Final report for the efficacy of withdrawals and recalls evaluation

August 2022

Authors: RSM Consulting UK LLP

Contents

List of figures

List of tables

1 Acronyms

Throughout this report, acronyms will be referred to and full references can be found in this table below:

Acronym	Meaning
B2B	Business to Business
CA	Competent Authorities
EMT	Executive Management Team
ESRG	External Stakeholder Reference Group
EU	European Union
FBO	Food Business Operator
FRSG	Food Recalls Steering Group
FSA	Food Standards Agency
FSS	Food Standards Scotland
FWD	Federation of Wholesale Distribution
HSA	Health Security Agency
LA	Local Authority
RCA	Root Cause Analysis
SERD	Science, Evidence and Research Division
SME	Small and Medium-sized Enterprises
SRO	Senior Responsible Officer
TOR	Terms of Reference
UK	United Kingdom
WGS	Whole Genome Sequencing
WHO	World Health Organisation

2 Lay Summary

Between 2016 and 2017, the Food Standards Agency (FSA) and Food Standards Scotland (FSS) reviewed the UK food sector. The aim of this review was to improve the way food is recalled within the UK. This review resulted in changes to the withdrawals and recalls system, including new guidance, changes to point of sales notices displayed in shops and additional training for food business operators (FBOs).

RSM UK Consulting LLP (RSM) was asked to piece together and understand how effective this system has been.

- **Objective 1:** To understand how the changes were carried out
- **Objective 2:** To evaluate the success of the system redesign, the roles of the agencies, how aware the public is of the safety around their food, and how the FSA/FSS can improve their work in the future

2.1 Key findings:

2.1.1 Objective 1: To understand how the changes were carried out

2.1.1.1 What we found out:

The people involved in designing the new system (ESRG members) felt that the changes were successful, and those involved worked well together. Four workstreams were created, which broke down the work, and helped to make the system redesign manageable.

Overall, ESRG members thought that the process was well managed. As the system redesign was a priority for the FSA/FSS, there was good resourcing, which included a project manager. The inclusion of a range of stakeholders (for example, food industry, enforcement authorities and consumer groups) was useful in making sure different views were heard. As a result, ESRG members said that the planned outcomes were met.

2.1.2 Objective 2: The success of the system redesign, the roles of the agencies, how aware the public is of the safety around their food, and how the FSA/FSS can an improve their work in the future.

2.1.2.1 What we found out:

Outcome 1: Roles and responsibilities in the new system

- Food Business Operators (FBOs), ESRG members and enforcement officers (those working for local authorities) said that there was a clear understanding of the new roles and responsibilities. This was an improvement on the previous system, which was less direct about roles and responsibilities.
- Consumers who had experienced a recall said that they had a clear understanding of their role. Those who had no experience were less confident of their role during a food recall.

Outcome 2: Accessible information provided to consumers, and cross-industry sharing of approaches and impact

- Consumers were less likely to think that the information available to consumers is accessible than enforcement officers and ESRG members.
- Consumer focus groups thought that awareness of recalls was dependent on chance (e.g. if they happened to see a notice in store or read about a recall in a newspaper). This suggests that information is not always consistently available.
- Consumers thought that the duty was on retailers (as opposed to regulators) to inform consumers of a recall, and that they should use a range of communication methods, for example via emails, loyalty schemes and posters in stores to inform consumers.

Outcome 3: Increased public awareness of food recalls and the actions they need to take

- FBOs, ESRG members and consumers had different views on how aware the public are of what to do during a food recall.
- FBOs said that consumers often contacted them directly to ask about next steps during the recall. This suggests that consumers are not always aware of what to do in the event of a recall.
- Consumers who had experienced a recall were aware of the process, while those consumers who had not experienced a recall were less aware of what they should do.

Outcome 4: System improvements in the future

- There is limited evidence that all parts of the system are working together to share good practice and improve the system. For example, enforcement officers reported that not all businesses have been completing a Root Cause Analysis (RCA) after their recall, which helps to identify how the issue happened, and what they can do in the future.
- When FBOs do complete an RCA, they do not always share the findings more widely (I.e with FSA/FSS on request in order to share with others in their industry). This is often due to limited awareness of how to share these findings. As a result, there are fewer opportunities to share learning across the food industry, local authorities and regulators.

2.1.3 Considerations for the future

The table below shows things that the FSA/ FSS might want to think about in the future:

Table 1: Things to think about in the future

Area	Consideration
Process	For any future FSA/FSS project which requires team working, the FSA/FSS should adopt a similar approach (for example, making sure that the purpose of the workstreams is clear, and engaging regularly with all key stakeholders).
Guidance	Because businesses were often not aware that guidance was available, the FSA/FSS should continue to raise awareness that the recalls guidance is available on their respective websites. When FBOs did access the guidance, they felt that it was helpful. Raising awareness could be done via trade organisations, Linkedin posts or during local authority inspections.
Point of sale notices	Because there is often inconsistency in the style of point of sale notices, consider making the point of sale template compulsory for FBOs. As more consumers shop online, consider producing guidance on where these notices should be displayed online. The point of sales notice template could also include a QR code, as consumer focus groups thought that this would be helpful.
Consumer awareness	Continue to make consumers aware of the steps to take during a food recall (for example, at FSA/FSS stands at food shows or online advertisement campaigns), as data shows that awareness is still lower than expected. The current FSA/FSS text alert service (informing consumers about products that have been recalled), could be promoted more widely, as focus groups liked this idea.
SME support	Consider offering more tailored support for smaller FBOs, so they are clear on their role within the recall process. Smaller FBOs were less likely than larger FBOs to have internal processes or resources in

Area	Consideration
	place in the event of a recall. Consider promoting the Quick Reference Guide with this group.
Communicating with consumers	Going forward, FBOs should use a mixture of ways to notify consumers of a recall (including existing methods such as point of sale notices in stores and newspaper advertisements, and online methods such as emails or loyalty app notifications).
Greater sharing of Root Cause Analysis findings	Make it clear who is responsible (either the FSA/FSS, local authorities or FBOs) for sharing RCA findings, and also how these findings could be shared. This would allow for continual improvement within the system. It may also be useful to create specific guidance for small/micro FBOs regarding RCAs. The FSA/FSS could also create a national database of RCAs, accessible by all local authorities.This would be useful in monitoring any current recall trends, as well as exploring any emerging trends.
Further promotion of the RCA e-learning course	To increase the number of people completing the RCA e-learning course, consider asking local authorities to share the RCA e-learning course with FBOs as part of the recalls process. As suggested by enforcement officers, it might also be helpful to produce simplified RCA guidance for smaller FBOs.
Standardise data collection categories	Consider making the FSA and FSS data collection categories the same, which will help the organisations to monitor recall trends.

3 Executive Summary

3.1 Introduction

Between 2016 and 2017, the Food Standards Agency (FSA) and Food Standards Scotland (FSS) undertook a review of the withdrawal and recall system in the UK food retail sector, to identify if improvements were needed to enhance the current system.

This system redesign aimed to increase consumer awareness of the recall process, outline clear roles and responsibilities during a recall event (for Food Business Operators, local authority enforcement officers and consumers) and increase legislative compliance among food business operators (FBOs). The system redesign resulted in the creation of a package of tools, including UK guidance on Traceability, Withdrawals and Recalls, best practice guidance on communicating food recalls to consumers, a template point of sale notice and a Root Cause Analysis (RCA) package.

RSM UK Consulting LLP (RSM) was commissioned jointly by FSA/FSS in 2021 to conduct a process evaluation to explore the following two objectives:

- **Objective 1:** The internal programme processes, which featured a partnership approach with stakeholders;
- **Objective 2:** The success (or otherwise) of achieving:
    - clear and distinct roles/ responsibilities in the new system;
    - consistent and accessible information provided to consumers, and cross-industry sharing of approaches and impact;
    - increased public awareness of food recalls and actions they need to take; and
    - commitment to continuous system improvement.

3.1.1Our approach

This mixed-method evaluation approach included:

1. **A desk review of existing programme documents and data (eg RCA Guidance and working groups Terms of Reference)**

Aim: to understand the original evidence base and problem statement/rationale for change, as well as the processes used to redesign the system.

2. **Interviews with External Stakeholder Reference Group (ESRG) members[1] (November-December 2021 and January-March 2022)**

Aim: to explore ESRG members' perceptions of the effectiveness of processes used to develop the new system (Nov-Dec 2021) and to understand how well the current withdrawals and recalls system responds to new and emerging food trends (Jan-March 2022).

3. **Anonymised real life recall case studies**

Aim: to capture the experiences and views of FBOs and enforcement agencies involved in recent recalls**.** These case studies involved a review of FSA/FSS documentation, followed up by in-depth virtual interviews with affected FBOs and relevant enforcement authorities.

4. **Exploration of hypothetical scenarios**

Aim: to glean learning on the ability of the redesigned recalls system to address new and emerging trends in the food sector. This involved interviews with ESRG members and enforcement officers.

5. **Consumer focus groups**

[1] The ESRG was a multi-stakeholder group involved in designing and delivering the system redesign, and included representatives from industry, local authorities, regulators and consumer groups.

Aim: to explore consumer awareness of product recalls, five virtual focus groups were conducted with consumers. These groups comprised four-eight participants in each, sampled by geography, age, gender and any experience of recalls.

6. **Secondary data analysis**

Aim: to establish a baseline, a review was undertaken of FSA/FSS datasets prior to system redesign (March 2018 – March 2019) and to explore implementation, for the post system redesign (April 2021 – March 2022).

3.2 Evaluation key findings

Key findings to address the two evaluation objectives include:

3.2.1 Evaluation objective 1: To evaluate the internal system redesign process, which featured a partnership approach with stakeholders

Overall, ESRG members regarded the internal system redesign process to have been effective, as it addressed the key outcomes and featured a strong co-design approach. The desk review highlighted key factors (such as having a dedicated project manager, clearly defined workstreams and a strong commitment to the system redesign) as being particularly successful.

The system redesign process involved the creation of four delivery workstreams:

- **Workstream 1** – Roles & responsibilities *(designed to develop and implement comprehensive UK guidance that clarified the roles and responsibilities of the key players involved in food withdrawals and recalls)*
- **Workstream 2** – Accessible & consistent consumer information *(designed to deliver a body of work to ensure that information to consumers is consistent and accessible, based on proven best practice and underpinned by cross-industry sharing of approaches)*
- **Workstream 3** – Improved trade-to-trade notifications *(designed to improve the consistency of trade-to-trade information)*

- **Workstream 4** – Feedback loops & incident prevention *(designed to develop and implement systematic root cause analysis procedures to be used by industry in the event of food withdrawals and recalls).*

Those involved in the internal system redesign process (including external stakeholders and FSA/FSS colleagues) were confident that these workstreams were developed following extensive research (both externally and internally commissioned by the FSA/FSS). This drew out best practice and provided a solid evidence base for the redesign. Having four workstreams also meant that delivery was divided into manageable sections, with clear objectives and remits.

ESRG members also agreed that the system redesign sufficiently engaged with representatives from relevant stakeholder groups, including local authorities, consumer research groups, food manufacturer organisations and regulators. This allowed for the consideration of issues from various viewpoints – for example, industry representatives suggested that it would not be feasible for the system redesign to mandate where to place point of sale notices in stores, given the diversity of store sizes and layouts. As a result of this strong and early engagement with stakeholders, the system redesign had significant buy-in, and did not require a piloting phase.

Overall, ESRG members regarded the governance and management structures as robust and effective as:

- the system redesign was a corporate priority for FSA/FSS, so it was assigned significant resource and support
- oversight from the ESRG kept the system redesign on track and ensured that objectives were delivered
- decision making by the ESRG was quick but thorough.

3.2.2 Evaluation objective 2: To evaluate the success (or otherwise) of achieving the four planned outcomes

Overall, the system redesign was successful in delivering the planned outcomes, with some areas for further development. The table below outlines each of the four planned objectives, and the extent to which these were achieved.

Outcome 1: Clear and distinct roles/ responsibilities in the new system

- FBOs, ESRG members and enforcement officers noted that there was a clear understanding of the roles and responsibilities, but with some minor areas for development.
- Consumers who had experienced a recall suggested that they had a clear understanding of their role, while those who had no experience were less confident of consumer actions during a food recall.
- All the FBOs interviewed reported that roles and responsibilities during the recall process were clearly stated by both the local authority and the FSA/FSS.
- Contrary to many micro FBOs' expectations (ie businesses with one-nine employees), the process was less daunting than expected, due to the responsiveness of the regulators to FBO queries, in addition to support and guidance received from local authorities.
- Enforcement officers suggested that not all FBOs were aware of the guidance. Findings from the FBO Tracker Wave 3 endorse this, as only 37% of Small and Micro FBOs were aware of this guidance.[2]
- ESRG members from industry expressed concerns that smaller FBOs may have fewer resources to implement the new processes and understand the legalities underpinning them, and that more tailored support may be required for this group.

[2] FSA Small and Micro FBO Tracking Survey Wave 3 (2021)

Outcome 2: Consistent and accessible information provided to consumers, and cross-industry sharing of approaches and impact

- Consumers were less likely to regard the information provided to consumers as accessible than enforcement officers and ESRG members. Consumer focus groups indicated that awareness of the recall process can be dependent on chance (e.g. if a consumer happened to see a notice in store or read about a recall in a newspaper), indicating that information is not always consistently available. Consumers maintained that the onus was on retailers (as opposed to regulators) to inform consumers of a recall, using a range of communication methods.

- ESRG members suggested that having a standardised template for the point of sale notice was a positive step in ensuring consistency. Some FBOs had used this template during their recall experience, and appreciated that it had saved them time and effort during a stressful period.

- Enforcement officers considered the point of sale notice template to be clear, and containing all the relevant information for consumers. Consumers themselves would welcome the addition of a QR code, as well as guidance on what consumers should do in the event of the foodstuff being consumed. In addition, there may be merit in promoting the use of supermarket loyalty schemes to contact consumers who have purchased affected items.

- Enforcement officers noted that there is currently no regulation covering where recall notices should be placed within a store, and use of the template is not mandatory. They also suggested that further thought should be given to how the system can adapt to changing consumer shopping habits (i.e. how best to display point of sale notices online).

- There is little current evidence of cross-industry sharing of approaches.

Outcome 3: Increased public awareness of food recalls and the actions they need to take

- Perceptions of consumer awareness differed between FBOs and ESRG members, and consumers themselves.
- Data suggests that consumer awareness has increased slightly between 2018 and 2021, but is still generally low: 23% of consumers in 2021 reported in the 2021 Food and You 2 survey that they were aware of alerts (a slight increase from 21% in the Public Attitudes Tracker 2018).
- FBOs highlighted that consumers often contacted them directly to ask about next steps during the recall, suggesting limited awareness of the required actions.
- Consumer focus groups suggested that those who had experienced a recall were aware of the process. However, the majority of participants had experienced a recent high-profile chocolate recall, during which steps were outlined in the media, which may have increased their knowledge.
- Those consumers who had not experienced a recall were less aware of the actions they should take, and many suggested they would be more likely to dispose of the product than return it to the store.
- However, data suggests that where consumers are aware of food recalls, they are increasingly returning food items. In 2021/22, 22% of consumers returned items to the store. Although a direct comparison cannot be madeonly 2% of those surveyed in 2018/19 returned an item (Public Attitudes Tracker & Food and You 2)[3]
- Several ESRG members indicated that the system redesign had not necessarily raised consumer awareness. They indicated that delivering the consumer awareness campaign that was envisaged was a challenge due to the pressures of EU Exit and Covid-19.

[3] Food and You 2: Wave 3, Ipsos MORI for the FSA (2022)

- One ESRG member suggested that this was potentially an overambitious objective.

Outcome 4: Commitment to continuous system improvement

- There is limited evidence to suggest that there is an ongoing commitment to continuous system improvement, although there has been an increased focus on the completion of the RCA as a result of this system redesign.
- Prior to the system redesign, not all businesses clearly defined the 'root cause' of their incidents and the level of understanding across industry sectors was variable. Therefore the development of the Root Cause Analysis (RCA) guidance and the e-learning course were viewed positively by ESRG members.
- Enforcement officers suggested that RCAs are being routinely conducted by larger FBOs, but there was still some further work required to ensure that smaller FBOs also took part in this process. A focus on dissemination and awareness would increase use and impact amongst SMEs.
- FBOs considered the completion of RCAs as beneficial for individual businesses, as it helped to identify the root cause of the incident, and enabled them to put specific measures in place to avoid future recall incidents. However, the majority of FBOs did not share these findings wider within their industries.
- ESRG members and enforcement officers suggested that the system has been less effective in ensuring industry-wide learning, as there is currently no formal process in place to share the RCA learnings.
- Enforcement officers and FBOs suggested that greater clarity is required regarding who is responsible (FSA/FSS, local authorities or FBOs) for sharing RCA findings, and for confirming the types of forums these findings could be shared in.
- There appears to be a limited awareness of the e-learning course amongst FBOs.

