate bought was on promotion compared to 10% after the introduction. (This was largely price marked packs that were subsequently permitted through HRS if the price took up 25% or less of the packaging on the side displayed to the public.)

Figure 20: Percentage of respondents who bought chocolate, fruit or salad, by promotion status pre and post introduction of the HRS



Very little of the fruit or salad bought was on promotion, either before or after the introduction of the HRS (**Figure 20**). The observational study of outlets (component 3) identified that after the introduction of the HRS, promotional activity on fruit or salad did not increase significantly.

[29] Initially no crisps were included in the compliant category. It was only after the evaluation had started that baked crisps were moved to the compliant category.

For those who bought chocolate, salad or fruit on promotion, nearly all reported that the promotion was why they purchased the food (data not shown).

Changes in the attitudes

Participants were asked about:

- their attitudes to the value for money from the outlets
- whether or not the outlet met their needs
- whether or not the outlet offered a range of healthy products
- if they had noticed any recent changes in the outlet.

Only modest changes in attitudes to the outlets were reported after the introduction of the HRS. Before the introduction of the HRS around one-fifth (21%) of respondents reported noticing changes to the outlets in the previous few months, rising to 28% after the introduction of the HRS (**Table 8**). Some customers were critical of the changes and others supportive (**Table 9**).

Table 8: Customer identifying changes in the outlet over the previous few months, pre and post introduction of the HRS

Answer	**Pre, N (%)**	**Post, N (%)**
Yes	330 (21)	463 (28)
No	1269 (79)	1194 (72)
Total	1599[1] (100)	1657[2] (100)

[1] Not applicable = 167, don't know/missing = 152; [2] Not applicable = 178, don't know/missing = 194.

Table 9: Changes noticed by respondents after the introduction of the HRS

Attitude	Verbatim comment
Neutral	'More healthy products on offer – new cabinet'
Critical of changes	'It's all healthy stuff now. The sandwiches aren't so good. It's all the low fat this, low sugar that. The sandwiches are bland, the mayonnaise is low fat so it's not so good. I don't like these baked crisps either. I wouldn't have them if it wasn't the only ones you can get in the meal deal. It's all too healthy' 'More healthy eating, nothing else. Treated like children.'
Supportive of changes	'Better salad range. Got rid of promotions on unhealthy products' 'Salad has more variety. Juices more healthy' 'The Graze range is fairly new – overpriced but at least it's a bit healthier. I think they have been told to try and go along a healthier route – it used to be all chocolate and crisps but now there are some better choices' 'Display of nutritional content is first thing you see. Good fruit and veg at front'

Value for money

There was little change in the attitudes around whether or not the outlets offered value for money. Just over half thought the outlets were value for money both before and after the introduction of the HRS (**Table 10**).

There was no notable difference in the views on value for money of the outlets by income group, either before or after the introduction of the HRS (**Table 11**).

Table 10: Customer attitudes to the value for money pre and post introduction of the HRS

Attitude	**Pre, N (%)**	**Post, N (%)**	**Percentage point difference**
Agree strongly	119 (6)	143 (7)	↑ 1
Agree	867 (46)	883 (45)	↓ 1
Neither agree nor disagree	255 (14)	250 (13)	↓ 1
Disagree	453 (24)	515 (26)	↑ 2
Disagree strongly	173 (9)	161 (8)	↓ 1
Total	1867[1]	1952[2]	

[1] N = 51; don't know/no response= 47, missing = 4; [2] N = 77 (don't know = 76: missing = 1).

Table 11: Customer attitudes to the value for money pre and post introduction of the HRS, by household income

Attitude	**Low (<£25,000)**		**Medium (£25,000 to <£45,000)**		**High (£45,000)**	
	Pre	Post	Pre	Post	Pre	Post
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Agree/strongly agree	311 (51)	306 (51)	276 (54)	286 (56)	277 (51)	307 (51)
Neither agree nor disagree	88 (14)	75 (13)	55 (11)	54 (11)	84 (16)	85 (14)
Disagree/strongly disagree	212 (35)	218 (36)	181 (35)	170 (33)	180 (33)	214 (35)
Total	611	599	512	510	541	606

Met their needs

There was no notable change in the attitudes to whether the outlet met the respondents' needs.

Table 12: Customer attitudes to if the range of food and drink meets their needs pre and post introduction of the HRS

Attitude	Pre, N (%)	Post, N (%)	Percentage point difference
Agree strongly	263 (14)	265 (14)	0
Agree	1353 (72)	1373 (70)	↓ 2
Neither agree nor disagree	97 (5)	122 (6)	↑ 1
Disagree	141 (7)	171 (9)	↑ 2
Disagree strongly	25 (1)	39 (2)	↑ 2
Total	1879[1]	1970[2]	

[1] N = 39 (don't know = 37, missing = 2); [2] N = 59 (don't know = 58, missing = 1)

Range of healthy products on offer

The majority (75%, agree or strongly agree) thought that the outlets provided a range of healthy products before the introduction of the HRS and this increased marginally (81%, agree or strongly agree) (**Table 13**).

Table 13: Customer attitudes: the outlet had a wide range of healthy products available, pre and post introduction of the HRS

Attitude	Pre, N (%)	Post, N (%)	Percentage point difference
Agree strongly	155 (9)	196 (11)	↑ 2
Agree	1123 (66)	1226 (70)	↑ 4
Neither agree nor disagree	160 (9)	125 (7)	↓ 2
Disagree	237 (14)	157 (9)	↓ 5
Disagree strongly	29 (2)	49 (3)	↑ 1
Total	1704[1]	1753[2]	

[1] Missing values: for Outlet type/not applicable/don't know N = 214; [2] don't know = 275, refused = 1

There was a similar modest rise in the percentage of respondents who thought that the outlets provided a 'wide range of healthy products' after the introduction of the HRS across all the different outlets (**Table 14**).

Table 14: Customer attitudes: the outlet had a wide range of healthy products available pre and post introduction of the HRS, for the different outlets

Attitude	**Outlet 1**		**Outlets 2 and 3**		**Outlet 4**	
	Pre	Post	Pre	Post	Pre	Post
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Agree/strongly agree	444 (91)	517 (95)	523 (68)	488 (75)	311 (70)	417 (75)
Neither agree nor disagree	22 (5)	19 (3)	97 (13)	79 (12)	41 (9)	27 (5)
disagree/strongly disagree	20 (4)	8 (1)	152 (20)	88 (13)	94 (21)	110 (20)
Total	486	544	772	655	446	554

The modest increase in the percentage of respondents agreeing that the outlets had a wide range of healthy products was also seen across all the income groups (**Table 15**).

Table 15: Customer attitudes: the outlet had a wide range of healthy products available pre and post introduction of the HRS, by household income

Attitude	**Low (<£25,000)**		**Medium (£25,000 to <£45,000)**		**High (£45,000+)**	
	Pre, N (%)	Post, N (%)	Pre, N (%)	Post, N (%)	Pre, N (%)	Post, N (%)
Agree/strongly agree	417 (76)	442 (82)	349 (76)	371 (83)	370 (71)	429 (76)
Neither agree nor disagree	54 (10)	40 (7)	42 (9)	30 (7)	52 (10)	41 (7)
disagree/ strongly disagree	76 (14)	57 (11)	70 (15)	46 (10)	99 (19)	92 (16)
Total	547	539	461	447	521	562

Component 3: changes to the outlets and retailer views of the HRS

Purpose

This component aimed to contribute to answering the following evaluation questions:

Q1: Was the HRS implemented as intended and in a way likely to impact on purchasing behaviour?

Q2: Were there variations in implementation (at outlet and Health Board level) and did it have a positive or negative effect on purchasing behaviour?

- Specifically, was there variation in retailers' awareness, attitudes and understanding of the HRS?

Q4: Did the cost of food and drink change?

- Specifically, has there been a change in the price of a selected range of products?

Q6: What is the impact of complying with the HRS on the outlet, including economic sustainability?

- Specifically, what is the retailers' experience of complying with the HRS.

Methods

Structured observation of stock, layout and promotions in 13 retail outlets and four trolley services[30] was carried out before (August to November 2016) and after (August to November 2017) the implementation of the HRS.

In addition, a structured interview was carried out with a retail manager, or a nominated member of staff, for each of the 13 outlets before and after the implementation of the HRS.

Structured observations

Outlets were recruited purposefully to get a mix in relation to: type of outlet (commercial, voluntary sector), Health Board, urban/rural mix and progress towards HRS compliance). All observations were carried out with the permission of the retail manager and the relevant NHS staff.

A structured observation protocol was developed and piloted in non-hospital outlets (Appendix A), collecting information on a number of items (**Table 16**).

[30] A trolley is a mobile cart which visits hospital wards with a range of products for sale. They are usually run by one of the outlets operating on the hospital site

Table 16: Items recorded in the structured observations of retail outlets

Structured observation
Size and layout of the store
Number (SKU[31]) of chocolate and fruit products on display
Assessment of quality and appeal of fruit on display (using a five-point scale: 1 = appealing and 5 = unappealing/dried out/rotten[32])
Number of promotions[33] for chocolate and fruit
Use, nature and price of meal deals
The price of the cheapest and most expensive sandwich, 500 ml water, and 330ml soft drink on display
The number of local competitor retail outlets on site and in the immediate vicinity of the site, within a 10-minute walk

The structured observations took 45–60 minutes per outlet.

Structured interviews with retail managers

Interviews took 45–60 minutes each, exploring the following themes: awareness, understanding of and attitudes towards HRS; challenges to implementation and level of support received; barriers and facilitators to implementation; impact on business; perceived customer response; and unintended or unforeseen consequences (see Appendix B for the interview discussion guide).

Interviews were recorded with the interviewee's consent. Interviewees were offered an incentive of £10 in cash at each wave as a thank you for their input and to compensate them for any inconvenience.

[31] SKU: stock-keeping unit. This is a distinct type of product differentiated from others on the basis of attributes such as brand, size, flavour and packaging, e.g. Brand X milk chocolate bars in different weights would each have different SKUs, as would different flavour variants. For fruit, we counted different varieties of the same fruit and different pack sizes as different SKUs.
[32] If half of the fruit looked appealing and half unappealing, a score of 3 would be given.
[33] Promotions included: **product displays** (temporary or permanent display stands, stacks or branded units designed to feature a particular brand or product); **price-marked packs** (products with the price printed in large type on the pack or wrappers); **multi-buys or quantity discounts** (offers such as '3 for the price of 2'); **advertising** (posters, stands, electronic screens, shelf-edge signage); **other** (e.g. verbal promotions at the till, large photographs or printed images of products). Where multiple identical items were present – such as branding on all shelves in a unit – these were coded once only.

Analysis

Structured interviews were recorded and fully transcribed. Text data were coded thematically by the researchers carrying out the interviews.

Ethical approval

Ethical review and approval were provided by the University of Dundee Research Ethics Committee.

A journal article describing this component is also available.[34]

[34] Stead M, Eadie D; McKell J; Sparks L; MacGregor A; Anderson A. Making hospital shops healthier: implementation of an innovative nutrition-based mandatory standard for products and promotions in hospital food retail outlets (submitted 2018 to International Journal of Behavioral Nutrition and Physical Activity).

Findings

Characteristics of the study sample

Nine of the 13 outlets included in the evaluation were based in large, city-based hospitals. The remaining were based in small or medium-sized hospitals (**Table 17**). There was a mix of management types and preparedness for the HRS (**Table 18**).

Some outlets had a large number of nearby competitors outside the hospital (e.g. outlets 3, 4, 9 and 11), and others had limited competitors nearby.

Interviews were conducted with 16 retail staff before and after implementation of the HRS (**Table 19**). For some retail outlets more than one person was interviewed. Ten of those interviewed before implementation were also interviewed after implementation. Where the manager was not available in the post-implementation period, an interview was conducted with their replacement or another nominated member of staff. Consent to be recorded was given for all but one interview. Notes were taken during and immediately after the interview with the manager who did not want their interview recorded.

Table 17: Retail outlets included in the structured observation and research interviews

	Hospital	**Retailer**	**Nearby competitors[1] (internal; external)**	**Trolley service included**
1	Large hospital	Large national retailer	1;1	No[a]
2	Large hospital	Large national retailer	1;1	No[a]
3	Large hospital	Large national retailer	2;11	No[a]
4	Large hospital	Small independent commercial retailer	2;11	No[a]
5	Medium-sized hospital	Local hospital volunteers	0;0	Yes
6	Large hospital	Large national retailer	1;1	No[b]
7	Large hospital	NHS run	1;1	No[a]
8	Large hospital	Large national retailer, voluntary sector	0;1	Yes
9	Large hospital	Large national retailer, voluntary sector	1;7	Yes
10	Large hospital	Large national retailer, voluntary sector	5;3	No[c]
11	Small, non-acute, specialist hospital	Large national retailer, voluntary sector	0;26	No[c]
12	Medium-sized hospital	Large national retailer, voluntary sector	0;0	No[c]
13	Medium-sized hospital	Large national retailer, voluntary sector	0;1	Yes

[1]: internal retailers refers to other retailers within the hospital site, external retailers refers to those external to the hospital site but within a 10-minute walk.
a: the retailer did not operate a trolley service, **b**: the retailer did not operate a trolley service pre HRS but had started to by post HRS, **c**: the retailer did operate a trolley service but was not included in the observations.

Table 18: Management type for retail outlets included in the structured observation and research interviews

	Fixed outlets	**Trolley services**
Type of management		
Commercial (national retailer)	4	-
Commercial (independent)	1	-
Voluntary sector (national retailer)	6	3
Voluntary sector (independent)	1	1
Other	1	-
Retail category		
Retail	9	3
Mixed retail and catering	4	1
Stage of HRS implementation at wave 1		
Not yet started	5	-
Partial	8	4

Table 19: Retailer interview sample by wave and professional role of interviewee

Professional role of interviewee	**Pre**	**Post**
Business proprietor	1	0
Regional manager	0	2
Outlet manager	13	11
Outlet deputy/supervisor	2	2
Outlet assistant	0	1
Total	16	16

Change in product range

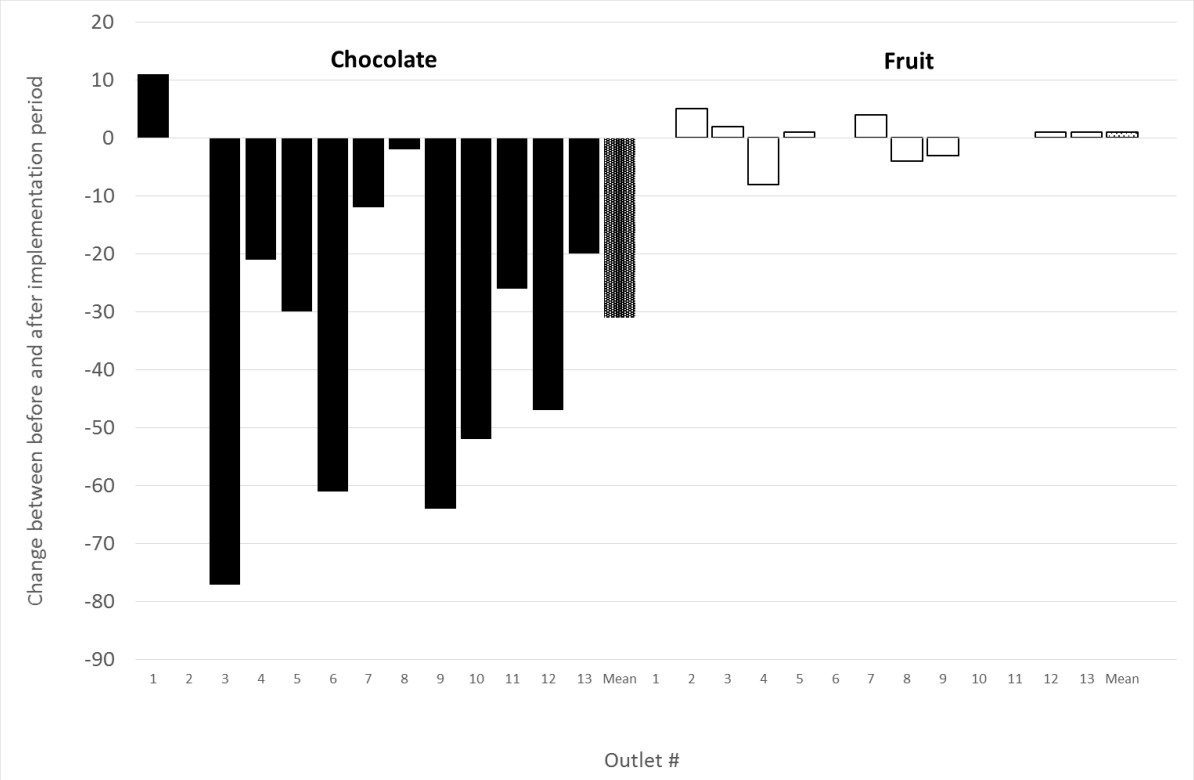
The number of lines of chocolate displayed decreased notably after the implementation of the HRS, although there was no consistent change in the number of fruit lines on display after HRS implementation (**Figure 21** and Appendix D). The change in the number of chocolate lines was similar for the commercially run outlets and the outlets run by the voluntary sector (data not shown).

The trolley services were observed at different times – for example just after it was loaded, after it had been around the wards and item purchased and before it was fully loaded. For this reason the observational data from the trolleys are not a reliable reflection of how compliant the trolley was and was not used further. As with the

fixed outlets, the trolleys tended to stock a lot more chocolates and crisps than HRS-compliant products before the HRS and had to make significant changes to the products stocked to comply with the HRS.

The fruit displayed in the fixed outlets was generally of good quality, with a mean score of 2 (range: 1–5, where 1 = most appealing and 5 = least appealing). There was no change in the quality of the fruit after HRS implementation.

Figure 21: Change in the number of chocolate and fruit on display before and after HRS implementation



Change in use of promotions

The number of promotions for chocolate decreased substantially after the implementation of the HRS. Some price mark pack promotions remained after implementation; those taking up less than 25% of the package were permitted under the HRS. A small number of product display promotions, not permitted under the HRS, were still evident after the implementation deadline (**Figure 22** and Appendix D).

There were fewer promotions for fruit than chocolate before the implementation of the HRS (n = 52 for fruit and n = 166 for chocolate). After implementation the number of promotions for fruit increased marginally (to n = 69) (**Figure 23** and Appendix D).

Figure 22: Number of promotions used for chocolate before and after HRS implementation

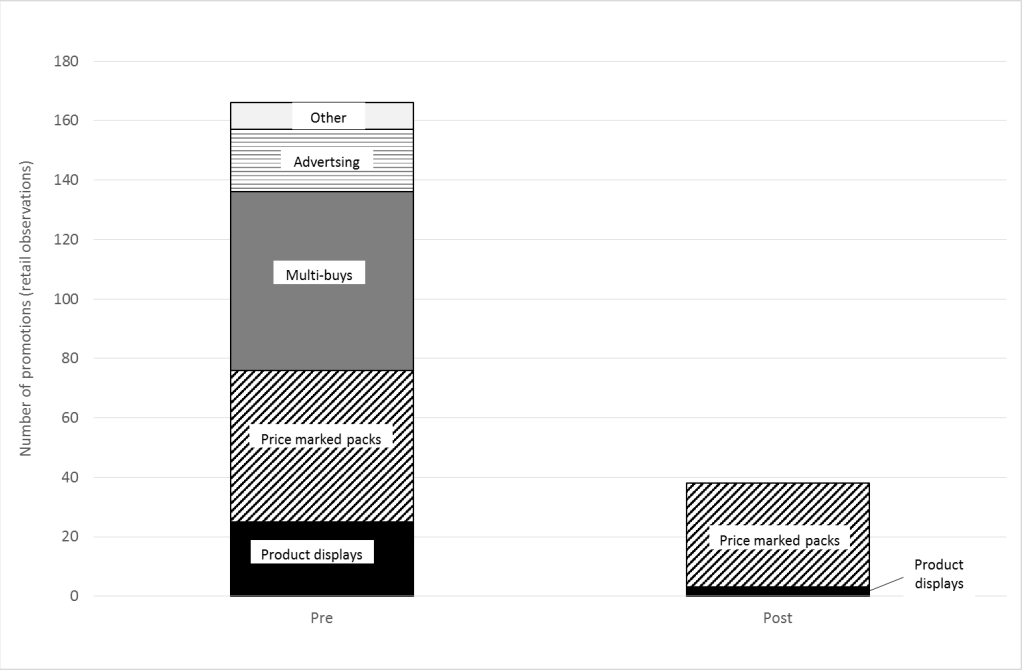
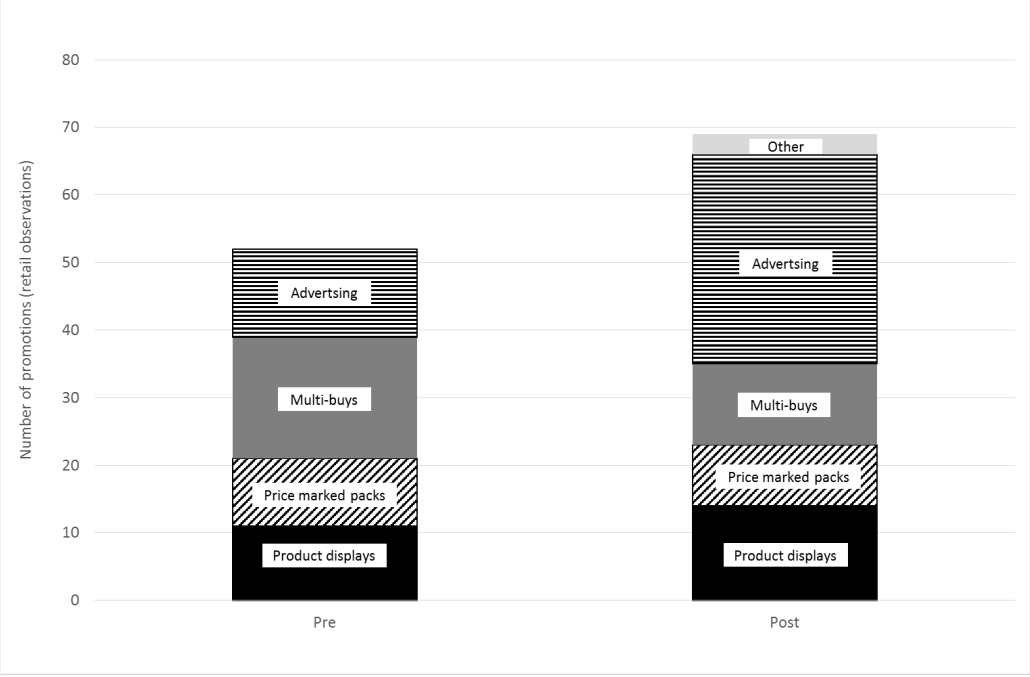


Figure 23: Number of promotions used for fruit before and after HRS implementation



Change in product prices

There was no notable increase in the cost of the food and drink after the implementation of the HRS (**Table 20**).