3.3 Considerations for the future

Based on these evaluation findings, the evaluation suggests the following considerations for the future:

Table 2: Considerations for the future

Area	Consideration
Process	For any future FSA/FSS project requiring partnership working, consider adopting a similar approach to that used in the system redesign (eg clearly defined workstreams and regular engagement with all key stakeholders).
Guidance	Continue to raise FBO awareness of the recalls guidance on the FSA/FSS websites, as FBOs and enforcement officers suggested that current awareness of its existence was limited. Once aware that the guidance was easily accessible, it was well regarded by FBOs. Raising awareness could be done via trade organisations, Linkedin posts or during local authority inspections. Consider also designing separate guidance documents on new and emerging trends, to ensure that the guidance remains current and responsive to new challenges within the industry (eg in the event of an online recall).
Point of sale notices	Consider making the point of sale notice template mandatory for FBOs to improve the consistency of information provided to consumers. As more consumers shop online, consider producing guidance on where these notices should be displayed online. The point of sales notice template could also include a QR code, as suggested by consumer focus groups.
Consumer awareness	Continue to raise consumer awareness of the steps to take during a food recall (eg at FSA/FSS stands at food shows or advertisement campaigns), as data suggests that awareness is still lower than expected. Consumers also require greater education about why they should return a product during a food recall as opposed to disposing of it themselves. Consider further promoting the current FSA/FSS text alert service, as focus group

Area	Consideration
	participants were responsive to this idea (as long as the alerts received were tailored to their food consumption habits).
SME support	Consider providing more tailored support for smaller FBOs to raise awareness of their role within the withdrawals and recalls process. SMEs are less likely than larger FBOs to have internal processes or resources in place in the event of a recall. This could include a series of webinars, paid advertisements on social media platforms or additional posts designed for smaller FBOs on the FSA/FSS website. Further promotion of the Quick Reference Guide may also be beneficial.
Communicating with consumers	Going forward, ensure that a combination of communication channels is being used by FBOs to notify consumers of a recall, to reflect consumer preferences and shopping habits. As part of this, the FSA/FSS could create a communication best practice guide, outlining the various methods that could be used, and local authorities could encourage FBOs to use a combination in-store notices, online notices, supermarket loyalty scheme notifications and social media posts.
Greater sharing of Root Cause Analysis findings	More clarity is required regarding who is responsible (FSA/FSS, local authorities or FBOs) for sharing RCA findings, and for confirming the types of forums that these findings could be shared. This would ensure continuous improvement within the system. Consider also developing a national database of RCAs, accessible by all local authorities.
Further promotion of the RCA e-learning course	To increase uptake of the RCA e-learning course, consider requesting local authorities share the RCA e-learning course with FBOs as part of the recalls process. Consider monitoring course completion rates, to explore if uptake increases post local authority promotion.

Area	Consideration
Standardise data collection categories	Consider standardising the FSA and FSS data collection categories, so data can be directly compared to monitor recall trends in the future.

4 Introduction

4.1 Background

In 2016, the Food Standards Agency (FSA) and Food Standards Scotland (FSS) undertook a project (Review of Food Withdrawal and Recall Processes in the Retail Food Sector project) to assess the effectiveness of the food withdrawal and recall processes in the UK food retail sector.[4] Before this system redesign, there was limited evidence on the application or effectiveness of legal requirements for food businesses and Competent Authorities (CA) against which to base decisions for change and improvement. The FSA/FSS also recognised that they did not have a clear understanding of consumer awareness of the recall procedure, as well as their behaviours in relation to the current food recall system.

The aim of the withdrawals and recalls system redesign was to elucidate learning and implement improvements to the withdrawals and recalls system. Improvements aligned to the FSA/FSS overarching ambition to protect public health from risks that may arise in connection with the consumption of food, and making sure that *"food is safe and what it says it is".*[5]

4.2 Overview of withdrawals and recalls incidents pre and post system redesign

This section outlines the most common types of incident categories, product types and notifiers pre system redesign (April 2018 – March 2019) and post system redesign (April 2021- March 2022).

Incident category: Prior to the system redesign, the largest incident categories reported by the FSA were pathogenic micro-organisms (16%), followed by allergens (13%). For

[4] The term 'food' refers to all food products and drinks

[5] https://www.food.gov.uk/sites/default/files/media/document/FSA-Strategic-plan-2015-2020.pdf

the FSS, the largest categories were allergens (19%) and regulatory breaches (16%). These categories remained consistent post-system redesign.

Product type: Prior to the system redesign, the two product types that accounted for the biggest proportion of incidents reported by the FSA were meat & meat products (16%) and fruits & vegetables (11%). For the FSS, meat & meat products (16%) and products not attributable to a particular food commodity (e.g. outbreaks (no food source identified) and fire/spill damage to crops) (18%) were the two product types accounting for the biggest proportion of incidents.Post system redesign, for the FSA, poultry meat and poultry meat products (15%) represented the biggest incident category, followed by meat and meat products (15%).For the FSS, meat and poultry (13%) were the most common categories, followed by feed for animals (10%)

Notifiers Prior to the system redesign, the four biggest notifiers of incidents to the FSA were local authorities (16%), Border Inspection Posts (13%), Rapid Alert System for Food and Feed (12%) and Industry (12%). For FSS-led incidents, the biggest notifiers of incidents were local authorities (41%), Other organisations, such as Health Protection Scotland and the EU Administrative Assistance and Cooperation System (29%) and the FSA (23%). Following the system resdesign, for the FSA, the biggest notifiers were RASFF (the Rapid Alert System for Food and Feed) (33%), and local authorities (24%). For the FSS, local authorities (32%) remained the biggest notifier, followed by RASFF (31%) and the FSA (14%).

4.3 Overview of this evaluation

The FSA and FSS jointly commissioned a process evaluation to understand how effective the processes involved in developing the new system have been, and the efficacy of the package developed, as well as the effectiveness of implementation. The evaluation also assesses whether the four planned outcomes were realised. An impact evaluation was outside of the scope due to the challenges in attribution.

This final report outlines our findings on the two evaluation main objectives:

Objective 1: To evaluate the internal programme process, which featured a partnership approach with stakeholders (sections 6 and 7).

Objective 2: To evaluate the success (or otherwise) of achieving the four planned outcomes (section 8).

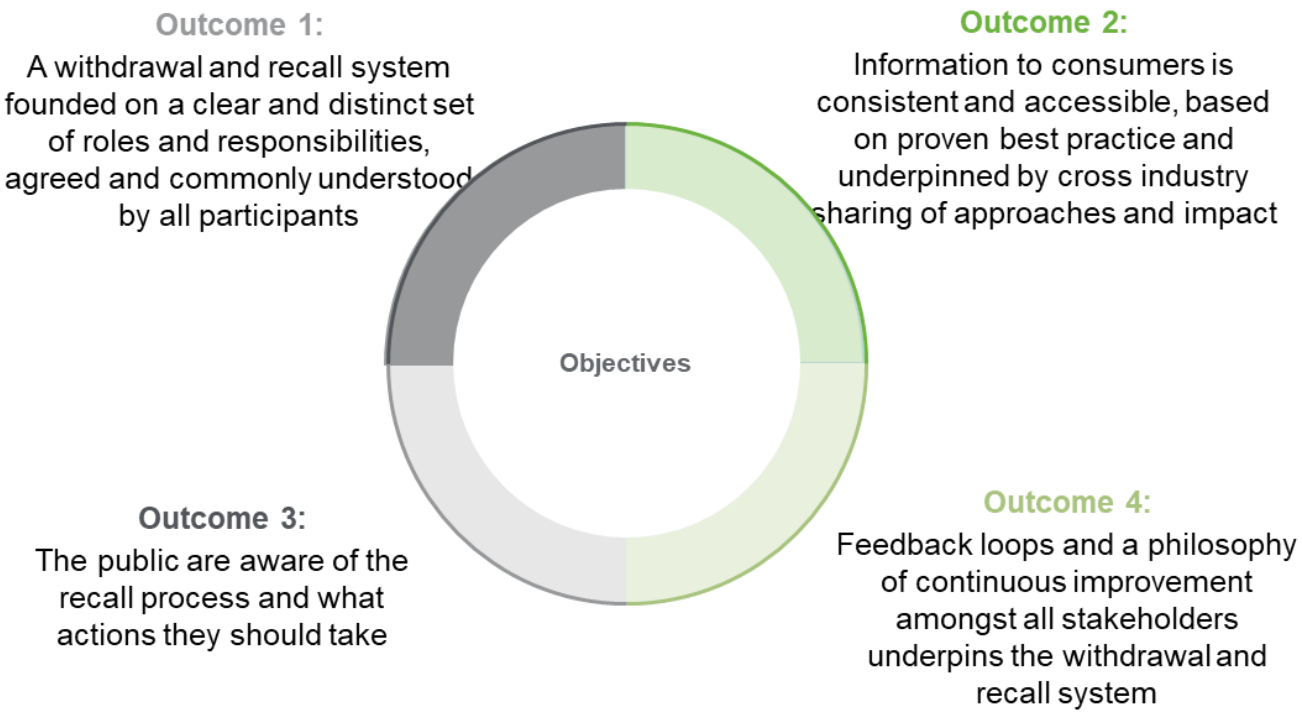
Section 9 outlines findings from recent anonymised case studies, Section 10 outlines the effectiveness of the system to respond to future food trends, and Section 11 provides key conclusions and suggestions for the future.

The system covers the jurisdictions of England, Northern Ireland, Scotland and Wales, and FBOs of all sizes are within scope for the evaluation.

4.3.1Planned outcomes of the project

Within the design phase of the system redesign, four key outcomes were agreed upon with FSA/FSS Boards. These outcomes were linked to planned improvements across the four delivery workstreams and are depicted in Figure 1.

Figure 1: Planned outcomes of the system redesign

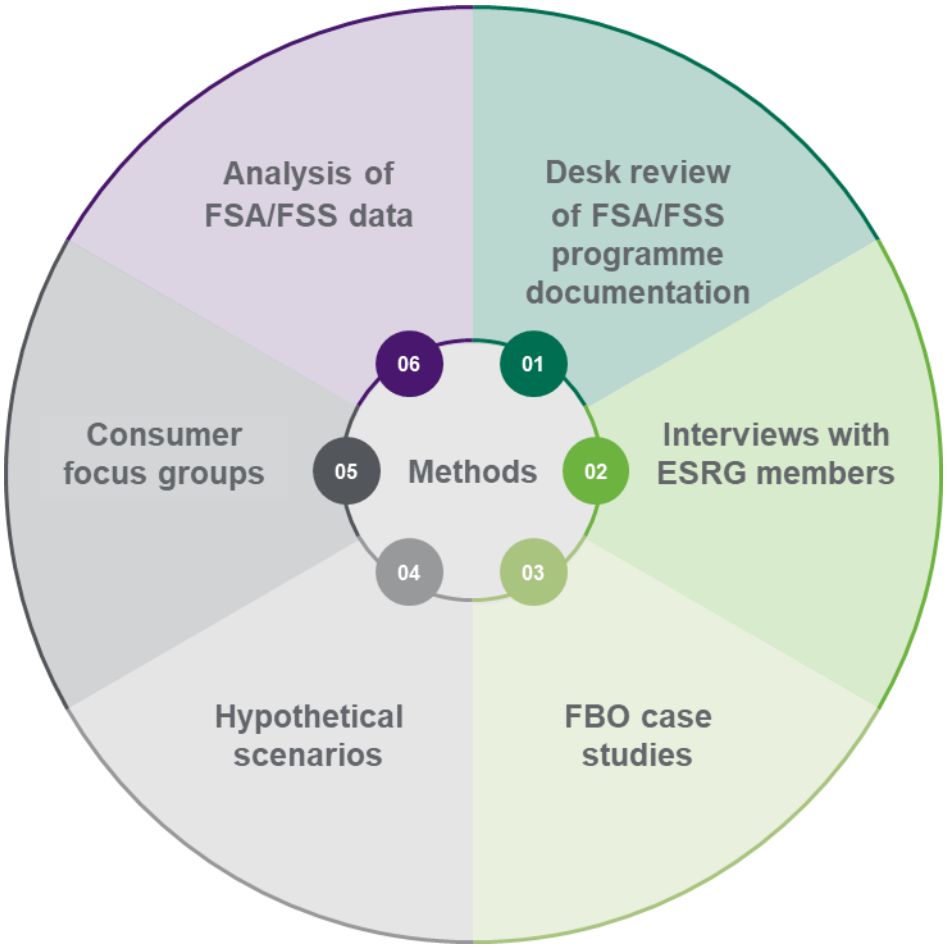


5 Evaluation methodology

The mixed-methods approach used in this evaluation captures evidence of the efficacy of implementation (process evaluation) and the likelihood (or otherwise) of achieving planned outcomes in future. An evaluation framework was agreed with the FSA/FSS project team and was used to guide this evaluation. The evaluation framework and evaluation limitations can be found in Appendix C.

The diagram below highlights the six elements in our evaluation approach for this final report:

Figure 2: Methodology



5.1 Desk review of FSA/FSS programme documentation

The evaluation team reviewed approximately 100 separate pieces of programme documentation provided by the FSA/FSS, including:

- Guidance on Food Traceability, Withdrawals and Recalls within the UK Food Industry Working Group papers and meeting notes for each workstream;
- Terms of References (TOR) for each working group; and
- Root Cause Analysis (RCA) guidance for LAs and Industry.

The purpose of this desk review was to understand the original evidence base and problem statement/rationale for change, as well as the processes used to design the programme. The documents were provided by the FSA/FSS Incidents & Resilience Team, and a gap analysis was conducted by the evaluation team to identify any additional documents.

5.2 Interviews with ESRG members

First set of interviews: November-December 2021

Between November and December 2021, eleven interviews were conducted with members of the ESRG, including representatives from local authorities (x3), FSA/FSS (x6) and industry bodies (x2). The purpose of these interviews was to explore ESRG members' perceptions on how effective the processes have been in developing the new system, as well as the effectiveness of its implementation in delivering the planned outcomes. ESRG members were sampled based on levels of involvement, region, workstream and stakeholder type (e.g. consumer, industry or local authority representative). The topic guide can be found in Appendix D.

Second set of interviews: January-March 2022

Between January and March 2022, another seven interviews were conducted with ESRG members. These interviews were designed to understand how well ESRG members considered the current withdrawals and recalls system to respond to new and emerging food trends. The topic guide can be found in Appendix E.

5.3 Case studies: combining findings from interviews with FBOs and associated enforcement officers

To assess the efficacy of system reform implementation and capture the experiences and views of FBOs and enforcement agencies involved in recent recalls, nine real-life anonymised case studies were developed. These case studies involved a review of FSA/FSS documentation, followed up by in-depth virtual interviews with affected FBOs and relevant enforcement authorities. The topic guide can be found in Appendix F.

The following sample of case studies was produced:

Table 3: Case study sampling

Reason for product recall/ withdrawal	Size of business	Geography
Physical contamination (x2) Biological contamination (x2) Chemical contamination (x1) Incorrect labelling (x4)	SMEs (x2) Large FBOs (x7)	England (x4) Northern Ireland (x1) Scotland (x3) Wales (x1)

5.4 Hypothetical scenarios: combining findings from interviews with ESRG members and enforcement officers

To glean learning on the ability of the redesigned system to address withdrawals and recalls relating to new and emerging trends in the food sector, we undertook seven interviews with ESRG members and eight interviews with enforcement officers. The topic guides can be found in Appendix E and Appendix H.

5.5 Consumer focus groups

To explore consumer awareness of product recalls, we conducted five virtual focus groups comprised of four-eight participants in each, including those who have and who

have not experienced a food product recall since 2019. Participants were sampled using the criteria outlined in the table below, to ensure that the sample was representative of consumer shopping habits (eg from all four nations, across age groups and those purchasing food for families and those shopping for themselves). The topic guide can be found inAppendix G.

Table 4: Sampling for the consumer focus groups conducted between 14th and 16th June 2022

	Focus group 1	Focus group 2	Focus group 3	Focus group 4	Focus group 5
Gender	x2 male, x4 female	x3 male, x2 female	x4 male, x4 female	x3 male, x1 female	x3 male, x2 female
Region	x1 England, x1 Northern Ireland, x2 Scotland, x2 Wales	x1 England, x1 Northern Ireland, x2 Scotland, x1 Wales	x3 England, x1 Northern Ireland, x2 Scotland, x2 Wales	x3 England, x1 Northern Ireland	x3 England, x1 Northern Ireland, x1 Scotland
Age	37 – 68 years	28 – 56 years	22 – 66 years	24 – 63 years	19 – 65 years
Children	x4 with children, x2 no children	x3 with children, x2 no children	x5 with children, x3 no children	x1 with children, x3 no children	x3 with children, x2 no children
Previous recall experience	x6 with recall experience	x2 with recall experience	x4 with recall experience	x3 with recall experience	x5 with recall experience

5.6 Secondary data analysis

In order to establish a baseline, a review was undertaken of FSA/FSS datasets prior to the rollout of reforms (March 2018 – March 2019). This review included:

- FSA/FSS incident data
- RCA data

- FSA/FSS web and social media data
- Public Attitudes Tracker survey data (until 2019) and Food and You 2 (post 2019)
- FSA Micro and Small Business Tracker survey data

5.7 Limitations

The table below outlines limitations associated with the methodology:

Table 5: Methodology limitations

Evaluation stage	Limitations
Desk review	• Limited documents were available for some workstreams (eg workstream three).
ESRG member interviews	• Despite repeated invitations, no consumer group representatives were available for interview, so their views were unable to be included in this evaluation. • Members from England, Northern Ireland and Scotland were interviewed; however, no member from Wales was available. • We were unable to secure an interview with the lead of the industry led Workstream 3(trade to trade work stream) • Some ESRG members had changed roles since the first set of interviews, and were unable to participate in the second set of interviews.
Case studies	• There were no withdrawals that would have easily added value to the learnings of the evaluation, so instead case studies focused on recalls. • There were no suitable incidents within agriculture and fisheries, and catering and hospitality which were originally suggested in our case study sampling framework.

Evaluation stage	Limitations
Hypothetical scenarios	• Despite repeated invitations, no ESRG consumer group representatives were available for interview, so the views of these groups cannot be included in this evaluation
Data analysis	• The desk review was limited to recall data, as withdrawal data was regarded as too complex by the FSA/FSS project team to extract from the FSA/FSS system. • Web analytics and social media data was unavailable from the FSS for the period 2021/22, so no comparison was possible • There were some differences in routinely collected data from the FSA and FSS, meaning that comparisons were not possible in some instances. • As products are sold in all four nations, there could be cases of incidents which are duplicated across both FSA and FSS datasets.

6 How effective was the system redesign? (objective 1)

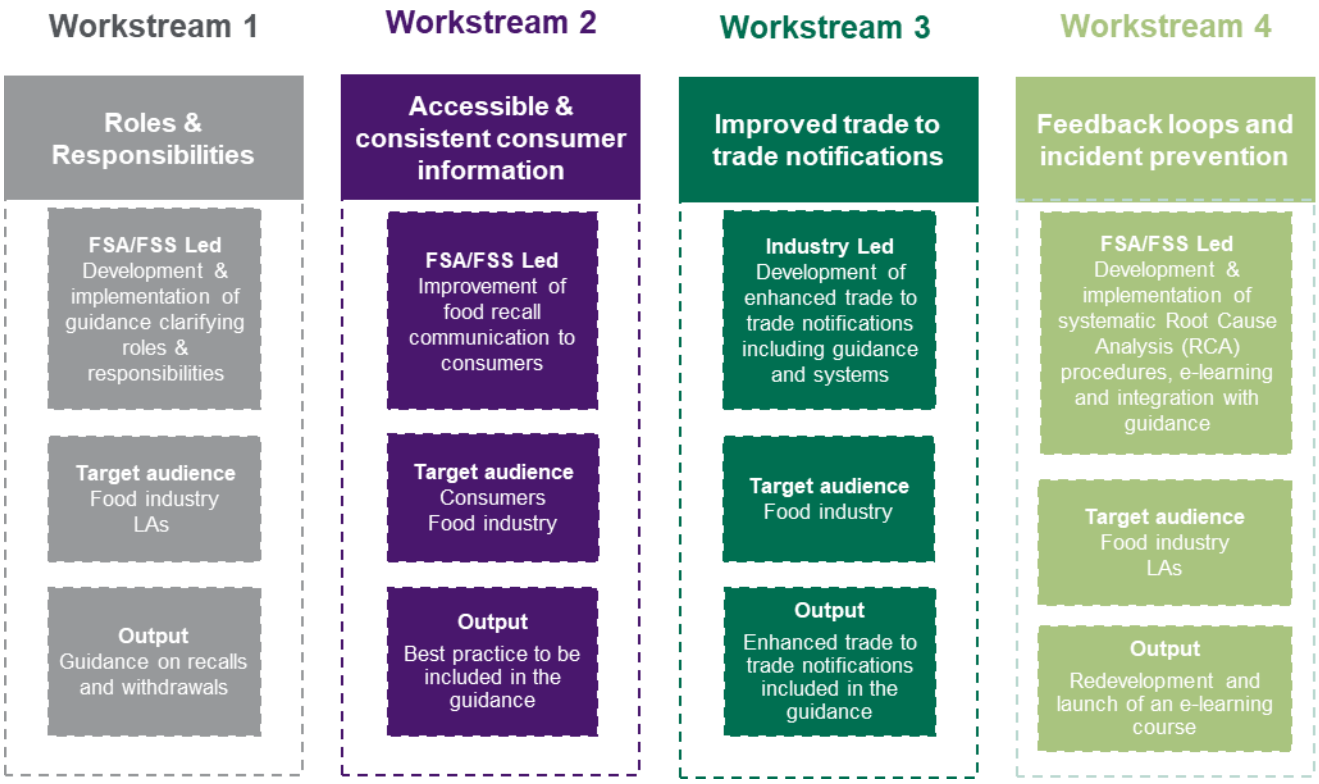
Section 6 evaluates the internal processes used to redesign the system, using evidence gathered from the desk review of programme documents, and interviews with ESRG members. This section provides an overview of the four workstreams for delivery of the system redesign, how the evidence gathered by the FSA/FSS informed this redesign, and the governance and management structures in place during the redesign and delivery.

6.1 What were the workstreams for delivery and their objectives?

6.1.1 Evidence from the desk review

Commencing in 2016, the system redesign was delivered by an overarching, multidisciplinary Food Recalls Steering Group (FRSG) and four main delivery workstreams that reported to the FRSG (shown in the figure below). This was overseen by the multi-stakeholder External Stakeholder Reference Group (ESRG). Workstreams 1, 2 and 4 were FSA/FSS led. Workstream 3 focused on developing enhanced trade-to-trade communications on withdrawals and recalls and was led by the industry body, the Federation of Wholesale Distributors (FWD). All workstreams developed multidisciplinary working groups to action their objectives.

Figure 3: Workstreams for the system redesign



6.1.1.1Workstream 1: Roles and Responsibilities

The focus of Workstream 1 was to develop and implement comprehensive UK guidance that clarified the roles and responsibilities of the key players involved in food withdrawal and recalls in the UK. This guidance took account of the principles detailed in The World Health Organisation (WHO) (2012) document "FAO/WHO guide for developing and improving national food recall systems"[6]. Key objectives for Workstream 1 are contained in Appendix A.

6.1.1.2Workstream 2: Accessible and consistent consumer information

The purpose of the FSA/FSS-led Workstream 2 was to deliver a body of work to ensure that information to consumers on food recalls is consistent and accessible, based on proven best practice and underpinned by cross-industry sharing of approaches.

Practical actions undertaken by Workstream 2 included:

[6] http://www.fao.org/docrep/017/i3006e/i3006e.pdf

- research with industry to better understand current and possible future practices, and barriers to new approaches
- research with consumers to identify best practice (from the consumer's perspective) for recall notifications in terms of content and style; placement in-store and online and relevant channels for communication of alerts
- development of best practice that takes into account the above, which will form part of the guidance developed under workstream one.

Key objectives for Workstream 2 are contained in Appendix A.

6.1.1.3Workstream 3: Improved trade to trade notifications

Workstream 3 was an industry-led workstream that worked on trade-to-trade information on food recalls to ensure its consistency and accessibility, based on proven best practice and underpinned by cross-industry sharing of approaches. Key objectives for Workstream 3 are contained in Appendix A.

6.1.1.4Workstream 4: Feedback loops and incident prevention

The purpose of FSA/FSS-led Workstream 4 was to develop and implement systematic root cause analysis procedures to be used by industry in the event of food withdrawals and recalls. These procedures included feedback loops to the FSA/FSS from industry (via enforcement authorities and/or businesses) identifying the chain of causal factors for a withdrawal/recall, the lessons learnt, and the measures taken by the businesses concerned to prevent recurrence. Outputs included:

- a redevelopment and launch of an e-learning course
- embedding RCA with LAs and the food industry.

Key objectives for Workstream 4 are contained in Appendix A.

Wider activities that supported the four key workstreams

It is important to recognise the role of other activities and workstreams which have contributed to the redesign and reform process, for example, the development of a Workstream 5. During the implementation phase, the communications strategy for the system redesign was coordinated by Workstream 5 (FSA and FSS staff). This workstream had the following objectives:

- to incorporate internal and external FSA/FSS communications about the system redesign
- to dovetail in with EU Exit messaging around incident management
- to incorporate consumer awareness-raising of the systems in place in the UK with respect to recalls, how to recognise a food recall and make informed choices.

This Workstream 5 was designed to complement the other four workstreams, and activities included recall communications around World Safety Day, discussions with major retailers around point of sale notices. Those involved in this workstream suggested that outputs were heavily impacted by Covid-19.

6.1.2 Insights from interviews with ESRG members

ESRG members interviewed by RSM highlighted that the overarching objective of the reforms was to better protect consumers. A formal review of the extent to which this objective has been met had not been carried out. Those interviewed were unable to specifically recall the objectives of each workstream, given the time lapse since the system redesign began.

Before the initiation of the reforms, ESRG members acknowledged that there was uncertainty about:

- how effectively recalls were being carried out;
- the reach of these to consumers; and
- the standardisation of the relevant processes.

6.2 How did evidence inform the redesign of the system?

As part of the system redesign, the FSA/FSS commissioned a number of research reports to draw out best practice and provide a solid evidence base. This section provides an overview of the key recommendations and findings from these reports (including Lynn Faulds Wood Review, Efficacy of Recalls, etc.).

6.2.1 Evidence from the desk review

Lynn Faulds Wood Review

The review was initiated in 2016 by the CEO and Executive Management Team (EMT) following publication of the *Lynn Faulds Wood Review of the UK's systems for the recall of unsafe products*. This Review explored the overarching theme of unsafe products, of which some elements applied to food.

The central recommendation of the Lynn Faulds Wood Review was to create a coherent system that would foster trust and an effective recall system with enhanced safety outcomes. Research showed that there was a strong consensus for a coordinating agency, with the necessary resources and competence, endorsed by central government to take the lead on this. The FSA was proposed to function in this role and were described as an example of a "national product safety agency"[7].

Other recommendations of the Lynn Faulds Wood Review included the need for:

- an official trusted website for businesses and the public
- a national injury database, with wider benefits beyond providing information and evidence for the recalls system
- improvement in funding, training, resources and procedures for enforcement officers
- mapping organisations involved in product recall, and better data sharing to prevent future incidents
- more reliable, detailed guidance on product recalls, developed in conjunction with industry

Externally commissioned research

In 2017, Kantar Public were commissioned by the FSA/FSS to conduct research with consumers and other stakeholders to establish the consumers' and stakeholders' views of the recalls process, to explore each step of the process in detail and where improvements might be made, and public awareness[8]. Recommendations from the review included:

---

[7] UK Consumer Product Recall Review by Lynn Faulds Wood

[8] FSA/FSS Efficacy of Recalls by Kantar Public

1. clarification of what is expected of FBOs in terms of when and how to involve the FSA/FSS in withdrawals and recalls
2. increased assistance and guidance for smaller FBOs
3. processes and forums for sharing best practice should be developed, mindful to potential commercial implications
4. a standadised industry recall noticifcation template for FBOs, accompanied by best-practice procedures
5. a review of the points at which the FSA/FSS interacts with FBOs during the withdrawals and recalls process
6. post-recall reflections captured from all stakeholders

This was complemented by the 2CV and Community Research **The Future of Food Recall Notifications** report[9] commissioned by the FSA/FSS in 2018. This report explored the development of a recall notification template, and included UK-wide testing of existing recall notifications and the development of potential new designs and content. The research recommended the following principles when communicating with the public about food/allergy recalls:

Principle type	Recommendations
Information principles	• **What the problem is:** Make it easy for customers to identify the issue/problem • **What they can do about it:** Clearly communicate what consumers need to do next if the issue is relevant • **Exactly how to do it:** Clearly communicate how consumers take next steps

[9] The Future of Food Recall Notifications - 2CV and Community Research for the FSA/FSS

Principle type	Recommendations
Key design principles	• **Clear and easy to read:** Using a simple layout; large font; banners with clear headings and sub-headings • **Use colour and iconography to grab attention:** Use of the colour red to denote risk; and use of iconography, banners, boxes and bordering to draw attention to crucial information • **Include a product image:** Where feasible, using an image of the affected product to draw attention • **Concisely worded:** Lay out information in a clear, simple and jargon-free manner, using bullet points or numbers to help organise information clearly.

Internally commissioned research

The above research was also supplemented by the research projects conducted internally by FSA colleagues in Science, Evidence and Research Division (SERD):

1. **An analysis of FSA/FSS food alert data** from 2013 to 2016, to broadly characterise major features and investigate trends over time.
2. **Live case reviews** that involved tracking ten food incidents resulting in a food alert to obtain in-depth information about how the recall process operated in practice.
3. **An International Comparison of Guidance on Food Recalls Systems**[10] (reported in 2017). A qualitative benchmarking exercise of the following countries' food recall systems: UK, Ireland, Australia, New Zealand, US, Canada. The specific elements examined included food recall procedures, traceability

[10] An International Comparison of Guidance on Food Recall Systems - Science, Evidence and Research Division, FSA

procedures and available guidance. The comparison identified that out of the six countries studied, the UK's guidance was the least comprehensive and focussed on interpretation of certain articles of Regulation (EC) No 178/2002 – the conclusion being that there is scope for the UK to develop more comprehensive guidance to assist food businesses and local authorities on actions necessary in the event of unsafe food needing to be removed from the food chain. The areas identified for further consideration were:

- the creation of a new guidance document for FBOs to help ensure that they are aware of and fulfil their responsibilities
- FBOs to follow FSA provided templates during the recall process;
- FBOs to have food recall plans prepared and available to the Competent Authorities upon request
- the potential for implementing an 'urgency classification system' (based on the US and Canadian systems)
- the potential for developing a new central recalls database that is accessible to both FBOs and the FSA

The FSA also undertook a pilot study of a range of incidents resulting in food alerts to understand how familiar food businesses and enforcement authorities are with RCA, and how capable they were at performing it. **The FSA Pilot study on RCA** also looked at the variation in levels of understanding that existed between different sized businesses, to inform where education on RCA would most effectively be targeted. The study involved 20 FBOs that had recently experienced a food recall and they were asked, with the assistance of LAs, to revisit the incidents chosen, and complete the '5 Whys' RCA methodology in order to identify the relevant root cause. This study led to the following conclusions:

- not all businesses clearly defined the 'root cause' of their incidents
- the level of understanding across industry sectors was variable
- some businesses (and local authorities) required greater assistance from the FSA/FSS in reaching a satisfactory root cause than others
- a number of businesses were reluctant to share details of their findings with the FSA/FSS, as it is not mandatory
- some businesses did not see the importance of conducting RCA and indeed a number did not respond to the FSA/FSS request for RCA at all

- feedback relating to the use of the '5 Whys' and the usefulness of the e-learning course was generally positive
- patterns in RCA that related to human error, procedural faults and issues involving standard operating procedures were apparent.

In addition to the FSA commissioned research for the system redesign, the FSA delivered **The Action Circle Project** as part of broader FSA engagements.[11] The main aim of this project was to analyse the level of knowledge about RCA with specific knowledge at industry and LA levels, and also within the FSA. This project recommended that the e-learning course should be disseminated at industry level, as well as re-circulated at a local authority level.

Overall, the evidence base collected during the design phase informed the formulation of the four main planned outcomes for the system redesign and the subsequent creation of the workstreams. Then, during the delivery phase, some working groups collected further evidence base to produce the required outputs for their workstreams. Table 7 below depicts how the evidence base informed the outcomes and the outputs of the project.

Table 6: The evidence base and the design and delivery phases of the system redesign

	Outcomes/outputs	Evidence base
Design phase: project outcomes	**Clear roles and responsibilities**	• An International Comparison of Guidance on Food Recall Systems by SERD, FSA • FSA/FSS Efficacy of Recalls by Kantar Public • Case Review study
	Accessible and Consistent Information	• Case Review study • An International Comparison of Guidance on Food Recall Systems by SERD, FSA • FSA/FSS Efficacy of Recalls by Kantar Public

[11] A similar project was organised by the FSS

	Outcomes/outputs	Evidence base
	Increased consumer awareness	• FSA/FSS Efficacy of Recalls by Kantar Public • FSA/FSS Food Alert Data analysis
	Feedback loops and a philosophy of continuous improvement	• An International Comparison of Guidance on Food Recall Systems by SERD, FSA • FSA/FSS Efficacy of Recalls by Kantar Public
Delivery phase: project outputs	**The Guidance on Food Traceability, Withdrawals and Recalls within the UK Food Industry (Workstream 1)**	• Consultation with the British Standards Institute
	Consumer notification templates (Workstreams 2 and 5)	• The Future of Food Recall Notifications report by Community Research and 2CV Report
	RCA Package (Workstream 4)	• FSA Pilot Study on RCA • The Action Circle Project (internal research, not commissioned for this project)

6.2.2 Insights from interviews with ESRG members

Reflections on the established evidence base

ESRG members involved in enforcing policy acknowledged the inadequacy of recall and withdrawal systems prior to the system redesign. There was a belief that FBOs had not been proactively engaging with FSA/FSS requests to recall products, and local

authorities were not consistently checking whether organisations had satisfactory processes in place.