Table 20: Price of selected products before and after HRS implementation

	Sandwich		**500ml water**		**330ml soft drink**	
	Cheapest, mean	Most expensive, mean	Cheapest, mean	Most expensive, mean	Cheapest, mean	Most expensive, mean
Pre-HRS (range)	£2.13 (£1.00–2.99)	£3.45 (£2.90–4.00)	£0.79 (£0.39–0.99)	£0.95 (£0.59–1.39)	£0.95 (£0.45–£1.40)	£1.22 (£0.80–1.85)
Post-HRS (range)	£2.28 (£1.00–3.00)	£3.27 (£2.45–3.80)	£0.76 (£0.39–1.09)	£0.96 (£0.59–1.59)	£0.98 (£0.50–£1.85)	£1.22 (£0.75–1.85)
Change, (%)	↑15p (7%)	↓18p (5%)	↓3p (4%)	↑1p (1%)	↑3p (3%)	0p

Eleven of the 13 outlets offered fixed price meal deals (for example, a free bottle of water with any sandwich and a snack) before and after implementation, the price varying from £2.50 to £4.79. Some outlets offered two meal deals, a budget deal and a more expensive deal. The price of meal deals did not increase notably after HRS implementation (**Table 21**).

Table 21: Price of meal deals before and after HRS implementation

Timing	No. of outlets	Price: cheapest[1]	Price: expensive[1]
Pre-HRS	11	£3.82	£4.03
Post-HRS	11	£3.84	£3.99
Difference	0	↑ £0.02	↓ £0.04

[1] Includes data from all 11 outlets. Where the outlets offers both a budget and more expensive meal deal, the price of the budget meal deal is used to calculate the cheapest price and the more expensive meal deal is used to calculate the expensive price.

Retailer views of the HRS

These findings are based on the interviews conducted with retail managers from 14 outlets (see Appendix B for the discussion guide). Managers were interviewed 4 to 7 months before implementation and again 5 to 8 months after implementation. See the methods section in this chapter for further details.

Business context

The retail managers saw NHS staff as a key customer group, visiting outlets regularly, typically for snacks and lunch.

Trolleys were seen as a contractual obligation or a service for bed-bound patients, rather than a commercial opportunity. Only four trolleys services were included in the sample. There was inconsistent reports of the impact of the HRS on these four trolley services from managers making it difficult to say with any accuracy what impact the HRS had on trolley services.

Managers' awareness of, and attitudes to, the HRS

In the pre-implementation period few managers were familiar with the term Healthcare Retail Standard. Although most had an awareness of the general requirements of the HRS even if they did not know it by that term, such as the requirement that at least 50% of the food range and 70% of the drinks range should comply with a certain standard, and the removal of promotions. They were less aware of the details, such as the nutritional criteria for defining compliance.

It was common for managers to confuse the HRS and the healthyliving award, a similar initiative for catering outlets brought in several years before. The similarity to CQUIN[35] criteria in England and Wales also created some confusion for managers.

After the implementation deadline the awareness of the details of the HRS was greater although there was still some confusion, particularly on the requirements around promotions.

Support for the HRS

Before implementation retail managers were largely not supportive of the HRS. Retail managers were concerned that it would be difficult to implement the HRS and would impact on business, even if there was not opposition to the purpose of the HRS, per se. Some managers voiced concern that the HRS would ultimately impact on jobs. Some suggested the HRS would limit choice and that customers (mainly staff) would bring into the hospital what they can no longer purchase in the store.

After implementation attitudes were more positive, with most managers reporting that implementation wasn't as difficult as they had initially thought it would be.

Experience of implementing the HRS

Variation in implementation

All but one of the 14 outlets included in the evaluation achieved compliance with the HRS by the deadline. There was variation in implementation, in terms of ease and timeliness of meeting the implementation deadline and achieving greater than the required proportion of compliant products. This variation was largely related to different management structures. National retailers had more resources so found implementation easier than the small independents. One national retailer had a large number of outlets in the high street but few outlets in hospitals in Scotland. Their focus on implementing the HRS was less than for the other retailers that had more of a presence in NHS Scotland facilities.

[35] www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19

For smaller premises, some of the criteria were difficult to implement and flexibility in applying the criteria was required. For example, under the HRS, non-compliant products are not allowed to be displayed next to the till. However, in smaller premises the area next to the till represents a large part of the shop. By and large, managers reported that a 'common sense' approach was adopted by the assessors during the compliance audits.

Time for implementation

Health Boards were informed about the HRS in October 2015, 17 months before the implementation deadline. Most managers felt this gave them sufficient time to implement the HRS. Typically, most outlets began to transition to implementation 6 to 8 months before the deadline. Managers identified that this relatively long lead-in time was needed to trial out new products and, in some circumstances, new layouts. Some outlets experimented with shifting their promotional activity from non-compliant products to non-food/drink items, such as facial wipes, etc.

> 'Just because our confectionery is down 40%, our sales are not down 40% because we've looked at different things to bring into the business'
>
> Retail manager.

A few outlets started to implement only a few months before the deadline, which posed challenges for achieving compliance as there was limited time to trial new products.

Product lines

Managers reported that the HRS required a substantial change in their product range to achieve the 50/50 balance between compliant and non-compliant products.

Initially, suppliers did not have a sufficient range of HRS-compliant products. However, suppliers did begin to reformulate their products to meet the HRS criteria. For example, for one outlet their supplier of sandwiches initially had only four

compliant sandwich lines, but after they reformulated their products the range of compliant sandwiches was better than the range of non-compliant sandwiches.

Managers found that many of the compliant products, snacks in particular, were more expensive than their non-compliant counterparts because the non-compliant snacks were generally produced at a smaller scale. Managers hoped that as sales and production increased, the costs of the compliant snacks would fall and make them more attractive to customers.
Managers did not tend to source fresh produce, such as fruit, to achieve compliance, but rather aimed to source processed compliant products. Managers generally reported fruit did not sell well.

Support for implementation

In general, retail managers reported that Health Board leads did not provide them sufficient support, although some Health Board staff did provide nutritional support and advice to, particularly, the small independent outlets.

The support offered by SGF was positively received by most retail managers. Managers generally saw them as an ally to help support and coach them to reach compliance. Managers did report that once they had reached compliance, contact with the assessment team effectively stopped. They had hoped that the assessors would provide continued support after the deadline.

Implementation resulted in a significant increase in the skill set of the manager, especially around understanding nutritional criteria and sourcing products.

Communicating with the customer

Managers reported that there was little or no awareness raising of the HRS to NHS staff and other customers. Outlets did receive complaints from customers (for example, when the customer could no longer get a product), and the managers felt that some awareness raising of the HRS would have allowed them to handle these complaints more easily, especially if the NHS had produced material that they could have directed customers to.

Some managers felt they needed to communicate the HRS positively to the customer, even if they weren't positive about it themselves. Others were less inclined to defend the HRS, reporting to the customer that it was something they had to comply with rather than something they supported.

Component 4: NHS implementation

Successful implementation of the HRS by the retail outlets relied on action from several national and local leads. The SGF HLP were tasked with supporting the outlets to comply with the HRS and carrying out the compliance audits. Each of the 14 Health Boards in Scotland were responsible for ensuring that all outlets on NHS facilities in their area were compliant. NHS Health Facilities Scotland (HFS) were tasked with supporting all NHS Health Boards to ensure their outlets complied with the HRS. A policy lead from the Scottish Government was responsible for overseeing the implementation at a national level. The national implementation team was made up of the Scottish Government, NHS HFS team and the SGF HLP team. In addition, a national HRS Implementation Group was created, which included the national implementation team together with other colleagues that could support the implementation.[36]

This component of the evaluation explored how well the processes within these organisations supported HRS implementation by the retail outlets.

Purpose

This component aimed to contribute to answering the following evaluation questions:

Q1: Was the HRS being implemented as intended and in a way likely to impact on purchasing behaviour?

Q2: Was there variation in implementation across Health Boards and did it have a positive or negative effect on purchasing behaviour?

[36] The group included representatives from the Scottish Government's diet policy team, Scottish Grocers' Federation Healthy Living Programme, NHS Health Scotland's diet and obesity team, NHS Health Facilities Scotland, one of the retailers operating in NHS Scotland, NHS Health Board staff from Greater Glasgow and Clyde (which had developed a food retail policy for their health board before the HRS was developed) and Grampian, and the healthyliving award team.

Methods

The key elements for successful implementation were identified (**Box 2**), based on the infrastructure support element of Food-EPI, Swinburn, 2013[37] and Phulkerd et al 2016.[38]

Box 2: Key elements for successful implementation

- What **monitoring and evaluation** mechanisms are in place?
- What is the (infrastructure) **support** available?
- What **resources** are available?
- What mechanisms are in place to **engage stakeholders**?
- What **enforcement** mechanisms are in place?
- What is the **leadership** around this? Nationally, locally?
- What are the implementation **governance** mechanisms?

Indicators for each of the key elements for successful implementation were developed (Appendix G). Interviews with local leads (i.e. from NHS Health Boards) and national implementation leads were carried out to provide data for each indicator.

Two fieldworkers carried out interviews either in person or by telephone, using a structured interview schedule (see Appendix E for all interview schedules). Written consent to conduct and record the interview (Appendix F.2) was obtained prior to carrying out the interviews. The interviews took approximately 45 minutes. Interviews were digitally recorded and notes made from the recording by the interviewer who did not carry out the interview. The interviewer who had carried out the interview then checked the notes before a final version of the interview notes was created.

[37] Swinburn et al, 2013. Monitoring and benchmarking government policies and actions to improve the healthiness of food environments: a proposed Government Healthy Food Environment Policy Index. Obes Rev 2013 Oct;14 Suppl 1:24–37. www.ncbi.nlm.nih.gov/pubmed/24074208

[38] Phulkerd et al. A review of methods and tools to assess the implementation of government policies to create healthy food environments for preventing obesity and diet-related non-communicable diseases. 2016. Implementation Science 11:15. www.ncbi.nlm.nih.gov/pubmed/26846789

There were no disagreements between the interviewers on the content of the interview notes.

Microsoft Excel (2013) was used to analyse the interview notes. Each indicator was populated with the relevant text from the interview notes and the data synthesised using the infrastructure support element of Food-EPI structure (**Box 2**).

Findings

Structured interviews were conducted with all but one of the Health Board leads and all of the three national leads. Each Health Board lead was interviewed once.

Interviews with Health Board leads took place between four months before and three months after the implementation deadline (see Appendix H for dates of interviews). National leads were interviewed three months after the deadline.

NHS Health Board leads came from public health or health improvement departments or from a facilities role.

Monitoring and evaluation mechanisms

The policy was accompanied by funding for an independent evaluation, culminating in this final report.

Available data

Key data (e.g. list of outlets in each Health Board, list of staff in each Health Board that were responsible for local implementation, etc.) that were needed to manage and monitor the implementation was not initially available and took several months for accurate national data sets to be produced. This was largely because there had been not prior reason for the data to be collected. This resulted in delays in the implementation at the early stages of the HRS. For example, an accurate list of the retail outlets was needed for communicating with and planning support for the retailers, for monitoring the completeness of reporting systems, etc.).

Reporting

Most Health Boards reported on the HRS alongside the healthyliving award Plus, an existing initiative similar to the HRS in that it requires catering outlets in hospitals in Scotland to adhere to a set of nutritional standards. As a result, reporting on the HRS by Health Boards required little additional resources.

Monitoring and quality control

The initial implementation largely relied on national-level stakeholders working together to ensure the necessary changes were brought about within the outlets. There were some exceptions where proactive Health Board staff were heavily involved in working with outlets to ensure compliance. Conversely, support for on-going compliance was more reliant on Health Board leads ensuring that the changes became standard practice, in terms of quality control checks in between the two yearly audits and monitoring.[39] Some Health Boards had begun this process but most had not identified what their role was in ensuring the HRS was standard practice. In addition, the relationship between Health Board leads and the outlets are in their infancy – there has been no reason for them to interact in the past.