The comprehensiveness of the process of building the evidence base was noted by several ESRG members. The process of developing evidence was iterative and was peer-reviewed, which gave a high level of confidence in the findings and their ability to inform the process redesign. ESRG members were clear that the best practice drawn out in the evidence base was directly used to create the four planned outcomes for the system redesign.

From those ESRG members interviewed, several key activities were described to evidence the need for system redesign and inform how this would be developed. This included the contracting of an independent third-party organisation to investigate potential areas for improvement, as described by the research section 6.2.1.

Table 7: Key evidence building activities

Key evidence building activities described by ESRG stakeholders
• conducted ten live case study reviews to understand the existing withdrawals and recalls process • analysed food alert data for four years and investigated trends over time • qualitative international benchmarking, comparing six English speaking countries' systems • completed 40 stakeholder interviews and a survey of the public • workshops with consumer groups, where the template for the point of sale notices was co-produced.

Reflections on the involvement of stakeholder groups in building the evidence base

The majority of ESRG members agreed that the evidence base for the system redesign was sound, and that they had consulted with representatives from different stakeholder groups. These included:

- local authorities and councils
- consumer research groups

- food manufacturer organisations
- the FSA/FSS and other government departments.

When describing the role of the ESRG, members were positive about this group and suggested that the most appropriate stakeholders were represented.

ESRG members were positive about the co-design seen in the system redesign, referencing examples of evidence-based insights being applied and tested with industry to inform design and implementation. It was suggested that testing these ideas with industry gave a more realistic view about what might be achieved in terms of implementation, ensuring that the system redesign was practical rather than theoretical. For example, the proposal to display the point of sale notice on every till was dismissed by industry as this would be unrealistic for larger retailers to implement and it was suggested that if consumers saw large numbers of in-store notices, it could undermine consumer confidence in food.

Due to the extensive engagement and co-development with a range of stakeholders, interviewees suggested that there had not been a need to pilot the outputs of the system redesign.

6.3 What governance and management structures were in place, and were they effective?

6.3.1 Evidence from the desk review

During the design stage of the review, the system redesign and Senior Responsible officer (SRO) were supported by a Project Board, workstream-specific Working Groups and the ESRG was formed to ensure stakeholder engagement. Each group had its own Terms of Reference (TOR) document that detailed:

- purpose and scope
- Board membership, roles and responsibilities
- frequency and format of meetings.

As the system redesign entered the delivery stage, these groups adapted their membership and scope to flex resources and skills required for the new tasks. This is denoted in Table 9. New terms of reference were developed for each of the newly formed governance layers within the programme.

Table 8: Governance structures

	Design: Stages 1 and 2	Deliver: Stages 3 and 4
Project Board into Programme Board	The project and SRO were supported by a Project Board. The role of the Project Board was to provide a mechanism to review, challenge, direct and support delivery of the project. The Board met on a quarterly basis and through membership provided a high-level link with other departments within the FSA, and as the project operated at a UK level with colleagues from FSS.	As the project was entering Stage 3, it was suggested that the working title for the Project Board to be changed to Programme Board, to reflect the development of multiple workstreams and broader governance responsibility.
Working Group into Working Groups	The project has also received internal support through a Working Group, which played a key role in guiding the development of research and reviewing research findings. This group was made up of staff from both within the FSA and FSS.	As workstreams were developed within the programme, it was suggested that each workstream should be allowed to create its own Working Group. Each group was responsible for the delivery of the related workstream. The project working groups reviewed risks, dependencies, project plans and reported to the Programme Board.
ESRG into FRSG	To ensure the project connected with stakeholders, an External Stakeholder Reference Group (ESRG) was formed. This group allowed two-way communications between the project team and representatives from industry, regulators and consumers.	As the project was entering Stage 3, it was suggested that ESRG should become the Food Recalls Steering Group (FRSG) and used to provide continued support for the project, particularly resourcing of workstreams. The Steering Group has concentrated on the technical development of the

	Design: Stages 1 and 2	Deliver: Stages 3 and 4
	The ESRG has played a key role in linking the project with stakeholders, providing a channel of communication with their members on project progress and providing input into the direction of research. Latterly it provided a key role in supporting the proposed outcomes and actions reported to the FSA Board.	actions (suggested by the FSA/FSS Board) and was provided with updates from the Working Groups. Retention of the ESRG as the future Steering Group has ensured that industry, regulators and consumers continue to work together and cooperate on the delivery of improvements.

6.3.2 Insights from interviews with ESRG members

ESRG members interviewed were positive about the governance and management structures for the system redesign. The majority suggested that these were effective and were fit for purpose, providing good oversight and support for delivery of the system redesign.

Several aspects of governance and management structures that worked well and less well were highlighted by ESRG members, as outlined in the Figure 4 below.

Figure 4: Governance and management structures – what worked well and worked less well?

Worked well	Worked less well
The programme was a corporate priority, so was assigned significant resource and support	Some changes in personnel within lower levels of governance part way through the programme meant that there was a learning curve for new members
Oversight from the ESRG and FSRG kept the redesign on track and ensured that oubjects were being delivered	Due to the EU Exit and Covid-19, the system redesign became less of a priority after the research and design pahase, meaning that some moment was loss

Decision making was quick but thorough	It was a challenge for the steering group to meet face-to-face (pre-pandemic) as stakeholders were located across the UK
The FSA and FSS understood the need for consumer and industry input, and were committed to delivering this. There was also good representation of all the relevant stakeholders within workstreams	Feedback from the FSA to stakeholders on their inputs could be slow to be delivered
Having four workstreams meant that delivery was divided into manageable sections	

7 How effective was the delivery of the redesign process? (objective 1)

This section explores the internal processes used to deliver the system redesign (evaluation objective 1), using evidence gathered from the desk review and interviews with ESRG members. This section provides insights from the delivery progress and partnership approach, and provides an overview of objectives and planned outcomes and whether these have been met.

7.1 What insights were gleaned from the delivery progress of the internal programme process and partnership approach?

7.1.1 Insights from interviews with ESRG members

The evidence collected in the research phase of the system redesign was used to create the four key workstreams for delivery. ESRG members described how terms of reference were developed for each of these to outline key activities and guide delivery. A multidisciplinary team was set up to plan and deliver the objectives for the four workstreams, with a project lead for each. ESRG members were very positive about this process and were confident in the objectives, due to extensive consultation with industry and consumers. They also highlighted the benefits of having four workstreams, which meant that delivery was divided into manageable sections and aligned with clear and distinct objectives.

ESRG members outlined some aspects of delivery that worked well and worked less well, as outlined in Figure 5 below.

Figure 5: Delivery of programme processes - worked well and worked less well

Worked well	Worked less well
The oversight of the system redesign and structure of delivery in four workstreams with different focuses	There were some delays in delivery of the workstream led by industry, and this was considered by some to be less efficiently managed

Engagement with stakeholders involved in the system redesign was extensive and through	Engagement with smaller FBOs and trade associations was limited
	It was sometimes difficult for industry to engage due to competing prioritites, particularly when there was an expectation for in-person engagement prior to the pandemic

It is worth noting that ESRG members from the regulators were more likely to be positive about the level of engagement and representativeness of the stakeholders included. ESRG members from industry and those involved in enforcement of policy were more likely to suggest improvements that could have been made in this process.

Suggested improvements in delivery included:

- more time to produce the guidance and templates, as these were delivered within tight timeframes
- more guidance offered to the industry-led workstream around requirements
- a policy enforcement stakeholder suggested that more regular updates would have been useful, as it often felt as though several activities had progressed before an update was provided
- as smaller FBOs can find implementing recalls processes more difficult than larger ones due to resourcing, there could have been additional support for these stakeholders or further engagement.

When asked specifically about the partnership approach taken for the system redesign, ESRG members were very positive, as it allowed for the consideration of issues from various viewpoints. Trust between internal and external stakeholders was highlighted as a key aspect of this, with the encouragement of open and honest discussions at ESRG meetings. ESRG members suggested that the immediate feedback from external stakeholders was extremely valuable and resulted in stronger outputs from the system redesign, and allowed for more pragmatic considerations when developing the guidance.

7.2 Have objectives and planned outcomes been met in the design of the new system and the 'package' for FBOs/LAs?

Overall, ESRG members were broadly positive that the workstream objectives had been met in terms of the design of the new system and the outputs produced by the system redesign. However, for each of the four key objectives, ESRG members were keen to outline areas where they believed the system redesign could have gone further in terms of implementation and the longer-term outcomes being realised for industry, enforcement agencies, and consumers.

This section describes learning relating to the outputs (as part of the objectives) and planned outcomes for the design of the new system.

7.2.1.1 Outcome 1

A withdrawal and recall system founded on a clear and distinct set of roles and responsibilities agreed and commonly understood by all participants

Outputs delivered to achieve Outcome 1:

- The guidance on Traceability, Withdrawals and Recalls within the UK food industry

Evidence from the desk review

In March 2019, the FSA and FSS published the Guidance on Food Traceability, Withdrawals and Recalls within the UK Food Industry [12]. It replaced the FSA Guidance Notes for Food Business Operators on Food Safety, Traceability, Product Withdrawal and Recall produced in 2007. The purpose of this guidance was to assist FBOs to comply with food law and to provide guidance on roles, responsibilities, and actions to take during food safety withdrawals and recalls in England, Northern Ireland, Scotland and Wales.

[12] https://www.food.gov.uk/sites/default/files/media/document/food-traceability-withdrawals-and-recalls-guidance.pdf

The Guidance has a separate chapter identifying roles and responsibilities of those involved in a withdrawal/recall, including FBOs, enforcement authorities and consumer organisations. It sets out specific actions and indicates whether these need to be followed in a case of recall or a withdrawal or both for a specific stakeholder group. The target audience of this guidance is FBOs and enforcement authorities.

The below is an example from the guidance that outlines key actions to be taken by retail FBOs receiving a withdrawal or recall notification.

Table 9: Example of actions to be taken in a withdrawal/recall scenario

51 The table below outlines the actions to be taken by retailers:

Actions	Withdrawal	Recall
Remove all unsafe food from sale or supply chain and ensure it is stored separately from other non-affected food	✔	✔
Issue POS recall notification to stores (where applicable) and inform consumers of a recall (where appropriate using material provided by FBO initiating the recall) and facilitate the retrieval of the unsafe food	n/a	✔
If appropriate, accept returns of the affected food from consumers, clearly identify and store such food separately from non-affected food	n/a	✔
Return the affected food to the FBO or dispose of it, if requested and in accordance with corresponding waste requirements (taking direction from the FBO who has initiated the withdrawal/recall)	✔	✔

Source: Guidance on Food Traceability, Withdrawals and Recalls within the UK Food Industry, p.22

Insights from interviews with ESRG members

ESRG members outlined that the guidance is clear and explains the roles and responsibilities of participants, and is an improvement on the previous guidance. The package was therefore said to have addressed this gap in knowledge and has made the process much easier for FBOs.

However, ESRG members did raise some areas for consideration in terms of maximising the impact of this objective. One area of concern was the smaller businesses that have

fewer resources to implement the new processes and understand the legalities underpinning them. Moreover, these organisations have been less involved in the delivery of the system redesign and would likely have less regular need to use and remain aware of recall processes. As such, they are less engaged in the updates to the process. Lack of resources was also discussed as a barrier in relation to local authorities, and it was suggested by one ESRG member that more could be done to raise awareness of the guidance and tools with this group.

7.2.1.2Outcome 2

Information to consumers is consistent and accessible, based on proven best practice and underpinned by cross-industry sharing of approaches and impact

Outputs delivered to achieve Outcome 2:

The guidance on Traceability, Withdrawals and Recalls within the UK food industry including:

- best practice guidance on communicating food recalls to consumers and template point of sale notices; and
- best practice guidance on communicating withdrawals and recalls from business to business, across the supply chain.

Evidence from the desk review

The Guidance on Food Traceability, Withdrawals and Recalls within the UK Food Industry includes the following Annexes G and H.

Annex G: Business-to-business communications for food safety withdrawals and recalls across the supply chain. This Annex outlines guidance for FBOs initiating a food withdrawal/recall and for FBOs receiving notification. Both guidance detail key elements of the communication and provide suggested templates for FBOs.

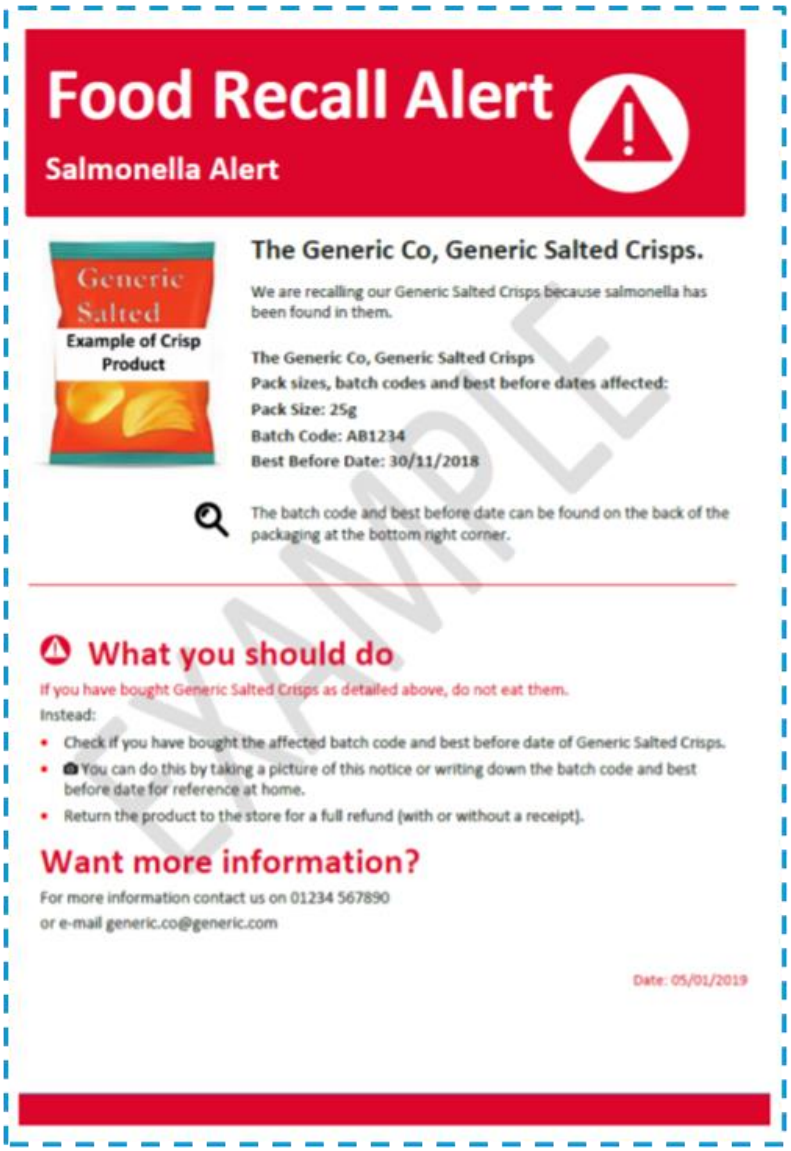
Annex H: Key principles and best practice template for accurate and effective consumer recall notifications. This Annex outlines the key aspects to consider when creating effective recall messages, such as:

- style and appearance;
- necessary content; and

- effective channels for communicating recall messages to consumers, including best location for displaying point of sale notices.

It also includes some examples of suggested wording and provides links to the editable point of sale notice templates. Annex H also illustrates examples of completed point of sale notices.

Figure 5: Example of food recall alert



Source: Guidance on Food Traceability, Withdrawals and Recalls within the UK Food Industry, Annex H, p.51

Insights from interviews with ESRG members

These adjustments were said by ESRG members to provide more accessible, consistent and clear information to consumers, due to the availability of templates and the best practice guidance.

However, industry ESRG members and those involved in enforcement were less confident in addressing whether this objective has been met, as in some ways the impact of this intended outcome is outside of regulator control. Other than mandating that a point of sale notice must be displayed, regulators do not control where they are placed within a store, meaning that the availability of information to consumers can be variable. It was, therefore, suggested that there is still some way to go in achieving this objective due to the relative freedom in implementation for FBOs.

7.2.1.3 Outcome 3

The public are aware of the recall process and what actions they should take

Insights from ESRG members

ESRG members were least confident in assessing whether this objective had been delivered in the design of the new system. One suggested that there is some increased awareness due to the text alert system and the widened scope in how consumers can access information, including the updated website with guidance on making product complaints. Another suggested that while there has been limited use of this guidance, the fact that this has been made available and highlighted to consumers is a positive step.