Support and resources

Pilot sites

Five outlets worked towards implementation in July 2016 (9 months before the deadline) to identify any implementation issues. From this process the criteria were modified. This was key in identifying unintended consequences and modifications needed to help outlets meet the criteria. It also provided the national leads with confidence that the criteria could be met, particularly when working with stakeholders that were less supportive or knowledgeable of the initiative.

From national leads to local NHS partners

The NHS HFS lead identified that working with 14 separate Health Boards leads was resource intensive but necessary. Health Board leads were generally positive about the support provided by the HFS team.

Health Board leads also worked with the HLP team and were largely positive about the support received, although some felt ‘side-lined’ and out of the loop in terms of the initial implementation. This suggests that including ‘engaged’ Health Board leads

[39] In 2018 the audits became 6-monthly, reflecting the need for more frequent monitoring.

during the initial implementation would have keep these Health Board leads on-board.

The Scottish Government produced a HRS criteria paper and the HLP team published retailer guidance to support action for compliance. HFS also produced guidance for Health Boards explaining the contractual requirements of the HRS. These were circulated to the relevant audiences and discussed at information-sharing events. However, there remained limited awareness of these three documents by Health Board leads; for all NHS leads the HRS was only one part of their remit. This suggests that more work was needed to raise awareness of this documentary support, taking into account that the relevant audience is likely to be bombarded with a large amount of information on not only the HRS, but also all the other areas they are responsible for.

The retail knowledge and understanding of HLP team was reported as invaluable by national implementation leads. This retail knowledge enabled the national implementation team to distinguish between what was not possible and what was not wanted in terms of the HRS criteria and helped identify unintended consequences.

Timeliness

There were a number of changes to the HRS criteria in the 17 months leading up to the implementation deadline. This was largely responding to learning from the pilots and other issues arising as outlets began to implement changes necessary to achieve compliance. In addition, it took time for the auditing framework and quality control processes to be developed. Some of these processes could only be developed as the outlets started to implement the HRS while others could have been developed before the HRS was launched.

Engaging stakeholders

The existence of the healthyliving award facilitated the implementation of the HRS in that: (1) there were existing relationships between local leads (both Health Board leads and outlets) and many of the national leads; (2) there was familiarity with the concept of a set of nutritional criteria; and (3) the Health Board leads were able to tap into existing groups for support with implementation.

HFS organised two events to inform and engage with Health Board leads, as well as providing a web-based seminar and producing newsletter-type communications. Most Health Board leads felt this was sufficient and proportionate.

Health Board leads largely felt they had the resources needed to support implementation of the HRS – in terms of their own time and the links with other relevant Health Board colleagues.

Engagement with customers was seen as a missed opportunity by many. Both the national HFS lead and many of the Health Board leads would have welcomed communications support and resources to be able to raise awareness of the HRS with customers and to 'sell' it to them. Other components of this evaluation also identified that outlet managers would have welcomed more awareness raising around the HRS. Although some Health Boards did raise awareness of the HRS through channels such as staff internet, most felt that it was the responsibility of the national implementation team to raise awareness of the HRS.

Enforcement

The HLP team were responsible for auditing the outlets and took a collaborative approach to enforcement, aiming to support outlets to achieve compliance if they failed initial audits.

Ultimately it was the Health Board leads responsibility to ensure compliance, through withdrawal of the contract (see **HRS Implementation process** for more details). Most Health Board leads knew the enforcement process, and envisaged a similar collaborative approach to enforcement to that taken by the HLP. Several were

sceptical that a contract would be withdrawn because of failure to comply with the HRS.

Challenges

Health Boards identified 'pop-ups'[40] and nearby food vans as a challenge to implementation. Many of the pop-ups sell a single category – e.g. a cheese stall. Innovative solutions will be required in these circumstances and are being actively sought by the national implementation team. Health Board leads who support the principles of the HRS are likely to pursue solutions that adheres to the principles of the HRS (i.e. provision of health-promoting food offer in NHS facilities) rather than a solution that subverts the HRS.

Leadership and governance

Significant support for the HRS was evident at various levels: national leads felt there was significant support for the HRS from Ministers and Chief Officers. Health Board leads reported that the HRS largely had the support of their senior managers in their Health Board, which facilitated their focus on the HRS.

Although Health Boards leads all supported the rhetoric of the HRS not all leads felt it was the primary concern of the NHS to influence the commercial food environment in hospitals. The degree to which the Health Board leads supported the principles of the HRS was not related to the background of the leads – i.e. if they were in public health or health improvement departments or from a facilities role. Lack of support for the HRS is likely to have an impact on the degree to which resources are dedicated to ensuring quality control and ongoing compliance.

There was some evidence of innovation in supporting the HRS. One Health Board in particular championed the HRS and was very proactive. One Health Board lead perceived NHS-run facilities as innovation because the goal of the outlet could be more easily aligned to the goal of the HRS and other NHS initiatives.

[40] A pop-up is a temporary outlet that is given permission to operate for a limited period of time (e.g. the pre-Christmas period, Easter) often in the entrance hall of a hospital.

Context

As identified above there was not universal support from NHS Health Board leads for the premise of the HRS. However, the trend in the commercial sphere towards providing “healthier” products did help with the acceptance of the HRS by Health Board leads.

Contractual arrangements

The HRS was a contractual requirement for all new contracts in NHS facilities in Scotland. So although the deadline for implementation was set for 31 March 2017, retail outlets were not contractually required to comply until the renewal of their contract. Some outlets did not have a contract.[41] In addition, in Private Finance Initiative hospitals many contracts were not due for renewal for eight or more years. In these circumstances there was no contractual obligation for the outlet to comply with the HRS. Initially, there was concern by most local and national leads that this would create disparity in the sector. In the event this was not the case. All outlets worked towards the March 2017 deadline regardless of their contractual arrangement. This is possibly because compliance with the HRS provided a competitive advantage in negotiating new contracts so there was an incentive for most outlets to adhere to the March 2017 deadline.

[41] This was mostly where the same provider had been operating in the same site for a long period of time.

Conclusions

What worked well?

- ✓ The HRS was successfully implemented, with 97% of outlets compliant soon after the deadline and 100% by the end of 2017.
- ✓ The national implementation team dedicated significant resources to developing relationships, finding allies and providing support to both the retailers and NHS Health Board staff responsible for ensuring compliance locally. This resulted in most of the stakeholders feeling they received the appropriate support and likely contributed to the high compliance rate.
- ✓ The HRS had a positive impact on purchasing – there was an increase in the amount of HRS compliant food and drink bought and a decrease in the amount of non-compliant products bought. The HRS did not change the cost of the food and drink offered or increase inequalities in access to healthier products.
- ✓ The HRS did result in a fall in overall sales. This was because the fall in sales of non-compliant products was greater than the increase in sales of compliant products. Sales have now begun to increase albeit not to pre-HRS levels. Retail outlets are still experimenting with different types of offer to increase sales and are still keen to expand their business in the hospital setting. Further monitoring of future sales will be needed to determine trends in the medium and long term.
- ✓ There was considerable anxiety among retailers about how they would comply with the HRS and of the impact of the HRS in on sales. After the successful implementation, retailers were generally more positive about the HRS.

What could have been done better?

- There was limited communication with customers – staff, patients and visitors – about the HRS, its purpose and its ambition. This was a missed opportunity to promote what the HRS was aiming to achieve and to build support, and an expectation, in the population that the food environment should work for us.
- Compliance with the HRS had begun to slip several months after the deadline. Processes to ensure continued compliance need to be strengthened. More engagement with NHS Health Board leads – who will be critical in ensuring ongoing compliance locally – is needed to ensure this agenda is seen as important. Re-engagement of the HLP team with outlets in between biennial audits will be necessary. Reflecting the slippage in compliance, the auditing schedule has been increased to 6 monthly.

Acknowledgments

The evaluation could not have happened without the enthusiasm and support of: The Evaluation Advisory Board: **Claire Hislop** (Organisational Lead – Diet & Healthy Weight, NHS Health Scotland); **Abigail Cork** (Programme Manager, Health Facilities Scotland, NHS NSS); **Gillian Purdon** (Diet and Nutrition Advisor, Food Standards Scotland); **Peter Faassen de Heer** (Diet Policy Executive, Scottish Government); **Elinor McCann** (Head of Catering, NHS Grampian), **Ross Kerr** (Scottish Grocers' Federation); **Kathryn Neil** (Programme Director, Scottish Grocers' Federation); **Ian Rankin** (Category Director, WHS Smith Travel); **Andrew Roberts** (Head of Retail Operations, Royal Voluntary Service); **Rebecca Sludden** (Research Services Officer, NHS Health Scotland); **Melanie Tsagalidou** (Project Officer, NHS Health Scotland).

Colleagues from Stirling and Dundee Universities and ScotCen, who carried out the customer survey, retails surveys and structured retail observations: **Martine Stead** (Deputy Director, Institute for Social Marketing, University of Stirling), **Andy MacGregor** (ScotCen Social Research), **Douglas Eadie** (Research Fellow, Institute for Social Marketing, University of Stirling), **Jennifer McKell** (Research Fellow, Institute for Social Marketing, University of Stirling), **Hannah Delaney** (ScotCen Social Research), **Annie Anderson** (Professor of Public Health Nutrition, University of Dundee), **Leigh Sparks** (Professor of Retail Studies, Institute for Retail Studies, University of Stirling).

NHS Health Boards leads and national implementation leads from Health Facilities Scotland, the Scottish Government and the Scottish Grocer's Federation Healthy Living Programme who kindly agreed to be interviewed and provided valuable insights into the implementation of the HRS.

The Royal Voluntary Service, WHSmith, Marks & Spencer and Scottish Grocers' Federation Healthy Living Programme for kindly providing valuable data.

Appendices

Appendix A: Retailer audit observation protocol

[The protocol for wave 1 was the same as for wave 2, spacing may be different in the operational tool]

ID ☐

SHeaRS AUDIT: Wave 1 observation protocol: Fixed outlets

Observer(s):

……

Day, date and time of visit:

……

Outlet name:

……

Location (hospital & Health Board area):

……

Opening hours (inc any variations at weekends etc):

……

Q1. Outlet category

a) Management category

- ☐ Externally managed: multiple (eg. WH Smith, M&S)
- ☐ Externally managed: symbol group (eg. Nisa)
- ☐ Externally managed: non-affiliated independent
- ☐ Voluntary (eg. RVS, League of Friends)
- ☐ Other: Write in:……..

b) Retail category

- ☐ 1. Newsagent/gift (eg. newspapers, gifts, confectionery, drinks)
- ☐ 2. Convenience (eg. snacks, grocery, sandwiches, salads, drinks)
- ☐ 3. Retail other (write in):
  ……
- ☐ 4. Mixed retail & catering (eg. includes takeaway hot food), assessed as predominantly retail

Q2. Size of sales area

If info not available from retailer, pace out sales area and write in (eg. 10 paces x 15 paces)

……

Q3. Layout of sales area

Using photographs where possible, produce a diagram of the sales area. Include in the diagram:

- Entrance/s and windows
- Till area and number of tills
- Fixed shelving (both gondola and wall)
- Free standing floor displays (including end of aisle displays, dump bins, temporary stacks)
- Countertop shelving and displays

SHADE all areas which display chocolate and all areas which display fruit (use two different colours).

Q4. Does the outlet sell chocolate (see definition)?

☐ Yes
☐ No

Q5. How many different chocolate products/ shop keeping units (SKUs) are on display?

Write number in each display area on diagram at Q3.

Count different sizes and flavours of same brand variant as distinct units.

Total number:……

Record any products you are uncertain about (inc. photos):

……

Q6. How many of the following types of promotions for chocolate are observed?

(*take photographs if possible*):

Type of promotion	**Number**
Promotional product displays (incl. temporary stacks, branded units, merchandising strips, dump bins)	
Price-marked packs (price printed on packaging or outer wrapper)	
Multibuys and quantity/bundle discounts (incl. "3 for 2", "3+1 free", reduced price fruit with newspaper)	
Advertising materials (incl. shelf signage, shelf danglers, posters, change mats etc. Where there are multiple identical signs/danglers in same shelving section, count once only.	
Other: write in type (include verbal offers by checkout staff)	

Q7. Does the outlet sell fruit (see definition):

- ☐ Yes
- ☐ No

Fruit products are:

Fresh fruit: Sold loose or pre-packed

Fresh fruit salad/fruit pots

Exclude:

Dried fruit bags or loose

Q8. How many different fruit products/SKUs are on display?

Write number in each display area on diagram at Q3.

Count different quantities (eg. loose and pre-packed) as separate units, also count different varieties as separate units.

Total number:……

Q9. How many of the following types of promotions for fruit are observed?

(*take photographs if possible*):

Type of promotion	**Number**
Promotional product displays (incl. temporary stacks, branded units, merchandising strips, dump bins)	
Price-marked packs (price printed on packaging or outer wrapper)	
Multi-buys and quantity/bundle discounts (incl. "3 for 2", "3+1 free", reduced price fruit with newspaper)	
Advertising materials (incl. shelf signage, shelf danglers, posters, change mats etc. If multiple identical signs/danglers in same shelving section, count once only).	
Other: write in type (include verbal offers by checkout staff)	

Q10. Quality/appeal of fresh fruit

Please photograph and rate the quality/appeal of the fresh fruit on display:

Most/all of the fruit looks appealing/fresh				Most/all of the fruit looks unappealing/ dried out/rotten
1	2	3	4	5

Q11. Standard food offer: meal deal availability

Does the outlet offer a meal deal (eg. bundle discount on sandwich/other meal item plus other items)?

- ☐ Yes: write in price and details (take photograph if possible)
  ……
  ……
- ☐ No, sells sandwiches/other meal items, snacks and drinks individually
- ☐ No, does not sell sandwiches/other meal items

Q12. Cost of individual items in a standard food offer

Please write in the prices of the following items, if sold.

If multiple items at cheapest/most expensive price, record details for all.

Take photographs of products showing FOP labelling if possible.

Item	Description	Price	Not sold
a. Cheapest roll/ sandwich/ wrap/ baguette	Include brand, filling, dressing/sauce, type of bread		
b. Most expensive roll/ sandwich/ wrap/ baguette			
c. Cheapest 500ml bottled pure water	Include brand, still/sparkling.		
d. Most expensive 500ml bottled pure water			
e. Cheapest 330ml soft drink excl, pure water	Include brand, flavour, any other info		
f. Most expensive 330ml soft drink excl. pure water			

Q13. Competing fixed outlets on study site

List each fixed outlet within the same study site by name in the left hand column and tick all that apply.

Include market stalls, fruit barras, mobile and pop-up shops.

FIXED RETAIL OUTLETS

Name of outlet	**Type of management**					**Retail category**				**Location**		**Write in ID if outlet included in audit**
	Ext. comm multi	Ext. comm symbol	Ext. comm ind	Vol	Other	News/ gift	Conv.	Retail other	Mixed retail/ catering	In same concourse	Elsewhere on site (write in how many mins walk)	

Q14. Competing retail outlets in local area (inc. mixed retail and catering outlets)

How many outlets of the following types are located within a one kilometre/ten minute walk radius?

Type of outlet	Number
Small stores	
CTN /newsagents	
Grocery/convenience	
Petrol station forecourt	
Fast food	
Off-license	
Mixed retail and catering	
Other (eg. market)	
Supermarkets	
TOTAL	

Appendix B: Retailer audit interview discussion guide

[This guide was used at wave 1 and 2]

Scottish Healthcare Retail Standard Study (SHeaRS)

Retailer Interview Topic Guide

A. Introduction

1. Recap purpose of study
2. Check you have sufficient time (approx. 40 mins) and privacy
3. Reiterate confidentiality and voluntary nature
4. Check participant is happy for the interview to be recorded and explain its purpose
5. Check participant is happy for the researcher to complete a short observation of in-store displays and to take some photographs of the shop layout after the interview
6. Check if the participant has any questions before proceeding

The following questions should NOT be regarded as prescriptive but rather as examples of probes for initiating discussion around key research themes. Interviews should be conducted in a naturalistic manner. Themes need not necessarily be explored in the following order and should be tailored in accordance with participant's position and experience.

B. Interviewee and case business (limit follow-ups to 'any changes since we last spoke'):

1. Confirm position - owner, shop manager, nominated representative etc
2. Overview of business ownership (including whether external lease or in-house NHS service), management arrangements (including whether voluntary or commercial) and range of services provided, including trolley services, market stalls and fruit barras
3. Overview of key business areas in terms of turn-over and customer groups
4. Overview of competitive context: other businesses on and off site, including those onsite also covered by the Standard and variation in implementation schedules.

C. Awareness, understanding and attitudes towards HRS

1. Awareness and understanding of the aims and purpose of the Standard (explore perceived importance of food choice to health) / check if already comply with the Healthy Living Award – HLA (mixed retail and catering only)

2. Awareness and understanding of the qualification criteria and implementation timetable – what are the qualifying criteria and when does the standard apply/need to be enacted? / (if appropriate)
3. Awareness and understanding of the scope of the Standard – what aspects of food provision and marketing does it cover? / how easy/difficult have you found it to understand?
4. What have been the main sources of advice and information on the Standard and its implementation (if any)? / how proactive have you been in seeking information? / what agencies have provided you with information? (Probe for external agencies including HLP guidance and local Health Board as well as support from within the retail group and other retailers as appropriate. Request copies of any documents used to support implementation such as planograms and guidance documents)
5. Attitudes and level of support for the Standard, esp. regarding its perceived value and effectiveness – how do you feel about the Standard? / what's you view on its (likely) impact and effectiveness? / have your views changed in any way overtime/having implemented the Standard? (follow-up only)

D. Implementation of HRS

1. What actions do you intend to take / have you taken in order to prepare for / implement the Standard? Will this / has this involve(ed) any staff training or briefing? (Request retailer to walk you through the store to highlight the physical changes planned and made, esp. regarding number of products on sale, display arrangements and layouts, and product promotions)
2. Do you expect it will / has it affect(ed) the products that you stock in any way / your product range in anyway? (Probe for any changes to key product categories: fruit, vegetables, chocolate, soft drinks, meal items, 'healthy items' including nuts and cereal bars)
3. What do you expected to be / have been the main challenges to implementing the Standard (if any) / what elements of the Standard do you anticipate will be / have been easier/more difficult to implement? how do you intend to /have you address(ed) these issues?
4. What do you expected to be / have been the main opportunities presented by the Standard (if any) and how do you intend to /have you taken advantage of these? (Probe for any impact of change in product lines and promotions to business image and customer profiles and purchase patterns – see under impact below)
5. Do you anticipate / have any other local businesses been affected by the Standard? In what way / how will/have they respond(ed)? Will/has it had any implications for your own business? (Probe for any variations in how other businesses have responded and been effected - see also competitive impact below)

6. What arrangements are in place for monitoring compliance with the Standard? / (if appropriate) are you aware if any efforts have been made to check compliance? / what kind of feedback have you received if any / how helpful has this been? (Probe for interactions with HLP and local Health Board)
7. What are the implications for you as a business for failing to comply or for any short comings in compliance, including sanctions and impact on lease renewal?

E. Expected and perceived impact of HRS

1. Do you anticipate the Standard will have / has had any impact on your business performance, including impact on turnover, profits, long term viability, (Probe for any changes in more/less profitable food lines)
2. Do you anticipate / has there been any costs to the business associated with making the necessary changes to accommodate the Standard? (Probe for installation of chiller shelves, level of food wastage) / has the Standard allowed you to make any savings? / (if appropriate) has it affected the value and attractiveness of lease agreements, willingness to renew lease agreements?
3. Do you anticipate the Standard will have / has had any impact on competitor environment / your ability to compete with other local businesses / has had a differential impact on your local competitors? (Probe for how the Standard will/has effect(ed) other local businesses and any actions anticipated/taken, including information on their implementation schedule / intentions)
4. Do you anticipate the Standard will have / has had any impact on customer numbers / profiles / loyalty / purchasing patterns / average spend? (Probe for any changes in type of customer, esp. perceived affluence, amount available to spend, shifts in popularity of types of food purchased re healthy and less healthy choices esp. fruit and chocolate, and shifts in motives for purchase esp. more/less customers buying meal choices)
5. How do you expect customers will respond / have responded to the Standard if at all? (Probe for level and nature of feedback, including any awareness of and attitudes towards the Standard and/or specific changes made in order to comply with the Standard)
6. Do you anticipate the Standard will have / has had any (other) unintended consequences, positive or negative?

F. Trolley service

(If the retailer also operates a trolley service in the hospital ask the following key questions. These are intended to cover the same broad areas)

1. What are your feelings about the Standard also applying to products offered as part of the hospital trolley service?
2. How difficult or straightforward do you anticipate it will be/has it been to implement in the trolley service?
3. What kind of changes do you expect to make /have you made to accommodate the Standard?
4. What do you anticipate will be /have been the main challenges? / how does this compare with the challenges in the shop setting?
5. What support and guidance have you received if any?
6. What do you anticipate will be /has been the financial impact?
7. How will it / has it impact(ed) on customers?

G. Introduce the observation

Confirm that retailer is happy for researcher to conduct observation. Probe the following as appropriate to assist in completing the observation form:

1. Sales floor area (metres square)
2. Opening times (inc any day variations)
3. Details of any promotions not able to be observed (eg. verbal promotions at the till)
4. Whether a planogram is used to guide layout

(Where appropriate) clarify details about trolley service:

1. How many trolleys operated
2. What times do they operate (inc any day variations)
3. What hospital areas does the trolley service cover (probe using protocol pre-coded list)
4. Check opportunities to observe trolley set-up and layout.

H. Next stages, admin and close:

1. Baseline interviews only:
   - Confirm interest in and likely timing for follow-up visit
2. Offer incentive and obtain receipt
3. Thank and close

Appendix C: Exit survey questionnaire

(The questions were the same for wave 1 and wave 2, spacing may be different in the operational tool)

ScotCen
Social Research that works for society

Healthcare Retail Standard Evaluation

Follow-up Exit Survey August-September 2017

Respondent Number ☐☐☐☐
1-4

Location code (Hospital site and outlet) 5-6 ☐☐

Interviewer name …….

Date …… / …… / …… 7-12 **Time** ☐☐☐☐ 13-16

Included in retailer panel ☐ 17 (18-20 BLANK)

Introduction (key points as covered in briefing

- Introduce self and ScotCen
- Show them the information leaflet
- Hoping to carry out short interview with them. Will take about 4-5 minutes.
- Recap purpose of evaluation:
    - ScotCen is carrying out an evaluation of Healthcare Retail Standard with University of Stirling & the University of Dundee.
    - We are interviewing a number of people who shop in retail outlets in hospitals.
    - We want to find out how often people go to these outlets, their motives for visiting the outlet, types of products purchased etc.