Several ESRG members indicated that the system redesign struggled with increasing consumer awareness and had not delivered the consumer awareness campaign that was envisaged. One ESRG member suggested that this was potentially an overambitious objective. Others highlighted the impact that EU Exit and Covid-19 have had on the system redesign's ability to engage consumers and the focus placed on these activities.

7.2.1.4Outcome 4

Feedback loops and a philosophy of continuous improvement amongst all stakeholders underpins the withdrawal and recall system

Outputs delivered to achieve Outcome 4:

- RCA Package
- Revised Food Law Codes of Practice in England and Northern Ireland

Evidence from the desk review

On the Food incidents, product withdrawals and recalls webpage[13], the FSA published a section on Undertaking Root Cause Analysis which presents three elements of the RCA package:

1. An Introduction to Root Cause Analysis Course online[14]. This online course offer two pathways: for enforcement authorities and for food businesses.
2. The RCA Report Form[15].
3. Best Practice Example[16].

The Guidance on Food Traceability, Withdrawals and Recalls within the UK Food Industry also includes Annex I: Background to root cause analysis. There is very limited information available on the RCA in the main Guidance and it does not direct the reader to the Report Forms or e-learning course on the FSA/FSS websites.

As part of this evaluation, RSM also received a copy of the Root Cause Analysis (RCA) Guidance for Local Authorities, Industry and FSA Staff.[17] The guidance covers the following questions:

- What is Root Cause Analysis (RCA)?
- What is the '5 Whys' principle?
- Why is the FSA promoting the area of RCA?
- Why is RCA data being collected?
- Summary of the FSA Trial into RCA
- What are we expecting from Industry?

---

[13] https://www.food.gov.uk/business-guidance/food-incidents-product-withdrawals-and-recalls

[14] Food Standards Agency - Root Cause Analysis

[15] https://www.food.gov.uk/sites/default/files/media/document/rca-report-form.docx

[16] https://www.food.gov.uk/sites/default/files/media/document/root-cause-analysis-best-practice-example-final.pdf

[17] This guidance is not currently available online, but was instead disseminated to all local authorities by the FSA and FSS (eg via FSA's Smarter Communications platform)

- What are we expecting from local authorities?

Insights from interviews with ESRG members

The development of RCA guidance and the e-learning course were viewed positively by regulation ESRG members, who believed that the design of these did meet the final objective for the system redesign. They suggested that the guidance includes detailed information and clarification around the processes, with good examples of RCA. One ESRG member suggested that retailers are using RCA to share lessons within their supply chains and ensure preventative action is taken. Another suggested that more detailed incidents reports are being seen due to the changes.

However, all ESRG members suggested that the impact could be increased. While the guidance and training were considered to be fit for purpose, focus on dissemination and awareness was highlighted as a key facilitator for increased use and impact. It was suggested that while utilisation of RCA has increased as a result of the system redesign, this uptake could be greater.

Again, the impact of EU Exit and Covid-19 were highlighted as limiting factors in the prioritisation of this work and industry's capacity to implement. One ESRG member also expressed concern over the uptake of RCA by smaller businesses and whether they are using this to extract lessons and influence actions going forward. This is linked to the limited resource within smaller organisations and the capacity and capabilities to conduct such analysis. ESRG members suggested that the system redesign tried to address this issue by ensuring that the e-learning course is as simple as possible, but that it would take time for industry to adopt these new processes. By contrast, one enforcement ESRG member considered whether the guidance could be simplified or shortened to encourage implementation in practice. They reflected that longer guidance is less likely to be utilised by local authorities.

8 How effective was the system redesign in delivering the planned outcomes? (objective 2)

This section outlines how effective the system redesign has been in delivering the four planned outcomes (evaluation objective 2), based on findings from consumer focus groups, interviews with FBOs, interviews with ESRG members, interviews with enforcement officers and desk review.

Overall, the system redesign was successful in delivering the planned outcomes, with some areas for further development. The sections below outlines each of the four planned objectives, and the extent to which these were achieved.

8.1 Outcome 1: a withdrawal and recall system founded on a clear and distinct set of roles and responsibilities, agreed and commonly understood by all participants

8.1.1 Evidence from consumer focus groups

Consumer understanding of their role during the recall process differed between those who had and those who had not experienced a food product recall. The majority of consumer group participants regarded food manufacturers and retailers as responsible for handling a recall, as opposed to the FSA/FSS and/or local authorities.

The majority had personal experience of a food product recall, and this group was clear about the roles of consumers and retailers. As one participant stated, *"I didn't have a receipt, but I took them back to the supermarket, and they were happy enough to accept them."* The majority of participants' recall experience involved a recent high-profile recall of chocolate products, while a smaller number of participants had experience of smaller product recalls (including chicken pieces, bread, pastries and beef jerky).

Those who had not experienced a recall were less certain of the process and their role – some were under the impression that a product had to be returned to the manufacturer as opposed to the retailer, and some suggested that they would *"just throw away, wouldn't go back to store for sake of a pound or two".*

8.1.2 Evidence from ESRG interviews

ESRG members indicated that the new recalls guidance is accessible, with a clear explanation around roles and responsibilities. Additionally, positive feedback was received by ESRG members from FBOs: *"an issue was identified by a Scottish FBO and they went straight to guidance document and followed the processes set out in the guidance, told their Local Authority contact, and the Local Authority informed the FSS. So, they followed guidance and it worked well."*

Some ESRG members felt that the guidance was less useful for consumers, but that its existence was a positive step as it *"advises them as to how it is being managed and gives them some assurance"*.

Some ESRG members shared that the new guidance worked for large businesses but raised concerns about smaller FBOs that have fewer resources and understanding of the processes. This group may require additional support (such as sharing of best practice). One ESRG member noted: "*We struggle to get businesses to do the legal requirements, the fact it isn't mandatory means that it's tricky to get businesses to do it."*

8.1.3 Evidence from FBOs

All FBOs interviewed reported that roles and responsibilities during the recall process were clearly stated by both the local authority and the FSA/FSS. Contrary to many micro FBOs' expectations (ie businesses with one-nine employees), the process was less daunting than expected, due to the responsiveness of the regulators to FBO queries, in addition to support and guidance received from local authorities.

One FBO was surprised that the decision to recall a product was determined by the FBO rather than the FSA/FSS, and would have preferred that regulators make the decision to recall a product. In the small number of cases where other agencies were involved e.g. the Health Security Agency (HSA), FBOs suggested that the process was slightly less clear, and that they would like to see a system for sharing information. FBOs considered

the guidance to be clear and straightforward (if somewhat lengthy). It was unclear if FBOs were aware of the quick reference guide that accompanied the guidance.[18]

8.1.4 Evidence from enforcement officers

Local authority officers considered roles and responsibilities to be generally clear. – *"[in this case] everyone knew what they needed to do, there was clear and concise communication… everything was well documented".*

One officer suggested that some FBOs were not sufficiently aware of their responsibilities and assumed that the decision to recall a product was always determined by their local authority. Another suggested that roles could be blurred if additional agencies (such as public health bodies) were involved, but did not provide a specific example.

The majority of enforcement officers regarded the guidance as clear, and the recall templates as helpful for providing consistency. However, they suggested that many small FBOs were unaware that guidance was available, and that local authorities were required to signpost them to the FSA/FSS website.

The majority of enforcement officers were not in post in 2019 when the previous recall system was in place, and therefore could not compare it with the redesigned system. One officer who had experienced both suggested that the redesigned system provided better clarity and guidance on the type of information that point of sale notices should contain.

8.1.5 Evidence from data

Survey data suggests that FBO awareness of the guidance is relatively low, but that communication from local authorities and/or the FSA/FSS was regarded as clear.

In November 2021, the FSA commissioned IFF research[19] to conduct the FBO Tracker Wave 3 which comprised 700 interviews with small (10-49 employees) and micro (fewer than 10 employees) FBOs. This indicated that:

---

[18] Food incidents, product withdrawals and recalls | Food Standards Agency

[19] FSA Small and Micro FBO Tracking Survey Wave 3 (2021)

- only 37% of businesses were aware of the FSA online guidance and templates for dealing with withdrawals and recalls. There was little difference across sector, size or country
- 94% of businesses who had experienced a recall rated the communications they received to be clear/very clear. These results indicate a significant improvement in the clarity of communications as only 42% of respondents stated 'very clear' in 2018.

How effective was the programme in delivering outcome one?

Overall, the system redesign was effective in ensuring that there is a clear understanding of roles and responsibilities among all stakeholders taking part in a food recall.

- FBOs, ESRG members and enforcement officers considered there to be a clear understanding of the roles and responsibilities, but with some areas for development.
- Enforcement officers suggested that not all FBOs were aware of the guidance. Findings from the FBO Tracker Wave 3 endorse this, as only 37% of FBOs were aware of this guidance.
- ESRG members from industry expressed concerns that smaller FBOs may have fewer resources to implement the new processes and understand the legalities underpinning them, and that more focus on providing tailored support to this group may be required.
- Consumers who had experienced a recall suggested that they had a clear understanding of the roles of the different organisations, while those who had no experience were less confident of roles during a food recall.

What does this mean for FSA/FSS?

The agencies should:

- Continue to raise awareness of the guidance and templates with FBOs (e.g. via trade organisations)
- Continue to raise consumer awareness of the steps to take during a food recall
- Consider further promotion of the current FSA/FSS text alert service, as focus group participants were responsive to this idea (as long as the alerts received were tailored to their food consumption habits).

8.2 Outcome 2: Information to consumers is consistent and accessible, based on proven best practice and underpinned by cross industry sharing of approaches and impact

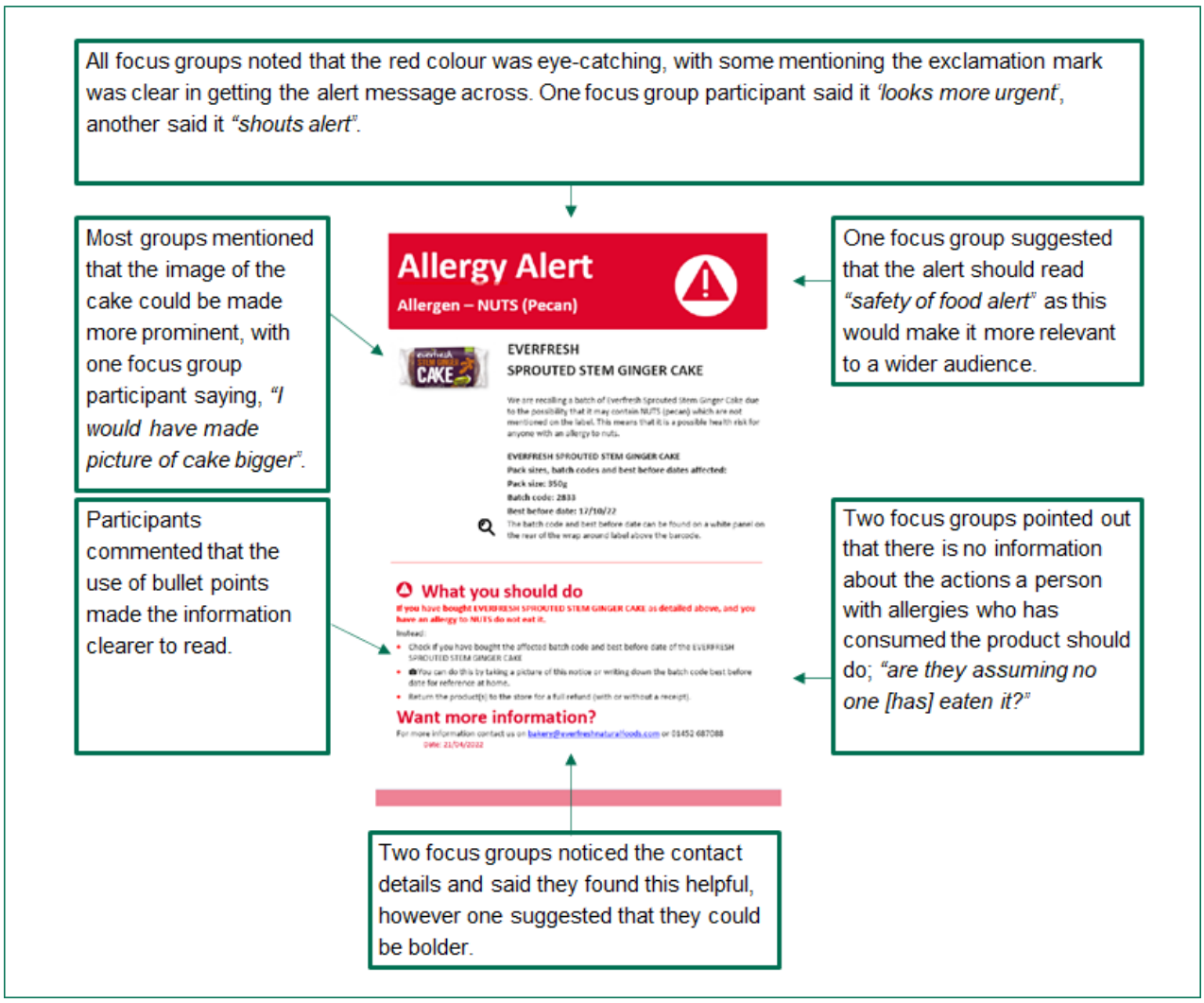
8.2.1 Evidence from consumer focus groups

Evidence from consumer focus groups suggested that information for consumers is inconsistent. Focus groups suggested that consumer awareness of a recall was often dependent on chance – *"I only found out about it when I happened to be in [a] lift"*. One group argued that more effort should be made by retailers to ensure that all consumers were notified of a recall.

Those who had experienced a food recall had been notified of the recall in different ways, suggesting that FBOs are using a variety of methods to inform consumers. This included:

- notices in supermarkets
- online news websites
- social media
- emails from supermarkets and online retailers
- print newspaper
- television and radio news alerts.

Focus groups were shown two examples of recent point of sale notices, one which used the updated non-mandatory template, and one that did not. Both these notices were obtained from the FSA and FSS websites. The content and visual appearance of the updated point of sale notice template was then discussed, and the comments are shown on the image below:



To improve the accessibility and consistency of information available to consumers, focus groups suggested the following recommendations for point of sale notices:

- **Use of QR codes:** This would enable consumers to read the notice in more depth at home as *"a lot of people don't have time to stand and read it"* in store. In addition, it was noted that post Covid-19 pandemic, more people were familiar with the use of QR codes. Others suggested that the QR code could link to the FSA/FSS website, and noted that *"a QR code could actually get you to a website with all the recalls on it".*
- **Place notices on shelves alongside recalled products**: *"if it was a recall on biscuits, put it [the notice] in the biscuit aisle... rather than just an area where they all are gathered."*

- **Include a clear image of the recalled product and place a clear 'recall' title on the notice:** *"if it doesn't clearly state that there's a problem, it could just be a poster for the products really"*
- **Uniformity of notices was a positive idea:** *"surely the format should be consistent, and you should know the parts of the poster or whatever that you can automatically look at and expect to get that information from."*
- **Include advice on next steps in the event of consumers having consumed the product** (e.g. telephone numbers of relevant health services or allergy groups)

Many focus group participants were members of supermarket loyalty schemes and considered these to be an accessible way of alerting consumers to a product recall. There was a strong preference for loyalty schemes to contact consumers via text as opposed to email, as it was suggested that emails from supermarkets could be considered spam. One participant outlined their experience: *"I didn't read it as soon as it said it landed in my inbox and maybe if I'd have been contacted by another way, I may have taken more prompt action".*

No focus group participant was registered to receive allergen or food recall text alerts from the FSA/FSS, and all groups suggested that the service should be better promoted by the FSA/FSS to raise consumer awareness. Once the principles of the text alerts were discussed, participants considered this to be a useful service, particularly for those with food allergies. Participants stressed that they would want these alerts to be tailored (e.g. by region or food type), as many were concerned that *"my phone would be pinging all the time if not".*

8.2.2 Evidence from ESRG members

ESRG members considered the system redesign to have improved the consistency and accessibility of consumer information. ESRG members identified the point of sale notices as positive, as they are more concise, clearer and more colourful. The template had initial input from consumers, and then later draft notices were tested with consumer groups, suggesting that best practice had been deployed. Generally, ESRG members felt that point of sale notices are now more accessible on the website and in store.

Several ESRG members mentioned that the displaying point of sale notices is dependent on the individual FBO, resulting in inconsistency for consumers. One ESRG regulator

noted challenges in how notices are displayed "*The difficulty is where these are displayed – noticeable that some major retailers are more willing to display the notices in full view, whereas others can hide them behind backs of doors etc. This is difficult to manage."*

ESRG members also noted that consumer uptake of the FSA/FSA alert text service was generally low; *"food alerts subscriptions are very low – more likely to be people in the food industry or those with severe allergies. The general public doesn't engage…there's an assumption that food is safe."*

8.2.3 Evidence from FBOs

As the majority of FBOs had only been involved in a specific recall, they were unable to comment on whether consumer information was generally more consistent or accessible. Interviews with FBOs indicates that a range of methods were used to alert consumers of a recall. This included contacting suppliers directly to remove products, emailing consumers and creating in-store recall notices.