What's involved (key points as covered in briefing:

- Format of the interview (yes/no answers, coded questions, few open answers)
- Please say if you want a question repeated at any time
- No right or wrong answers – it's your views we're interested in
- Confidentiality – any identifiable information will be kept confidential and will not be used in any reports.
- Your data will be stored securely in accordance with the Data protection Act. An anonymised version of the collated responses from the exit survey will be shared with our research partners and with NHS Health Scotland (who are funding this research).
- Taking part is voluntary – you're free to stop the interview at any time or to say you don't want to answer a particular question.
- Check if respondent has any questions
- Check if happy to proceed

INTERVIEWER – CONFIRM RESPONDENT HAS BEEN GIVEN OPPORTUNITY TO ASK ANY QUESTIONS AND IS HAPPY TO PROCEED 21

Yes, consent obtained ☐ 1

No, interview terminated ☐ 2

About your visit to the retail outlet

[*Read Out*]: I'd like to start with a few questions about your visit to this hospital shop today.

Tick one only

Q.1 What brings you to the hospital today? 22

Work at the hospital (NHS staff)	1	**ASK Q.1a**
Work at the hospital (non-NHS staff)	2	
Out-patient	3	**GO TO Q.2**
In-patient	4	
Visiting a patient	5	
Other (WRITE IN) (e.g. visiting for work purposes)	6	
…… ……		
(Refused)	9	

Q.1a Have you been working at this hospital for 1 year or more?

		23
Yes	☐	1
No	☐	2
(Don't know)	☐	8

Q.2 Have you been to this hospital shop before today?

		24	
Yes	☐	1	**ASK Q.3**
No	☐	2	**GO TO Q.4**
(Refused)	☐	9	

Q.3 **Show CARD A**

And how frequently do you visit **this** shop?

		25-26
More than once a day	☐	1
Every day	☐	2
5 or 6 days a week	☐	3
3 or 4 days a week	☐	4
Once or twice a week	☐	5
Once or twice a month	☐	6
Once every couple of months	☐	7
Once or twice in the last 12 months	☐	8
Once or twice over 12 months ago	☐	9
(Refused)	☐	10

Q.4 Did you purchase anything on this visit?

			27	
Yes	☐	1		**ASK Q.5**
No	☐	2		**GO TO Q.9**
(Refused)	☐	9		

Q.5 **(Ask if purchased anything at Q.4)**

What food and drink, if any, did you purchase on this visit?

Tick all that apply

Cereal bar	☐	1	29
Chocolate (*Check against* **CARD B**)	☐	1	30
Crisps/other savoury snack	☐	1	31
Other confectionery	☐	1	32
Sandwich/rolls/wraps	☐	1	33
Salad	☐	1	34
Fruit (*Check against* **CARD B**)	☐	1	35
Dried fruit and/or nut mixes	☐	1	36
Vegetables	☐	1	37
Cakes / Pastries	☐	1	38
Hot food (pies, etc)	☐	1	39
Soft drink	☐	1	40
Water	☐	1	41
'Meal Deal' (WRITE IN what this was made up of (e.g. fizzy drink, sandwich, chocolate or water, salad, fruit)	☐	1	42

……

Other (WRITE IN) ☐ 1 **43**

……

……

(Refused) ☐ 9 **44**

Q.6 Who did you purchase this/these items for? ***Tick all that apply***

Self ☐ 1 **45**

Family/friend who is a patient ☐ 1 **46**

Family/friend(s) who are here visiting someone ☐ 1 **47**

Colleague(s) ☐ 1 **48**

Other (WRITE IN) ☐ **49**

1

……

……

(Refused) ☐ 9 **50**

Q.7a How much did you spend in total?

51-55

Write in exact amount:……

Q7b How much did you spend on food and drink?

56-60

Write in exact amount:……

INTERVIEWER - IF EXACT AMOUNTS KNOWN AT Q7 a and b – GO TO Q.8a

(If exact amount **not known**, please code to the appropriate category)

Total Spend -

61

< £1.00	☐	1
£1.01 to < £3.00	☐	2
£3.01 to < £5.00	☐	3
£5.01 to < £10.00	☐	4
£10.01 to < £15.00	☐	5
£15.01 or more	☐	6
(Refused)	☐	9
(Not applicable)	☐	0

(If exact amount **not known**, please code to the appropriate category)

Food and Drink -

62

< £1.00	☐	1
£1.01 to < £3.00	☐	2
£3.01 to < £5.00	☐	3
£5.01 to < £10.00	☐	4
£10.01 to < £15.00	☐	5
£15.01 or more	☐	6
(Refused)	☐	9
(Not applicable)	☐	0

(Spare 63-70)

Awareness/views of the range of stock and promotions (incl. meal deals)

Q.8a Did you purchase any of these items that were on promotion?

(a) Chocolate		(b) Fruit		(c) Salad		(d) Crisps	
☐	☐	☐	☐	☐	☐	☐	☐
Yes 1	No 2	Yes 1	No 2	Yes 1	No 2	Yes 1	No 2
71		72		73		74	

Q.8b (**ONLY ASK IF 'Yes' to any of 8a-d**) Did you purchase any of these items **because** they were on promotion?

(a) Chocolate		(b) Fruit		(c) Salad		(d) Crisps	
☐	☐	☐	☐	☐	☐	☐	☐
Yes 1	No 2	Yes 1	No 2	Yes 1	No 2	Yes 1	No 2
75		76		77		78	

ASK ALL

Show **CARD C**

Q.9 Thinking about the range of food and drink this shop offers, to what extent do you agree or disagree that it is sufficient to meet your needs?

79

Agree strongly	☐	1
Agree	☐	2
Neither agree nor disagree	☐	3
Disagree	☐	4
Disagree strongly	☐	5
(Don't know)	☐	8
(Refused)	☐	9

Q.10 **CARD C**

(And how much do you agree or disagree that) the food and drink products in this shop are value for money?

80

Agree strongly	☐	1
Agree	☐	2
Neither agree nor disagree	☐	3
Disagree	☐	4
Disagree strongly	☐	5
(Don't know)	☐	88
(Refused)	☐	99

Q.11 **CARD C**

And how much do you agree or disagree that, overall, this shop offers a wide range of healthy products?

		81
Agree strongly	☐	1
Agree	☐	2
Neither agree nor disagree	☐	3
Disagree	☐	4
Disagree strongly	☐	5
(Don't know)	☐	8
(Refused)	☐	9

Q.12 Have you noticed any changes over the last few months in the food and drink available in this shop?

		82	
Yes	☐	1	**ASK Q13**
No	☐	2	
Not applicable (e.g. those who have not visited the shop before- see Q.2)	☐	3	**GO TO Q14**
(Don't know)	☐	8	
(Refused)	☐	9	

Q.13 What are the changes you have noticed in relation to the food and drink on offer?

[Probe fully] 83-90

EXAMPLES OF ISSUES:

- *Range of healthy foods compared to unhealthy foods*
- *Number of promotions for chocolate/confectionery etc.*
- *Changes in way fruit is displayed*

Q.14 Do you ever buy food and drink from nearby shops outside the hospital?

91

Yes ☐	1	**ASK Q15**
No ☐	2	**GO TO Q16**
(Refused) ☐	9	

Q.15 How frequently do you buy food and drink from nearby shops outside the hospital? **Show CARD A**

		92-93
More than once a day	☐	1
Every day	☐	2
5 or 6 days a week	☐	3
3 or 4 days a week	☐	4
Once or twice a week	☐	5
Once or twice a month	☐	6
Once every couple of months	☐	7
Once or twice in the last 12 months	☐	8
Once or twice over 12 months ago	☐	9
(Never)	☐	88
(Refused)	☐	99

About you

ASK ALL: I'd now like to ask a few questions about you.

Q.16

[Code Gender – Confirm if necessary]

(Interviewer – please code - male/female)

		94
Male	☐	1
Female	☐	2

Q.17 What was your age last birthday?

		95-96
16-24	☐	1
25-29	☐	2
30-34	☐	3
35-39	☐	4
40-44	☐	5
45-49	☐	6
50-54	☐	7
55-59	☐	8
60-64	☐	9
65+	☐	10
(Refused)	☐	99

Income question

Q.18 **Show CARD D**

Which of the letters on this card represents the total annual income of your household from **all** sources before tax - including benefits, savings and so on? Please just tell me the letter.

Tick one box only **97-98**

Q	☐	1
T	☐	2
W	☐	3
K	☐	4
L	☐	5
B	☐	6
Z	☐	7
M	☐	8
F	☐	9
(Don't know/not sure)	☐	88
(Refused)	☐	99

Additional comments

Q.19 That's the end of the interview. Is there anything else you would like to add? **99-100**

READ OUT: Thank you very much for taking the time to take part in this interview.

Showcards and definitions

(Text size and colour may vary in the operational tool)

CARD A

More than once a day

Every day

5 or 6 days a week

3 or 4 days a week

Once or twice a week

Once or twice a month

Once every couple of months

Once or twice in the last 12 months

Once or twice over 12 months ago

CARD B

CHOCOLATE PRODUCTS ARE:

- Chocolate blocks: Solid blocks of chocolate incl. milk, plain & white, of all sizes. Includes blocks with added ingredients, such as fruit and nuts. Includes eggs.
- *Countlines: Products that contain chocolate as main ingredient, as well as other ingredients such as caramel, fruit, wafer & biscuit*
  - *e.g. Mars bars, Snickers, Twix and Crunchie.*
- Selflines: Bags, roll-wraps & tubes of all sizes, containing individual pieces of product coated in chocolate
  - e.g. Smarties, Maltesers, Revels and Munchies.

EXCLUDE:

- Chocolate ice cream
- Chocolate biscuit such as McVitie's/Cadbury Chocolate Digestives, where chocolate is not major ingredient/where marketed as biscuits.
- Confectionery items based mainly on sugar
- Cereal bars
- Cakes and desserts

FRUIT PRODUCTS ARE:

- Fresh fruit: Sold loose or pre-packed
- Fresh fruit salad/fruit pots

EXCLUDE:

- Dried fruit bags or loose
- Tinned fruit
- Chocolate coated fruit
- Dried fruit and nut mixes

CARD C

Agree strongly

Agree

Neither agree nor disagree

Disagree

Disagree strongly

CARD D

	ANNUAL Household income BEFORE tax
Q	Less than £15,000
T	£15,000 – 24,999
W	£25,000 – 34,999
K	£35,000 – 44,999
L	£45,000 – 54,999
B	£55,000 – 64,999
Z	£65,000 – 74,999
M	£75,000 – 84,999
F	£85,000 or more

Appendix D: Data accompanying figures in the main report

Retail observations

Table D.1: Number of chocolate and fruit SKUs on display on fixed outlets

Outlet IDs	No. chocolate SKUs		No. fruit SKUs	
	pre	post	pre	post
1	10	21	51	56
2	26	26	3	5
3	126	49	15	7
4	51	30	10	11
5	70	40	4	4
6	111	50	3	7
7	34	22	9	5
8	31	29	8	5
9	102	38	8	12
10	69	17	5	5
11	38	12	3	4
12	71	24	8	9
13	36	16	4	5
(Range)	*(10-126)*	*(12-50)*	*(3-51)*	*(4-56)*
Mean	**60**	**29**	**10**	**10**

Table D.2: Number of promotions for chocolate in fixed outlets, pre and post HRS implementation

Management type		Product displays		PMPs		Multi-buys/ quantity discounts		Advertising		Other	
	N	n	(%[1])	n	(%)	N	(%)	n	(%)	n	%
Pre implementation											
Total	**166**	25	(15)	51	(31)	60	(30)	21	(13)	9	(5)
Post implementation											
Total	**38**	3	(8)	35	(92)	0	(0)	0	(0)	0	(0)

1: row %

Table D.3: Number of promotions for fruit in fixed outlets, pre and post HRS implementation

Manage-ment type		Product displays		PMPs		Multi-buys/ quantity discounts		Advert-ising		Other	
	N	n	(%[1])	n	(%)	n	(%)	n	(%)	n	%
Pre implementation											
Total	**52**	11	(21)	10	(19)	18	(35)	13	(25)	0	(0)
Post implementation											
Total	**69**	14	(20)	9	(13)	12	(17)	31	(45)	3	(4)

1: row %

Appendix E: Interviews schedules for the evaluation of the implementation process

Appendix E.1

Evaluation of the implementation of the HRS

(NHS leads)

Name of interviewee:
Health Board of interviewee:
Name of interviewer:
Date of interview:
Telephone or in person:
Name (date) of person making notes:
Notes checked (name and date):

1. Views of the HRS:

1.1 What is your job title?

1.2 What do you understand as the aim of the HRS on the ground?

(PROMPT: in terms of what it aims to achieve in the outlets in hospitals)

1.3 Would you say the NHS is responsible for ensuring that healthy foods are provided for staff, patients and visitors within their facilities?
(Where possible alter this question to reflect the stated aims of the respondent)

1.4 To what extent do you think the HRS will improve the food provided commercially to staff, visitors, and patients within the hospitals in your Health Board?