One large FBO suggested that the consistency of consumer information could be improved by providing guidelines for the wording of the point of sale notices (eg adopting 'may contain' or 'contains' as standardised terminology). FBOs interviewed indicated that time pressures and limited awareness of opportunities to share lessons learned, prevented more approaches to recalls being shared with others in the industry.

8.2.4 Evidence from enforcement officers

Enforcement officers suggested that point of sales notices were clear, and contained all the relevant information for consumers. Going forward, they suggested that in-store notices should be retained, but there should also be increasing use of social media posts to raise consumer awareness.

8.2.5 Evidence from data

Evidence from the 2018 FSA-commissioned the *Public Attitudes Tracker (Wave 17)*[20] and 2021 *Food and You 2 (Wave 3)*[21] suggests that consumers are receiving information about recalls from a variety of sources.

Survey data from pre and post system design indicates that consumers are still largely unaware of recall alerts: 79% of consumers reported that they were not aware of any in 2018, compared to 77% in 2021. In 2018, 81% of consumers never checked for food recall alerts, decreasing to 61% in 2021. This indicates that recall information may not always be consistent or accessible.

Both surveys indicated that consumers were unlikely to be signed up to food/allergy alerts or food recall information – only 1% of consumers received these.

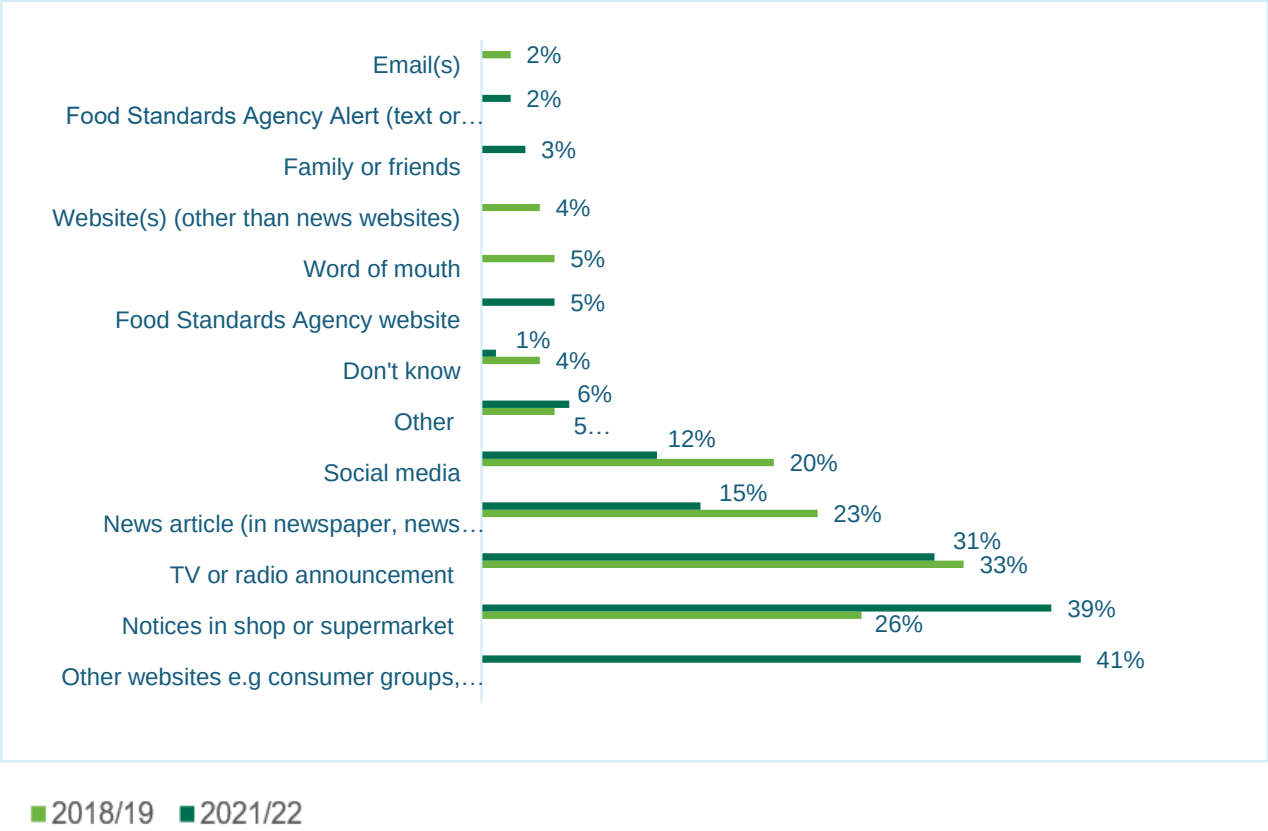
Further information on access to FSA social media can be found in Appendix B.

As illustrated in the graph below, consumers are increasingly gaining recall information from a variety of websites (41%). Both in-store point of sale notices and TV/radio announcements continue to be key information channels.

[20] Biannual Public Attitudes Tracker Wave 17, FSA (2018)

[21] Food and You 2: Wave 3, Ipsos MORI for the FSA (2022)

Figure 6: Source of information for adults who were aware of any food recall alerts in the past 12 months, 2018/19 vs 2021/22



Source: Public Attitudes Tracker (2018), n = 352; Food and You Wave 3 (2021), n=698

How effective was the programme in delivering outcome two?

On the whole, the consistency of information for consumers has improved, but there are still some areas for future consideration.

- Consumers were less likely to regard information as accessible than enforcement officers and ESRG members. Consumer focus groups indicated that awareness of the recall process can be dependent on chance (e.g. if a consumer happened to see a notice in store or read about a recall in a newspaper), indicating that information is not always consistently available. Consumers maintained that the onus was on retailers (as opposed to regulators) to inform consumers of a recall, using a range of communication methods.
- ESRG members suggested that having a standardised template for the point of sale notice was a positive step in ensuring consistency. Some FBOs had used this template

How effective was the programme in delivering outcome two?

during their recall experience, and appreciated that it had saved time and effort in creating something from scratch.

- Enforcement officers considered the point of sale notice template to be clear, and containing all the relevant information for consumers. Consumers themselves would welcome the addition of a QR code, as well as guidance on what consumers should do in the event of food consumption. Additionally, FBOs could ensure that loyalty scheme members were automatically emailed/contacted via loyalty apps regarding food recalls.
- However enforcement officers noted that there is currently no regulation covering where recall notices are placed within a store, and use of the template is not mandatory. They suggested that further thought should be given to how the system can adapt to changing consumer shopping habits (i.e. as there is more online shopping how best to display point of sale notices online).
- There is little current evidence of cross-industry sharing of approaches.

What does this mean for FSA/FSS?

The agencies should:

- Consider working with retailers to ensure that recall notices are also placed online.
- Ensure that FBOs are aware that a recalls notice template is available on the FSA/FSS website.
- Consider making use of this template mandatory for FBOs to improve consistency, and consider guidance on where this should be displayed in store.

8.3 Outcome 3: the public are aware of the recall process and what actions they should take

8.3.18.3.1 Evidence from consumer focus groups

As outlined in Outcome 1, the majority of participants were clear on the steps involved in a recall. They suggested that consumers did not require any additional support during the process (e.g. a specific recalls/withdrawals helpline). Those who had not experienced a recall suggested that they would be more likely to dispose of the product at home than return the product to the store, so additional help was not required.

Consumers in the focus groups discussed how best to alert consumers of a product recall, to further raise awareness of the process. There was a consensus that a range of different online and in-store methods should be used to ensure that as many consumers as possible from different demographic groups were informed of a recall. There was also a sentiment that consumers would prefer to be notified on a number of occasions rather than potentially miss an alert – *"there's nothing wrong with them contacting you in as many ways as possible".* Ideas for notifying consumers included:

- placing recall notices on shelves alongside affected items (as opposed to on notice boards/at the store entrance) *"you need signs near the products that there has been a problem with"*
- placing notices in supermarket newsletters *"pop it in the deals of the week brochure"*
- creating pop-up alerts on supermarket website homepages
- placing the alert on the affected item's webpage on supermarket websites
- placing alerts on the homepage of supermarket shopping apps *"if it's through an app notification you wouldn't miss it"*
- placing alerts in free local newspapers
- issuing text messages to loyalty scheme members *"a text would capture my attention"*
- Supermarket staff informing consumers at the till of a recall.

8.3.28.3.2 Evidence from ESRG interviews

Several ESRG members indicated that the system redesign had not necessarily raised consumer awareness, but had widened the range of information that consumers now have access to. A small number of ESRG members noted that historically consumer awareness of the recall process was low, making this outcome more challenging to achieve.

They suggested that the way in which consumers receive information has changed over time, and that the alert system needed to reflect this. For example, traditional point of sale notices and newspaper advertisements should be supplemented with online notices, to further raise awareness: "*Newspapers are no longer used. Folk get their news online – could be better e.g. text alerts systems could be bigger take-up there could be better advertisement of this service."*

8.3.38.3.3 Evidence from FBOs

FBOs considered the majority of consumers to be largely unaware of the actions required during a recall. They highlighted that consumers often contacted them directly to ask about next steps during their recall. Other FBOs suggested that public awareness was often dependent on chance, for example if consumers encountered a recall notice in store or interacted with FBO social media or websites.

8.3.48.3.4 Evidence from enforcement officers

Enforcement officers considered consumer awareness of the recalls process to be limited, as:

- many consumers do not see in-store notices (particularly as consumers moved increasingly to online shopping during the Covid-19 pandemic);
- it depends on consumers returning to the same store again (which was often not the case with smaller retailers, such as convenience stores); and
- consumers are unlikely to be aware of alerts placed on the FSA/FSS website; *"stuff on the website – who sees that?".*

8.3.58.3.5 Evidence from data

Data indicates that consumers are now more aware of the actions they should take during a recall. In 2021/22, Food and You 2 (Wave 3) research found that 22% returned the item to the store, and 31% of consumers took no action[22]. This is an increase from 2018/19, where 59% of consumers took no action; 6% disposed of the product and only 2% returned the item to the store for a refund[23].

How effective was the programme in delivering outcome three?
On the whole, the evidence suggests that those consumers who had experienced a food recall were aware of the process. However, those who had not experienced a recall were less aware of what steps to take.

[22] Food and You 2: Wave 3, Ipsos MORI for the FSA (2022)

[23] Biannual Public Attitudes Tracker Wave 17, FSA (2018)

How effective was the programme in delivering outcome three?

- Perceptions of consumer awareness differed between enforcement officers, FBOs and ESRG members, and consumers themselves.
- Focus groups with consumers suggested that those who had experience of recalls were knowledgeable about the process, however this may be due to the majority of participants having experienced a high-profile chocolate recall, where steps were outlined in the media. Those who had not experienced a recall were less aware of what steps to take, and many suggested they would dispose of the product.
- ESRG members, FBOs and enforcement officers were less confident about consumer awareness, suggesting that it was dependent on consumers seeing notices in-store.
- Data suggests that consumers increasingly return food items: in 2021/22, 22% of consumers returned items to the store, compared to only 2% in 2018/19.
- FBOs highlighted that consumers often contacted them directly to ask about next steps during the recall, suggesting limited awareness of the required actions.
- Several ESRG members indicated that the system redesign had not necessarily raised consumer awareness. They indicated that delivering the consumer awareness campaign that was envisaged was a challenge due to the pressures of Brexit and Covid-19.

What does this mean for FSA/FSS?

The agencies should:

- A combination of communication channels should be used to notify consumers – promote the use of point of sale notices, online notices and social media posts.
- Consumers require greater awareness of why they should return a product during a food recall as opposed to disposing of it themselves.

8.4 Outcome 4: feedback loops and a philosophy of continuous improvement amongst all stakeholders underpins the withdrawal and recall system

8.4.1 Evidence from consumer focus groups

Consumer focus groups indicated that they would welcome FBOs sharing learnings from food recalls with the public, and that this would further instil confidence in the UK food system. A number of focus group participants suggested that FBOs who initiated food recalls should be praised as opposed to demonised as *"[the system] should encourage companies to come forward and own up… companies should be congratulated rather than trashed in press".*

8.4.2 Evidence from ESRG members

The development of RCA (see section 6.2.1) was considered to have largely worked well by regulation ESRG members, with the e-learning course and guidance package ensuring consistent standards and more detail being reported for incidents.

However, some ESRG members indicated that more information and learnings on how to carry out an RCA needed to be shared more widely. One regulation member added that the RCA should be made mandatory to improve compliance and sharing of good practice. One industry ESRG member noted that it was compulsory in the frozen food industry, and was surprised it was not required by other parts of the food system.

Broadly ESRG members viewed the feedback loops as a good approach to reducing the number of incidents and to highlight best practice. However, ESRG members suggested that more needs to be done to reach SMEs;

"The feedback loops are a really good approach in terms of reducing the number of incidents and getting best practice out there. But there is a long way to go in terms of getting best practice out there, that businesses see this, that it is implemented, and that Local Authorities make sure that the processes are used."

8.4.3 Evidence from FBOs

All those FBOs interviewed had undertaken an RCA to determine the root cause of the recall incident. Some commented that this was a helpful process, and that their

experience had led to a number of internal changes/improvements within their businesses, including:

- changing suppliers
- altering food preparation practices
- updating labelling
- providing additional staff training
- reviewing internal recall procedures and organising annual mock recalls.

Following these incidents, the FBOs interviewed did not share their RCA with others within their industries, due to a limited awareness of industry forum where these could be shared, uncertainty over who was responsible for sharing RCAs (i.e. FBOs themselves or enforcement officers) and a focus on business demands. Only one FBO had spoken to their industry representation group about the recall. None of the FBOs were familiar with e-learning course on RCA, although a few indicated that they would be interested in undertaking it.

8.4.4Evidence from enforcement officers

Enforcement officers suggested that RCAs were being routinely conducted by larger FBOs, but that there was still some further work required to ensure that smaller FBOs also took part in this process; *"It's normally the smaller ones where you have to go back and ask... they normally do some kind of process internally, but not a written document".*

Enforcement officers interviewed indicated that widespread analysis of RCAs and/or recall trends was not routinely conducted within their local areas, due to resourcing constraints. They suggested that it would be useful for the FSA/FSS to share high level RCA findings with local authorities on an annual basis, to enable enforcement officers to monitor any emerging trends/ explore good practice.

8.4.5Evidence from data review

RCA records were updated after the system redesign, and now contains additional information and categories compared to the 2018/19 version (which only had the root cause and corrective actions). Currently, the FSA records the following categories:

- Incident type
- Hazard type
- Product type
- 5 Why's (see section 7.2.4)
- Root cause
- Corrective actions
- RCA categorisation

In 2021/22, the root cause for every incident was categorised using the 'PEMPEM' model. This uses six commonly observed areas associated with food production: Process, Equipment, Material, People, Environment and Method; with associated sub-categories providing further descriptive information regarding the root cause type.

Between April and September 2021, only 10% of incidents in the RCA database had not determined root cause suggesting that, overall, the industry is being successful in finding the cause.[24] Moreover, 99% of the FBOs who determined the root cause shared their corrective actions with the FSA. This shows that more FBOs are now sharing their corrective actions.

Data from the FSA indicates that, between March 2021 and February 2022, 2,643 FBOs and 463 enforcement officers completed the RCA training. This was supplemented by a further 563 completions by FBOs and 60 completions by enforcement officers between March and July 2022. The training course does not currently collect information regarding FBOs, so we cannot determine if uptake is higher within certain sectors, size of FBOs or locations.

How effective was the programme in delivering Outcome 4?

There is limited evidence that there is an ongoing commitment to continuous system improvement, although there clearly has been an increased focus on the completion of the RCA as a result of this system redesign.

[24] The FSA does not request this for all incidents, but for those where an alert is issued, all allergy incidents and micro incidents

- Prior to the system redesign, not all businesses clearly defined the 'root cause' of their incidents and the level of understanding across industry sectors was variable. Therefore the development of the Root Cause Analysis (RCA) guidance and the e-learning course were viewed positively by ESRG members.
- FBOs considered the completion of RCAs as beneficial for individual businesses, as it helped to identify the root cause of the incident and enabled them to put specific measures in place to avoid future recall incidents.
- Enforcement officers suggested that RCAs are being routinely conducted by larger FBOs, but there was still some further work required to ensure that smaller FBOs also took part in this process
- However, the programme is not as effective in ensuring that the learnings from the RCA are being used to help other businesses avoid the same problems. There is currently no process that could be followed to share the learnings more widely.
- Enforcement officers and FBOs suggested that greater clarity is required regarding who is responsible (FSA/FSS, local authorities or FBOs) for sharing RCA findings
- There appears to be limited awareness of the e-learning course amongst FBOs, with ESRG members reporting limited completion.

What does this mean for FSA/FSS?