1.5 We know there are inequalities in the quality of people's diet – do you think the HRS will help to address this?

1.6 In your opinion, how are the changes brought about by the HRS likely to be received by customers?

2. Local structure to support implementation

2.1 Currently, is there support among senior managers for the HRS in your HB area?

(PROBE: if just yes/no answer…What kind of involvement is there from senior managers? What kind of support is there from senior managers? How is the lack of support felt?)

2.2 What groups, if any, exist locally to support the implementation of the HRS? For example, groups that you or others have set up to implement the HRS. (Ask the respondent to identify each group, its purpose, the people on the group, their job title and the regularity of meeting.)

2.3 In your opinion, do these groups work together as you had hoped? Have you managed to get the right people together/involved?

2.4 In your opinion, how well do the national stakeholders work together to implement the HRS?

[NOTE: they may not feel in the position to answer this depending on how long they have been lead for HRS]

3. Support for HRS implementation

3.1 Are you aware of guidance documents for the implementation of the HRS? If yes, what documents are you aware of?

3.2 How useful have you found these documents in understanding and implementing the HRS or in dealing with retailers?

PROMPT: have you had any feedback from retailers or other colleagues involved?

3.3 Do you know who to contact for support in implementing the HRS (names, and organisation and their type of support)?

- ask separately for contacts at national and local level
- if they don't have any national contacts then email them the relevant contacts

3.4 Have you worked with Scottish Grocers' Federation in the implementation of the HRS?

3.5 How have you found their support in the implementation of the HRS?

(PROBE: if necessary probe for details – are there examples that you could give of the support you have found useful/not useful?)

3.6 Do you know how the HLP audit process will work? Can you explain how you think it will work? (Frequency of audit, HB to get HLP audit data)

3.7 What do you think about the HLP audit process?

NOTE: do not ask if they have insufficient knowledge to answer this)

3.8 Have you worked with NHS Health Facilities Scotland in the implementation of the HRS?

3.9 How have you found their support in the implementation of the HRS?

(PROBE: if necessary probe for details – are there examples that you could give of the support you have found useful/not useful?)

3.10 How well have national bodies raising awareness of what was coming down the line? What worked well? What could have been done differently?

(if they are stuck: :

- *For example, what would you have like to have been told about (or told about earlier) that you weren't?*
- *How might you have like the HB to have been involved where is wasn't?*

3.11 Are you aware of how the HB has engaged or communicated with others - such as others within the HB, the outlets, customers (e.g. staff, patients, visitors). PROBE for examples.

3.12 As I understand it retailers provide some assessment about which of their products meet the HRS criteria. Is there any processes within the HB to check/quality control this? If yes, can you describe it?

(NOTE: they haven't specifically been asked to QC retailers' self-assessment but many might have developed a process of doing this)

IF THE HB ARE DOING SOME QC:

3.13 Do you feel these processes are sufficient to adequately monitor the compliance data that outlets submit? If not, why not? What else could be done?

IF NO HB QC IS OCCURING:

3.14 What impact do you think there will be of no HB QC of retailer self-assessment?

4. Compliance

4.1 Refer to the level of compliance that they reported via email before the interview - Do you see this level of compliance/progress as reasonable/appropriate?

4.2 Are you beginning to see any changes in the outlets in your area as a result of the HRS?

4.3 What is your understanding of the process that will take place if an outlet in your hospital fails to comply with the HRS by 31 March 2017? – Specifically thinking about the action that the HB will be involved in.

4.4 Do you feel this is feasible/appropriate for your HB to carry out?

4.5 Do you feel that these (the enforcement processes) will be effectiveness in ensuring compliance?

(PROBE: if yes, probe into how this works in their Health Board

If no, what would work to ensure compliance?)

4.6 Do you know if there is a process in the contract renewal process where compliance to the HRS can be incorporated?

IF NO:

4.7 Do you know who in your Health Board is responsible for the contract renewal?

4.8 Are you in contact/working with these colleague to implement this aspect of the HRS?

5. Implementation processes

5.1 How is your HB going to report on the HRS?

5.2 Do you think this the right way to report on the HRS? How could it be improved?

5.3 Do you think that the HRS can be implemented effectively with the resources provided?

IF NO:

6.7 What further resources (personnel or otherwise) are needed to implement the HRS effectively?

5.4 In implementing the HRS what barriers or challenges have you faced?

5.5 Can you think of examples where you or your colleagues in your Health Board have developed new or innovative ways to implement the HRS?

(e.g. processes that have had to be put in place locally to manage the HRS implementation)

7. Ending the interview

- Is there anything else you want to mention that we haven't covered?
- Thank you for your time.
- Are you happy for us to contact you for points of clarity?
- **Is there was anything in the interview that you would prefer wasn't included or quoted.**
- [Please note: We are happy to provide participants with a copy of our notes should they request it]
- We will be interviewing people from now until after the deadline for implementation and feeding general observations back to national and local implementers. A final report will come out late 2017.
- Thank you for your time
- We will send you the report once it has been written – after implementation in 2017

Appendix E.2

Evaluation of the implementation of the HRS

(Scottish Government lead)

Views of the HRS:

1. What is your role with respect to the implementation of the HRS?
2. What is the aim of the HRS?
3. How does, if at all, the HRS fit into the broader picture of improving Scotland's diet?
4. To what extent do you think the HRS has improved the food provided commercially to staff, visitors, and patients within hospitals in Scotland?
5. Do you think the HRS will help to address inequalities in the quality of diet in Scotland?
6. How are the changes brought about by the HRS being received by customers?

Leadership

7. What is the level of support for the HRS among senior players in the **your organisation/politically**?
8. Has there been support for the HRS among **senior managers** the **Health Boards**.
9. Has there been support for the HRS among those **responsible for implementing the HRS?**
10. How well have colleagues operating in Health Boards worked together to implement the HRS…..

Implementation support

11. How well has the **national implementation group** worked together to implement the HRS…..
12. Have you received the support **you need to** carry out your role in implementing the HRS?
13. In terms of support provided to **HBs** by SG, other national bodies and locally….
14. In terms of support provided to retailers (by SG, HLP, HFS and locally)….

Implementation process

15. The HRS was piloted in a number of outlets (circa around July 2016?) – what was the learning from these pilots?
16. In terms of rising awareness and communication around the HRS what worked well and what could have been done differently?

Compliance

17. What is your opinion on the level of compliance that was achieved after the deadline? (Probe for reasons for the observed change)

What is your opinion on the process to ensure compliance?

Reporting processes

18. How the HRS will be monitored nationally?

Appendix E.3

Evaluation of the implementation of the HRS

(Scottish Grocers' Federation)

1. Views of the HRS:

1.1 What is your job title?

1.2 What do you see as your role with regards to the HRS?

1.2 What do you understand as the aim of the HRS on the ground?

1.3 Would you say the NHS is responsible for ensuring that healthy foods are provided for staff, patients and visitors within their facilities?

1.4 To what extent do you think the HRS will improve the food provided commercially to staff, visitors, and patients within the hospitals in your Health Board?

1.5 We know there are inequalities in the quality of people's diet – do you think the HRS will help to address this?

1.6 In your opinion, how are the changes brought about by the HRS likely to be received by customers?

2 Support for HRS

2.1 To what degree you feel there is support among those responsible for implementing the HRS?

Was there any variation in the support you've offered boards and did that affect the implementation?

2.2 How have the retailers responded to the HRS?

2.3 In your opinion, how well have NHS staff and outlets worked together to implement HRS? (Across all HB) and are there any examples?

3. Support for Health Boards and retailers in the implementing of HRS (by HLP, other national bodies and locally)

3.1 In terms for support provided to the HBs by yourself, other national bodies and locally, what do you think has worked well?

That was one type of support, was there any other type of support?

Was there anything that could have been differently in terms of the support you provided over the year?

3.2 In terms of support provided to retailers…..and to the HB

3.3 Health Board leads came from a variety of settings (Retail, PH etc.) Do you feel that the background of the HRS leads had an impact (positive or negative) in implementing HRS?

3.4 What is your opinion on the level of compliance achieved?

3.5 Thinking about the audit process for the HRS, and focusing on the processes up and around the deadline, what worked well and what could have been done differently?

3.6 In terms of the process of ensuring continued compliance in the coming years, is that in place? Is it going to be sufficient?

Some HB did quality assurance this year. Do you think that this is necessary?

Does it have to be continued in the future?

Is the requirement for QA sustainable? Would it be consistent across all HB?

3.7 Have you received the support you needed to carry out your role to implement the HRS?

4. Implementation process

Compliance:

In terms of the process what would happen when an outlet does not comply?

Reporting Process

4.1 How would you report on HRS?

Is there any improvements needed?

5. Overall

5.1 In providing support for HRS implementation and auditing the HRS what barriers or challenges have you faced?

5.2 Can you think of examples where partners or colleagues (national, local, political) have developed new or innovative ways to implement the HRS?

Is there anything else you want to mention that we haven't covered?
Are you happy for us to contact you for points of clarity?
Is there was anything in the interview that you would prefer wasn't included or quoted.
Do they want a copy of our notes?

Appendix E.4

Evaluation of the implementation of the HRS

(Health Facilities Scotland)

1. Views of the HRS:

1.1 What is your job title?
1.2 What is the aim of the HRS?
1.3 To what degree do you think the NHS is responsible for ensuring that healthy foods are provided for staff, patients and visitors within their facilities?
1.4 To what extent do you think the HRS has improved the food provided commercially to staff, visitors, and patients within hospitals in Scotland?
1.5 Do you think the HRS will help to address inequalities in the quality of diet in Scotland?
1.6 How are the changes brought about by the HRS being received by customers?

2. Support for HRS

2.1 Has there been support for the HRS among senior players in your organisation?
2.2 Has there been support for the HRS among senior managers the Health Boards.
2.3 Has there been support for the HRS among those responsible for implementing the HRS?
2.4 How have the **retailers** responded to the HRS?
2.5 How well have your colleagues operating in Health Boards worked together to implement the HRS…..
    Are there examples where it has worked well, and why?
    Are there examples where there have been challenges, and what could have been done differently?

3 Support for Health Board and retailers in the implementing the HRS (by HFS, other national bodies and locally)

3.1 In terms of support provided to HBs by HFS, other national bodies and locally….
    What has worked well and why?
    What could have been done differently?
3.2 In terms of support provided to retailers by HFS, other national bodies and locally….
    What has worked well and why?
    What could have been done differently?
3.3 The HB leads came from a variety of settings – some HI leads, some from facilities. Did the setting of the HRS leads impact positively or negatively on the implementation of the HRS
3.4 Have you received the support you need to carry pout your role in implementing the HRS?

4. Implementation process

4.1 In terms of rising awareness and communication around the HRS what worked well and what could have been done differently?

5. Compliance:

5.1 What is your opinion on the level of compliance that was achieved after the deadline?

5.2 What is your opinion on the audit process for the HRS? (What worked well, what could have been done differently?)

5.3. In terms of the process to ensure continued compliance – are the currently process sufficient?

5.4 Some Health Boards have carried out QC checks of the information on compliance provided by the outlets. In your opinion, is this necessary?

5.5 What is your understanding of the process that will take place if an outlet fails to comply with the HRS?

6. Reporting processes

6.1 How is the HRS going to be reported on?

6.2 Do you know how the HRS will be monitored nationally?

6.3 Were the resources provided (nationally and locally) sufficient to implement the HRS effectively?

7. Overall

7.1 In implementing the HRS what barriers or challenges have you faced?

7.2 Reflecting on the overall process what other barriers or challenges has the HRS faced?

7.3 Can you think of examples where you or your colleagues (national, local, political) have developed new or innovative ways to implement the HRS?

Appendix F: Participant information sheet (HB implementation) and consent form

Appendix F.1: NHS Health Board leads

Healthcare Retail Standard:

Study to evaluation the implementation process

Information for interviewees

August 2016, V1.0

What is the evaluation about?

NHS Health Scotland is looking at how the Healthcare Retail Standard (HRS) is being implemented. We are looking at the implementation journey from before to after the deadline for compliance.

This evaluation is designed to support the implementation of the HRS and as such has been designed to be collaborative and co-operative.

Why have I been asked to take part?

As the lead in your Health Board for overseeing the implementation of the HRS we would like to find out about your views and experiences of the implementation so far.

Taking part in this study is entirely up to you, before you decide we would like you to read this sheet to understand why the study is being done and what it will involve. If you do agree to be interviewed you will be asked to sign a consent form. You do not have to answer any questions you do not wish to. You can withdraw from the interview at any time, without giving a reason.

What is involved?

If you agree to take part you will be interviewed at a pre-agreed time by someone in NHS Health Scotland (Deborah Shipton or Melanie Tsagalidou). For quality control purposes someone form the team may listen into the conversation. We will let you know if we plan to do this and we would only do this if you agreed to it.

The interview will take no more than 45 minutes and we will ask you about:

- Your views of the HRS
- The local structures that are involved in the implementation and how they are working
- The support provided to you for the implementation
- The different processes of the implementation, for example those that are needed to measure compliance, the reporting processes that are involved, etc.

With your permission we might contact you after the interview if we need to clarify anything from the interview.

There are no right or wrong answers as we are interested in your experiences and views. You can stop the interview at any stage, take a break or pass on any question you would prefer not to answer.

Who else is involved?

We will be interviewing the main HRS contact from several Health Boards across Scotland. We will also be interviewing representatives from the Scottish Government, NHS Health Facilities Scotland and the Scottish Grocer's Federation.

Who is carrying out the evaluation?

NHS Health Scotland is conducting the evaluation. We are a national Health Board working with public, private and third sectors to reduce health inequalities and improve health.

How will my data be used?

With your permission we'd like to audio record the interview. The recording will only be accessible to NHS Health Scotland staff. We will make notes from the recording. Some general information may be shared with the national leads responsible for implementation to help inform the ongoing implementation, but no information which can identify you or your Health Board will be shared. For example, if you identify that you are struggling to access appropriate nutritional information we will identify that some Health Board leads require more nutritional support to implement the HRS, but we will not identify which Health Boards raised this is an issue.

We will also publish a report in mid-2017 sharing the learning from the evaluation to support the implementation of future similar policy. No information that can identify you or your Health Board will be included in this report.

We will ask you at the end of the interview if there is anything that you would prefer not to be cited directly in any outputs and you can get in touch with us afterwards if you do have any concerns. We will always respect any requests not to cite something mentioned in an interview.

All data collected from you will be held on a secure server in NHS Health Scotland premises for a period of 3 years after completion of the study then destroyed. The information you provide **will only be used for the purposes of this evaluation.**

Who has approved this study?

Details of this work were shared with a Research Ethics Committee, who considered it a piece of audit work and therefore no further review by the committee was warranted.

Any questions?

If you have any questions about the research, please contact Deborah Shipton (Deborah.shipton@nhs.net, 0141 414 2791) from NHS Health Scotland

If you would like any other information or have any concerns about the study or wish to make a complaint then please contact Clare Beeston (Clare.beeston@nhs.net, 0141 414 2740) from NHS Health Scotland.

This information sheet is for you to keep. Thank you for your time.

Healthcare Retail Standard:

Study to evaluation the implementation process

Consent form for interviewees

(NHS Health Board leads, August 2016, V1.0)

Please tick the appropriate box

Yes	No	
		I have had the opportunity to read and consider the information provided by the evaluation team, ask any questions and have had these answered satisfactorily.
		I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason.
		I give permission for the interview to be audio recorded.
		I agree to be re-contacted for follow-up questions related to the evaluation (if needed).
		I agree to the use of anonymised quotes in publications.
		I agree to take part in the above evaluation.

Name of interviewee (Print name)	*Date*	*Signature*
Name of researcher:		

Appendix F.2: From Scottish Grocers' Federation, Scottish Government and Health Facilities Scotland

Healthcare Retail Standard:

Study to evaluation the implementation process

Information for interviewees

(From Scottish Grocers' Federation, Scottish Government and Health Facilities Scotland)
August 2016, V1.0

Why have I been asked to take part?

As the national lead responsible for overseeing an aspect of the implementation of the HRS we would like to find out about your views and experiences.

Taking part in this study is entirely up to you, before you decide we would like you to read this sheet to understand why the study is being done and what it will involve. If you do agree to be interviewed you will be asked to sign a consent form. You do not have to answer any questions you do not wish to. You can withdraw from the interview at any time, without giving a reason.

What is involved?

If you agree to take part someone from NHS Health Scotland will contact you to arrange a telephone interview at a time that is convenient for you. We will ask you about your experiences of implementing the HRS.

In your interview we will ask you about:

- Your views of the HRS as a policy
- Your role in the implementation process
- The implement processes relevant to your role
- Your views on what worked well and what could have been done differently

How will my data be used?

With your permission we'd like to audio record the interview. The recording will only be accessible to NHS Health Scotland Staff. We will make notes from the recording.

We will publish a report in mid-2017 sharing the learning from the evaluation to support the implementation of future similar policy.

Although we will not use your name in reporting the findings**, given you are the national lead for implementing HRS in your organisation it will be possible for the reader to attribute your comments to you**. We will ask you at the end of the interview if there is anything that you would prefer not to be cited directly in any outputs and you can get in touch with us afterwards if you do have any concerns. We will always respect any requests not to cite something mentioned in an interview.

All data collected from you will be held on a secure server in NHS Health Scotland premises for a period of 3 years after the project has ended then destroyed. The information you provide **will only be used for the purposes of this evaluation.**

Who has approved this study?

Details of this work were shared with a Research Ethics Committee, who considered it a piece of audit work and therefore no further review by the committee was warranted.

Any questions?

If you have any questions about the research, please contact Deborah Shipton (Deborah.shipton@nhs.net, 0141 414 2791) from NHS Health Scotland

If you would like any other information or have any concerns about the study or wish to make a complaint then please contact Clare Beeston (Clare.beeston@nhs.net, 0141 414 2740) from NHS Health Scotland.

This information sheet is for you to keep. Thank you for your time.

Healthcare Retail Standard:

Study to evaluation the implementation process

Consent form for interviewees

(From Scottish Grocers' Federation, Scottish Government and Health Facilities Scotland)
August 2016, V1.0

Please tick the appropriate box

Yes	No	
		I have had the opportunity to read and consider the information provided by the evaluation team, ask any questions and have had these answered satisfactorily.
		I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason.
		I am aware that the results from the evaluation will be published and understand that due to my unique professional role it may be possible that the reader could attribute information to me.
		I give permission for the interview to be audio recorded.
		I agree to be re-contacted for follow-up questions related to the evaluation (if needed).
		I agree to take part in the above evaluation.

Name of interviewee (Print name)	*Date*	*Signature*
Name of researcher:		

Appendix G: Indicators for the key elements for successful implementation

Indicator
Monitoring and evaluation mechanisms
Reporting and assessment framework (HPHS and HRS)
Existence and description of reporting instruments
Completeness of reporting instruments
Effectiveness of reporting instruments
Support
Learning from pilot sites
Existence of guidance (national, local)
Appropriateness of provided guidance
HLP support
Awareness and usefulness of HLP support
Resources (including implementation planning)
Named person with strategic responsibility
Other staff available to support implementation of HRS
further resources needed
implementation planning
Mechanisms to engage stakeholders (incl. relationship element of governance)
Identify stakeholders
National: list of groups (membership, meeting regularity, purpose), meetings, communication
Local: list of groups (membership, meeting regularity, purpose), meetings, communication
HB contact know who to contact for support and guidance
Qual evidence of engagement
Enforcement mechanisms
Description of enforcement process
Stats around compliance and enforcement
Appropriateness/effectiveness of enforcement mechanisms
Leadership
Attitudes of local implementers to the HRS
Local innovation to implementation
Local champion of HRS
Support of senior managers in HB
Effective cross working across stakeholders
Barriers to implementation (locally, nationally)

Appendix H: Interview dates of implementation leads

Lead	Date interviewed	In relation to the
Health Board Leads		
Shetland	Not interviewed – no outlets in the area	
Greater Glasgow & Clyde	December 2016	4 months before
Lothian	December 2016	4 months before
Borders	January 2017	2 months before
Orkney	January 2017	2 months before
Grampian	February 2017	1 months before
Fife	March 2017	<1 months before
Highlands	March 2017	<1 months before
A&A	April 2017	1 months after
Tayside	April 2017	1 months after
Dumfries and Gallaway	April 2017	1 months after
Lanarkshire	May 2017	2 months after
Forth Valley[1]	April 2017	1 months after
Forth Valley[1]	May 2017	2 months after
Western Isles	June 2017	3 months after
National Leads		
Health Facilities Scotland Scotland	June 2017	3 months after
Scottish Grocers' Federation	June 2017	3 months after
Scottish Government	June 2017	3 months after

1: two people were interviewed from NHS Forth Valley because of recent changes in roles within the Health Board.

Appendix I: Data fields in till reports

Retailer 1

Sales of RVS compliant lines (as % of overall) - food
Sales of RVS compliant lines (as % of overall) – drink
Unit of HRS compliant food sold
Unit of HRS compliant drink sold
Unit of non HRS compliant food sold
Unit of non HRS compliant drink sold
Value (£) of HRS compliant food sold
Value (£) of HRS compliant drink sold
Value (£) of non HRS compliant food sold
Value (£) of non HRS compliant drink sold
Average price per unit (of stocked products) – of compliant and non HRS compliant food
Average price per unit (of stocked products) – of compliant and non HRS compliant drink
Average basket value
% change in turnover in comparison the previous data point.
% change in profit in comparison the previous data point.

Appendix J: Questionnaire sent to area managers

Questions:

1. Has the HRS had an impact on the profits of your retail outlets in NHS facilities in Scotland? If yes, can you say:
   a) Was this largely driven by changes in costs, changes in revenues, or a mixture of both?
   b) **When** was the impact felt? For example, was the impact immediate? Did the impact take a while to be seen?
   c) Was there any change in the impact **over time**? For example, if profits were initially reduced did you see profits begin to rise over time or is the impact now the same as initially?
   d) What, if anything, did your organisation do in **response** to any negative impact in your profits and did this make a difference?

2. Has the introduction of the HRS affected your organisations decision to continue, expand or reduce its presence in NHS facilities in Scotland? If yes, can you say more about this?

3. Has the HRS presented you with any positive marketing opportunities? If yes, can you say more about this?

www.healthscotland.scot

6596 1/2019