The agencies should:

- Consider the development of a national database of RCAs, accessible by all local authorities to better share findings nationally.
- The corrective actions could be shared with FBOs from the same industry or at conferences (eg the FSA and FSS Food Safety conference) as this potentially can prevent future incidents.
- Greater clarity is required in documents listing who is responsible (FSA/FSS, local authorities or FBOs) for sharing RCA findings to ensure continuous improvement within the system.
- To increase uptake of the RCA e-learning course, local authorities could be requested to share the RCA e-learning course with FBOs as part of the recalls process.

9 Case studies

This section outlines nine anonymised case studies of recent recalls, which capture the experiences and views of the system redesign from the FBOs and enforcement agencies involved. Case studies were sampled across nations, and include small, medium and large FBOs and a range of recall types.

Case study 1: Physical contamination of butter

Recall of butter due to the possible presence of metal:

A dairy Food Business Operator (FBO) was contacted by a consumer alerting them to the possible presence of a foreign object (small piece of metal) in a butter product. The FBO conducted an internal investigation and found that damage to a butter trolley was the likely source of the metal. After consultation with their local authority, the FBO decided to initiate a voluntary recall of the butter. This involved the FBOs themselves deciding to recall the products distributed via major UK supermarkets, online retailers and a small exporter as a precautionary measure.

Experience of the recent product recall

Following a second consumer notifying the business about the presence of a foreign object in the butter, the FBO consulted with the local authority regarding next steps. After this call with the local authority, the FBO then decided to initiate a voluntary recall of the butter. For the FBO, it was surprising that the decision to recall the butter was determined by their own judgement rather than direct instructions from the FSA/FSS to initiate a recall. On reflection the FBO agrees that a recall in this circumstance should remain the decision of the FBO.

How did the FBO communicate with retailers and consumers?

As part of the recall process, the FBO contacted retailers immediately via emergency contact details. They noted that they did not have up-to-date contact details for one retailer, which made the process slightly longer (i.e. over 24 hours). They also communicated with a small number of anxious consumers directly via their regular telephone line. They suggested that, in hindsight, they would have made more staff available over the weekend to respond to all consumers as soon as they contacted the business.

How did the FBO communicate with the local authority and FSA/FSS?

Throughout the incident, the FBO was in contact with the environmental health team within their local authority and the Incidents Team within the FSA/FSS, via emails and conference calls. A Root Cause Analysis (RCA) investigation was undertaken by the

FBO, with the findings shared with the local authority and FSA/FSS. Both the local authority and the FBO acknowledged that this process was helped by having a good relationship prior to the incident.

Reflections on the new product withdrawals and recalls system

How clear were the roles and responsibilities?

The FBO reported that roles and responsibilities during the recall were clearly outlined by both the local authority and the FSA/FSS. The local authority reported that they had a good relationship with the FBO, which made the process straightforward.

The FBO praised the FSA/FSS for being responsive and available out-of-hours (given that the incident was around Christmas), and they welcomed the FSA/FSS ongoing communication and support during this stressful event (e.g. responding to emails outside of regular working hours). They suggested that there was a perception within industry that interaction with the regulator could be *"scary",* but they did not find that to be the case.

Learning and wider impacts of the improved product withdrawals andrecalls system

As a result of the incident and corresponding RCA, the FBO removed the equipment in question and conducted fortnightly inspections of equipment. The FBO then redesigned the equipment to ensure no further issues could arise and following a risk assessment, they have chosen not to incorporate any other FSA/FSS guidance in their systems as they consider their current food safety incident protocol to be robust.

The FBO itself had not had any previous experience of a product recall, so were unable to comment on any differences with the previous withdrawals and recalls system.

Recommendations for the future

1. **Use a variety of consumer alert mechanisms** – as customer bases are often diverse, using a variety of methods to alert consumers (e.g. social media, newspaper adverts) helps to alert different demographic groups.
2. **Consider developing a tailored recall message for website responses and regular out-of-hours monitoring during incidents** - the FBO suggested that other FBOs develop a tailored message to communicate with consumers affected by the recall.
3. **Consider developing more tailored withdrawals and recalls guidance for Small and Medium Enterprises (SME)** – these FBOs tend not to have the same levels of processes or experience as larger businesses, and may benefit from additional guidance aimed at SMEs.

4. **Ensure that FBOs keep up-to-date contact details for distributors** – this means that any withdrawal or recall decision can be communicated quickly, and products can be removed from shelves as soon as possible.
5. **Consider developing a single form for a recall** – the FBO noted that both the local authority and FSA/FSS had separate forms, which were time consuming to complete. They suggested that a single form for both organisations would save time.
6. **Continue to ensure the recalls system contributes to be flexible to cover the wide variety of FBOs** – a one-size-fits-all approach does not work in this diverse industry.

Case study 2: Defective packaging of water bottles

Recall of water bottles due to production error (exploding/shattering bottles):

The FBO producing sparkling water received a complaint from a consumer claiming their glass bottle exploded. After receiving another complaint, the FBO initiated their internal process for an incident and contacted FSA/FSS. After a consultation with the local authority and the FSA/FSS, the FBO instigated a recall of the sparkling water because of a manufacturing fault that was causing the glass bottles to explode. This involved recalling products distributed via UK supermarkets and other businesses that were purchasing the bottles directly from the FBO. The product was also exported.

Experience of the recent product recall

How did the FBO communicate with retailers and consumers?

The recall notices were displayed in stores to notify the consumers. The FBO had several discussions with FSA/FSS to decide on the wording of the recall notice. They also posted the notice on their website.

How did the FBO communicate with the local authority and FSA/FSS?

For this FBO, it was their first time dealing with the FSA/FSS and they noted it was *a "good learning experience".* The FBO suggested that having a named contact within the local authority would have been useful.

The FBO used the guidance and had no issues in taking the appropriate actions. They also had an internal colleague from their media team supporting them to share information with consumers during the recall process.

Reflections on the new product withdrawals and recalls system

How clear were the roles and responsibilities?

The FBO reported that roles and responsibilities during the recall were clearly outlined by the FSA/FSS. The FBO also praised their Incident Manager from the FSA/FSS for their effective communication. They also emphasised that contrary to their expectation of having a stressful recall, it was an easy and reassuring process.

Learning and wider impacts of the improved product withdrawals and recalls system

An RCA was undertaken, with an independent company assigned to undertake tests on the glass. The investigation findings support the likely root cause of bottles breaking as 'Static Fatigue' caused by a combination of: Increased pressure caused by HSG filler charge-up pressures and variable fill level control and increased ambient summer temperatures in the supply chain/consumers houses, affecting underlying micro-fractures within bottles which in some cases could cause the bottle to shatter. These findings were shared with the FSA/FSS as well as their bottle manufacturer.

As a result of this incident, the FBO and their supplier had to reconsider the design of certain bottles, and ultimately moved to another bottle design. They also increased the testing of their bottles and testing for overfills, to ensure the safety of the product.

Recommendations for the future

1. **Consumer notifications through social media** – the FBO suggested companies to share the recall notice on social media (e.g. Facebook and Twitter) on their company accounts as this would potentially allow to reach more people.
2. **FBOs need improved education** – in some areas of their products, and use of packaging materials in production.
3. **Cross-industry sharing of learnings** - should be encouraged as learnings from the RCA can be applied more widely.

Case study 3: Salmonella incident

Recall of breaded chicken products due to contamination with salmonella:

The FBO issued a notification of a food incident after receiving a positive salmonella result for one of their supplied breaded chicken products. The sample was taken as part of the FSA/FSS Chicken Survey.[25] By the time this incident was identified, the FBO confirmed that the batches were sold out and, therefore, no longer on sale.

Experience of the recent product recall

How did the FBO communicate with retailers and consumers?

The FBO issued email alerts, posted notices online, and displayed them in store.

Did the FBO undertake a Root Cause Analysis?

The FBO communicated with the supplier to check their process to identify the root cause, however, the RCA was unsuccessful in identifying the problem. The RCA contained an in-depth overview of the issue identifying the batch details, the level of risk, any communication made during the investigation, any potential root cause along with corrective and preventative actions that the supplier will implement.

Reflections on the new product withdrawals and recalls system

How clear were the roles and responsibilities?

The FBO agreed that the roles and responsibilities were clear.

How effective was the support and guidance?

The FBO used an online application form to complete an RCA, however, they noted that sometimes the FSA/FSS would ask the FBO to complete a separate form for an RCA in addition to the online one. The format of that MS Word version fo the RCA document was remarked as "*not user friendly*".

Moreover, the stakeholder interviewed indicated that the FSA/FSS guidance contains useful information, for example, contacts for allergy organisations. They also used the decision tree available in the guidance to decide whether the situation should be

[25] Survey of consumer practices with respect to coated frozen chicken products | Food Standards Agency

classed as a withdrawal or a recall. Overall, the stakeholder found the guidance supplementary to their own established internal processes and policies.

Learning and wider impacts of the improved product withdrawals and recalls system

The supplier of the breaded chicken products no longer sources chicken from certain companies where salmonella was detected. All products are also now fully cooked on site.

Recommendations for the future

1. **Improve the online forms to make them more user friendly** – the stakeholder suggested that an option to download the form and complete it offline would make this process easier.

Case study 4: Possible contamination with Hepatitis A

Recall of medjool dates due to possible contamination with Hepatitis A:

The UK Health Security Agency (UKHSA) discovered an outbreak of Hepatitis A related to the consumption of medjool dates. They notified the FSA/FSS who, in turn, notified the FBO. At the time, the FBO had not received any complaints and all tests of sample dates were negative for Hepatitis A. However, the HSA advised the FSA/FSS and the FBO that there is strong epidemiological evidence linking this FBO to the medjool dates incidents in the community. Once the UKHSA shared their epidemiological report with the retailer, the FBO initiated a recall.

Experience of the recent product recall

How did the FBO communicate with retailers and consumers?

The FBO displayed notices in stores and emailed consumers via a loyalty scheme.

Did the FBO undertake a Root Cause Analysis?

The FBO undertook an RCA, however, even after thorough investigations, such as handling controls, and water control, they did not manage to establish the root cause.

Reflections on the new product withdrawals and recalls system

How clear were the roles and responsibilities?

The FBO reflected that the process was clear in terms of roles for each party involved and what the expectations were. Due to the nature of this incident, there was also involvement of the UKHSA. Going forward, the FBO suggested having direct communications with the UKHSA as opposed to via the FSA/FSS as it would speed up the information exchange and investigation, allowing action to be taken sooner.

How effective was the support and guidance?

The stakeholder said that the FSA/FSS guidance was "*perfectly accessible*", and they used the templates online to create their recall notices.

Learning and wider impacts of the improved product withdrawals and recalls system

The FBO explained that they review their recall processes on an annual basis regardless of whether an incident had occurred or not. The FBO's supplier follows the GLOBAL G.A.P. (an international food safety standard for farms) and as a result of this recall, they will challenge this standard as they followed all the requirements and the incident occurred anyway.

Recommendations for the future

1. **Industry-wide guidance on Whole Genome Sequencing (WGS)** – The stakeholder suggested that the power of WGS will help to identify more outbreaks than it was previously possible to. If the industry is going to be basing recalls on epidemiology and probabilities, there needs to be more online guidance for industry on understanding statistics and thresholds.
2. **Ensure the consistency of the guidance used –** while recognising that the quality of guidance is good, the FBO noted a lack of consistent enforcement of the guidance as they reflected some businesses would use "may contain" instead of "does contain" which affects how consumers perceive the significance of an incident.
3. **FSA/FSS should play a stronger role in enforcing recalls with brands** – the stakeholder stressed that retailers do not have any oversight over the technical processes of their branded suppliers, however, they have been asked to push their branded suppliers to recall on occasions. The stakeholder suggested that the FSA/FSS should be responsible for ensuring brands take the right action to protect the public whilst retailers take technical accountability for their own brand.

Case study 5: Incorrect allergen labelling on bread

Recall of bread due to the presence of undeclared sesame seeds:

A small Food Business Operator (FBO) was informed by their local authority during a routine inspection that the label on one of their loaves did not correctly declare the presence of sesame seeds. Sesame seeds are one of fourteen ingredients that are required to be declared as allergens by food law within the UK, to ensure that food is safe for consumers with food allergies. The label indicating that the product contained sesame seeds was applied to the front of the packaging rather than explicitly named in the ingredients list. The FBO undertook a recall of product following consultation with local authority and FSA/FSS.

Experience of the recent product recall

After being alerted to the incorrect labelling by the local authority, the FBO initiated the recall process. Slightly over 100 incorrectly labelled loaves were on supermarket shelves at the point at which the recall began. Although no ill effects were reported by consumers, the FBO took the decision to cease production of the sesame seed loaf.

How did the FBO communicate with retailers and consumers?

As there were relatively few shops selling this product, the FBO was able to inform retailers directly to remove the product. A point of sale notice was also placed in shops to alert consumers.

How did the FBO communicate with the local authority and FSA/FSS?

As the recall came through a routine local authority inspection, the local authority was involved from the outset, and also led on communication with the FSA/FSS. There was a high level of communication between the local authority and the FBO via email and telephone calls, which was useful to ensure that the recall was initiated quickly.

Reflections on the new product withdrawals and recalls system

How clear were the roles and responsibilities?

As a small business, the FBO indicated that the recall process was unfamiliar and slightly daunting, compounded by tight timeframes. This was the first time they had had to undertake a recall, so were unfamiliar with the process. The FBO reported some uncertainty around terminology used in the FSA/FSS guidance and Root Cause Analysis (RCA) document, and that they required some additional support from the local authority to complete this, who were able to explain the process.

Learning and wider impacts of the improved product withdrawals and recalls system

The FBO undertook an RCA following the incident. As a result of the recall, the FBO ensured that the labelling machine is now able to amend labels, and products are placed in transparent bags. The FBO analysed all other products to check that they were compliant, and that all allergens were noted on the labels. They also provided training to staff to ensure that they were aware of the potential allergy risks and how to prevent any future contamination.

The recall was described as a stressful experience for the FBO, and consequently they decided not to continue producing the sesame seed loaf, given the small quantities produced.

Recommendations for the future

1. **Provide tailored guidance for small FBOs** - only a limited number of small FBOs will have had experience of a previous recall, and many will not have specific staff to undertake this role. Therefore, small FBOs are more likely to require additional support to navigate the recalls process. Specific guidance (including common recalls case studies) could be provided for small FBOs, as well as a glossary of key terminology.
2. **Consider providing face-to-face training or webinars for small FBOs** - this would ensure that FBOs were aware of the steps required in any recall, as well as provide opportunities to share learning with other local businesses.

Case study 6: Chemical contamination of a food supplement

Recall of a food supplement due to the presence of Ethylene Oxide:

The FBO received a notification from their trade group that there had been an international contamination of calcium carbonate, an ingredient in the FBO's food supplement. The calcium carbonate had been contaminated by ethylene oxide, a pesticide which is not permitted in the UK.Correspondingly, after discussion with their local authority, the FBO decided to recall the product.

Experience of the recent product recall

As the product was on an introductory trial within the UK, the product was only available in a small number of retailers. However, an internal risk assessment conducted by the FBO suggested that in the unlikely event of a single consumer buying more than six products and any associated health risks with this quantity, a

recall should be instigated. The FBO detailed this risk and the consequences in their incident report form which was then agreed with the local authorities.

The majority of the products were returned to the FBO from retailers, with a small number (less than ten) coming from consumers.

How did the FBO communicate with retailers and consumers?

Following the decision to recall the product, a point of sale notice was created, and the FBO communicated directly with the retailers.

How did the FBO communicate with the local authority and FSA/FSS?

The majority of communication was with the local authority, who co-ordinated with the FSA/FSS on the FBO's behalf.

Reflections on the new product withdrawals and recalls system

How clear were the roles and responsibilities?

Overall, the FBO described the process as *"well done",* with clear roles and responsibilities. The local authority was praised for being responsive. The FBO suggested that the guidance was extensive, but comprehensive, and answered all of their questions. They also found the annex and examples contained in the guidance to be particularly helpful. Interestingly, they suggested that, without the guidance, they would have been unlikely to follow the official process and reach out to their local authority first, and would have instead gone directly to the FSA/FSS.

Learning and wider impacts of the improved product withdrawals and recalls system

The FBO undertook an RCA investigation, and have adapted the FSA/FSS RCA template for mock recalls, as they found it *"gold standard".*

Recommendations for the future

1. **Consider promoting the RCA e-learning module** - the FBO suggested that there was limited awareness of its existence within the industry, and it could be promoted via trade bodies.
2. **Periodically share the guidance flowchart amongst FBOs** - this was regarded as extremely helpful, as it was concise and alerted the FBO about next steps, so further awareness of this would be useful.

Case study 7: Allergen contamination of a Thai style sauce

Recall of a Thai style sauce due to undeclared allergen (milk):

A large supermarket chain was notified by one of their suppliers that milk was detected in routine testing of a product. Milk was not an intended ingredient in this product, therefore, not declared on the label. The FBO initiated an internal recall process and removed products from the stores. As the FBO had a previous recall experience, they directly got in touch with the FSA/FSS to initiate the wider formal process of a recall.

Experience of the recent product recall

How did the FBO communicate with retailers and consumers?

The FBO notified the consumers by putting a notice on their website, sending direct messages to online shoppers and sharing notices on social media. According to the FSA/FSS procedures, an allergy alert was issued as well.

Did the FBO undertake a Root Cause Analysis?

During the RCA, it transpired that supplier's procedures for cleaning were not followed accurately and, thus, caused cross-contamination. However, as those procedures were not clear enough, an action plan was created and additional monitoring enforced. The learnings from the RCA were then shared with the FSA/FSS. The FBO felt this process was a standard response for them.

Reflections on the new product withdrawals and recalls system

How clear were the roles and responsibilities?

The FBO reported that roles and responsibilities were very clear across the FSA/FSS and the FBO. As the FBO had previous experience of dealing with recalls, they got in touch with the FSA/FSS directly without approaching local authorities first.

How effective was the support and guidance?

The FBO acknowledged that the guidance is very clear guidance and contains best practice examples and notice templates. The guidance is embedded in the FBO's procedures as they followed the best practice examples and adapted it to their practices.

Learning and wider impacts of the improved product withdrawals and recalls system

As a result of this incident, the supplier updated their cleaning procedures. They carried out some refresher training on the procedures and there was supervision of cleaning procedures across all shifts. The supplier also shared their learning with the FBO to identify gaps in similar procedures.

The FBO stakeholder noticed that the current recall system ensures standardised content of recall messages which is really important to ensure that consumers received all the key information about the recall process. They suggested that previously this level of information was not consistent. Moreover, the stakeholder noted improved clarity and improved messaging from the FSA/FSS. There are clear expectations for businesses regarding how and what should be communicated to consumers. Additionally, it was acknowledged that learnings on how to conduct RCA have also improved in the updated system of recalls.

Recommendations for the future

1. **Educate the consumer** – more information from the FSA/FSS on what consumers need to do in the recall situation, so it is handled safely in their homes.
2. **Introduce consumer notifications through social media** – the FBO shared that as consumer behaviour is changing with more consumers shopping online, they will not be using point of sale notices going forward. Instead, the focus will be on social media, direct communications to online shoppers via email and loyalty scheme members.
3. **Ensure consistent use of the guidance** – the FBO noted that retailers tend to follow the guidance and templates more closely compared to their suppliers.
4. **FSA/FSS should play a stronger role in coordination between the retailers and suppliers** – the FBO felt that the cascade of information from the branded supplier during the recall was not as fast as they would like to see which is a common issue for them when dealing with suppliers.

Case study 8: Allergen contamination of a pie

Recall of a baked scallop pie due to undeclared allergen (fish stock):

The FBO became aware that their production line had altered the contents of their frozen baked scallop pie, which now contained fish stock. This fish stock was not declared on the label, meaning a potential shellfish allergy issue. After discussion with their certification body, the FBO contacted the FSA/FSS to discuss the incident.

Subsequently, the FBO decided to recall the product, and the FSA/ FSS issued an allergy alert.

Experience of the recent product recall

Approximately 60 cases of the unlabelled product were retailing in different stores, including garden centres. The FBO ceased production of the pie, and any remaining cases in stock were not distributed to retailers.

How did the FBO communicate with retailers and consumers?

The FBO issued a point of sale notice for retailers to display. Where consumers had purchased the product directly from the FBO, they contacted these consumers individually via email.

How did the FBO communicate with the local authority and FSA/FSS?

The majority of communication was with the FSA/FSS, as the FBO found it challenging to find the contact details of their local authority, and communicate during Covid-19.

Reflections on the new product withdrawals and recalls system

How clear were the roles and responsibilities?

The FBO agreed that the roles and responsibilities were clear. They praised the FSS for uploading the notice on the website after-hours, and for helping them to navigate the process. They also found the point of saletemplate extremely helpful, as they were unsure of the type of details that should be included. The FBO stated that the recalls guidance was clear, as they were unaware of its existence prior to the incident. Interestingly, they suggested that they would have been unlikely to have notified allergy organisations to the recall without the input of the FSA/FSS.

Learning and wider impacts of the improved product withdrawals and recalls system

The FBO undertook an RCA, which identified that a change of recipe had altered the allergen content of the pie. Following the incident, the FBO required all staff to undertake in-house training on allergens, to ensure that staff were aware of the implications of altering recipes.

The FBO has also introduced new procedures as a result of the incident. These include a new labelling checklist for each product, as well as requirement for all products to be signed off by both Quality Assurance and the production manager before distribution.

Recommendations for the future

1. **Ensure that local authority contact details are kept up to date** - this is key in the event of personnel change, and speeds up the process. The FBO suggested to keep contact details up to date on local authority environmental health websites.
2. **Ensure that staff are aware of how alterations to recipes can affect the allergen content of products** - consider periodic in-house training so staff are aware of allergen implications.

Case study 9: Gluten contamination of sausages

Recall of pork sausages due to gluten contamination:

Sausages containing gluten had been incorrectly dispatched with sleeves of a different product that did not contain gluten in the ingredient list and was was specifically labelled as 'gluten free'. A product recall was initiated by the business. The FBO had to get in touch with their distributors to remove the products from the shelves.

Experience of the recent product recall

How did the FBO communicate with retailers and consumers?

The FBO notified their retailers to remove products from the shelves. In some instances, it took around 12 hours to get in touch with retailers which was considered by the FBO as critical lost time. This was due to the FBO waiting for a response from the retailer. Additionally, the FBO contacted the Coeliac Society about this incident to notify gluten intolerant individuals and coeliacs through this channel.

How did the FBO communicate with the LA and FSA/FSS?

The FBO told that during this recall, there was a three-way communication between them, the FSA/FSS and the Environmental Health Officer (EHO). Reflecting on the process, the stakeholder noted that the conversation was duplicated many times as there was also a separate conversation between the FSA/FSS and EHO. This was perceived to be inefficient and slowed the decision making on the recall.

Did the FBO undertake a Root Cause Analysis?

The FBO concluded the root cause was a human error. A colleague inadvertently collected the wrong sleeves from the warehouse and supplied them to the production line. This meant that sausages containing gluten had been dispatched with sleeves of a new gluten-free product.

Reflections on the new product withdrawals and recalls system

How clear were the roles and responsibilities?

Whilst the FSA/FSS, FBO and EHO were involved in this incident, the FBO said the roles and responsibilities were quite clear and there was not much debate between the parties involved.

How effective was the support and guidance?

The FBO highlighted that they have a lot of in-house guidance, however, they use the FSA/FSS template for incident notification. During this incident, they drafted a template which was then approved by the FSA/FSS. The stakeholder noted that "*it is useful to have an FSA/FSS template so you can quickly adapt it*".

Learning and wider impacts of the improved product withdrawals and recalls system

As a result of this incident, the FBO reviewed their internal procedures for label verification and started checking the presence of allergens in their products. Additionally, as a precautionary step, they have now updated their pallet signage, so all of the sides of the pallet contain notices alerting to the presence of gluten.

Recommendations for the future

1. **Quicker decision making from the FSA/FSS** as the FBO recalled it took almost 24 hours to confirm a recall even though they definitely knew that gluten-containing product has gone out advertised as being gluten-free.
2. The FBO suggested **an initial conference call between them, the FSA/FSS and EHO** once the decision to recall a product was made. This would reduce duplication of messages and speed the recalls process.

10 Effectiveness of the system to respond to future trends

This section explores how effective stakeholders consider the current withdrawals and recalls system to be in responding to new and emerging trends in the food sector.

10.110.1 Background

Consumers shopping habits are shifting, with increasing use of food delivery services as well as social media to purchase products: 1% of UK customers used Facebook Marketplace to shop for food once a week in 2020.[26] Although the overall numbers at present remain low, this is a predicted growth area.

During 2020-2021,100 food disruptions were recorded and prevented from entering the market, due to FSA's National Food Crime Unit and FSS's Scottish Food Crime and Incidents Unit.[27] As new food products enter the market, and shopping habits adapt, there is recognition that food crime trends will echo these changes. Food crime events may also be recall incidents, and may also lead to recall alerts being issued. The current withdrawals and recalls system will need to respond to these changes to the food supply system and consumer priorities.

The food industry is becoming increasingly diverse with novel and new foods entering the market such as the introduction of Cannabidiol products as having novel food status in 2019.[28] These foods could present greater levels of risk to consumers due to [less certainty about safety and safety of processing methods] higher levels of processing or potential long-term health implications due to a lack of longitudinal studies on them [and they are a fragmented market with higher levels of online sales some involving other country suppliers with different national standards). There are several emerging food

---

[26] Frequency of purchase on Facebook Marketplace among consumers in the UK in 2020.

[27] Annual review of food standards across the UK: Chapter 3: Safe and sound the latest trends in food incidents and food crime

[28] Novel foods authorisation guidance

trends that are predicted to evolve over the next decade and have increased uptake from consumers. The below food trends have been identified as areas that the FSA/FSS may need to respond to in the future:

- gut health, prebiotics, probiotics and fermented drinks
- further rises in plant-based substitutes[29]
- increase in the use of adaptogens (herbal medicines) and nootropics (supplements that improve cognitive function)
- alternative food sources including insects and cultured meats[30]
- sustainability in food packaging[31]
- a rise in direct-to-consumer brands.[32]

10.2 Hypothetical scenarios

Three hypothetical scenarios were posed to ESRG members and enforcement officers, to explore their views on how the current system may respond to future trends. This activity explored any differences in views of those involved in the system design, and those responsible for enforcing the system on the ground.

Following discussion with the FSA/FSS, three hypothetical scenarios were selected:

- Online sales
- Food crime
- International recalls

In addition, one hypothetical scenario about an online allergy incident was posed to consumer focus groups, to gain consumers' perspectives on online recalls.

[29] Exploding topics, food trends

[30] Delish: Predicted Food Trends 2025

[31] FHA: 10 future food trends 2030

[32] Exploding topics, food trends

Hypothetical scenario 1: Online sales (Facebook example)

Whilst on furlough during the Covid-19 pandemic, a keen home baker decided to use the opportunity to raise additional funds by selling home-cooked products. The baker produced an array of sweet goods and opted to sell them through Facebook Marketplace. The distributer was not registered with the Local Authority. After distributing food products for 18 weeks, it came to light that goods were being sold without allergy labels.

Overall, local authorities suggested that the current system is not able to sufficiently respond to online recalls, while ESRG views were more mixed. Some ESRG members suggested that the current system would work efficiently as online FBOs would have the contact details of their customers to notify them of a recall, and point of sale notices could also be placed online. Others however considered there to be a general lack of awareness amongst small FBOs about registration, limited local authority resource to monitor online sales and challenges identifying which Local Authority was responsible for addressing the recall.

Local Authority enforcement officers noted **challenges in identifying Facebook posts**, including:

- **A reliance on the public to alert local authorities:** All enforcement officers agreed that local authorities did not have the capacity to conduct online searches of unregulated FBOs themselves, and were reliant on the public to notify them of concerns; *"we need intelligence from the public to track them down".* They suggested that despite the growth of online sales during the Covid-19 pandemic, they were not considered 'high-risk', meaning that additional resources were not allocated to monitoring Facebook FBOs. Two enforcement officers also noted that some current officers were not familiar with Facebook, making identification additionally challenging "*the age of officers also affect this [checking]".*

- **Challenges in identifying online sales:** One officer added that many FBOs were increasingly re-wording their Facebook posts, moving away from direct sale advertisements to 'inquiries', making it more difficult to identify where sales were taking place. Another officer recounted how "we had situation where a lady was selling stuff from Facebook. Someone complained and then when we tried to check – the lady said she's not doing anything… there was nothing to do to prove this was happening".

- **Uncertainty around which online profile to use to contact FBOs:** Understandably, some officers were reluctant to use their personal profiles to

contact FBOs, and noted that equally, the *"Council wouldn't want to use their Facebook for 'policing' people online".* In addition, online FBOs did not always display their full contact details online (e.g. phone numbers and email addresses), making contact more challenging.

To improve the current system, local authorities and ESRG members suggested:

- **Informing the public about FBO registration:** enforcement officers and ESRG members both considered there to be limited awareness amongst the public around the need to register as an FBO and also their legal obligations as a food producer; "people think that they can make food at home and sell it but have no idea about the law". They suggested that articles in local authority newsletters or a YouTube video could be good ways of raising awareness.

- **Consider a centralised resource for investigating Facebook concerns:** given that local authorities had limited resources, some form of centralised resource/advice from FSA/FSS may be helpful. This could be designed in collaboration with online platforms such as Facebook.

- **Greater training for local authorities:** focusing on how to identify FBOs and how to investigate these cases.

- **A separate guidance document for online sales**: e.g. additional guidance on how to display point of sale notices online and how to contact consumers.

Hypothetical scenario 2: Counterfeit candy

Recently, a criminal gang has been repackaging candy drops and selling them in American food stores across the UK as a well-known brand.

Overall, both ESRG members and local authorities had mixed views on whether the current system would be able to respond to a counterfeit candy incident. Some ESRG members suggested the system would respond well, but it would depend on the cause of the alert, as if it doesn't fall into one of the three alert types it is less clear how to take action. However, others suggested that counterfeit candy incidents would be difficult to process due to the remit of FSA/FSS, communications between authorities, a lack of awareness for small FBOs and a lack of cooperation from some FBOs.

Challenges in identifying counterfeit candy, including:

- **Uncertainty around guidance and roles of different bodies:** Some ESRG members, advised that the role and remit of different bodies that would investigate an incident wasn't clear. They suggested that the approaches and legislation of each nation and local authorities are inconsistent, resulting in investigations being carried out differently across the nations. One officer added that information sharing between local authorities varied from area to area. Some ESRG members also questioned the role of the FSA/FSS and scope in a counterfeit candy incident wasn't clear as unless there was a clear food safety issue, it wasn't clear how the guidance would work. They added that as this is more about information and investigation, it is out of scope for the FSA/FSS until a product that needs removing from the market has been identified.

- **Communication between FBO's, consumers and authorities:** Most ESRG members shared that recall notices and FAFA (Food Alert for Action) information aren't set up for counterfeit products unless there is a food safety issue. Some ESRG member added that there was no set method of communicating with FBO's about penalties and consumers about counterfeit products. One ESRG member added that it is not clear whether local authorities or FSA/FSS would issue a notice/letter.

- **Challenge in identifying counterfeit products:** Some local authorities added that access to information depends on the FBO and whether they want to comply with guidance. One officer added that some FBO's operate as fraudulent businesses so wouldn't be as transparent about an incident. One ESRG member further suggested that because it is a counterfeit product, businesses might not know it is counterfeit and those producing it would take no action to withdraw the product.

To improve the current system, local authorities and ESRG members suggested:

- **Developing a new communication channel:** Both enforcement officers and ESRG members highlighted communications between consumers, FBO's and authorities as being problematic. Some suggested that creating a separate mechanism and channel of communication for counterfeit goods to raise awareness and share information.

- **Consider evaluating the current system:** An evaluation of the different remits and processes of the different bodies, involved across the nations to identify who they work with, relevant legislation and scope of powers to take action.

- **Consider additional resource for exploring counterfeit candy incidents:** Given the limited resources available, the development of a workstream to look at how to

tackle counterfeit goods going forward would need additional resources to be allocated to carry out this work.

Hypothetical scenario 3: International recall

A batch of Canadian maple syrup has been subject to an international recall due to concerns about the potential presence of small pieces of glass. No distribution to the UK is recorded, however, the Receipt and Management (RAM) Team identifies various outlets and wholesalers where the batch of maple syrup looks to be available to purchase. The Local Authorities are investigating if, and to what extent, the affected products are being sold in the UK.

Overall, ESRG members and local authorities suggested that the current system would respond well. Some local authorities suggested that the current system would scale up easily and would work efficiently for this type of recall especially for those local authorities with good local knowledge. ESRG members shared that once the product had been identified then the system would work as the legislation, guidance and tools are in place to process this type of incident.

Challenges in processing an international recall, including:

- **Communications with other countries:** ESRG members shared that the UK's departure from the EU had slowed international communications for the UK. One ESRG member added that previously the UK was able to use its support from the EU to leverage countries without strong relationships for information.

- **FBO coordination:** One ESRG member explained that it would be difficult for wholesalers to coordinate point of sale notices when the product is from another country.

- **Access to monitoring systems:** ESRG members shared that the UK no longer has access to RASIFF (Rapid Alert System for Food and Feed) portal enabling information on food safety to be shared post EU exit, resulting in reduced information access for the FSA/FSS slowing down the system. Information is now received through INFOSAN (The International Food Safety Authorities Network) a database of contacts that can be slower to react to an incident, in addition there is a lack of consistency across countries.

To improve the current system, local authorities and ESRG members suggested:

- **Consider improving communication guidance:** One ESRG member shared that there is low awareness of different international authorities' responsibilities in terms of communication with FBOs. A review of current guidance and making sure all parties are aware of roles, responsibilities and who to contact is suggested. Furthermore, one ESRG member suggested developing a communications channel that provides broad messages to other countries, local authorities and consumers.

- **Access to monitoring systems:** Renewed access to RASFF would allow FSA/FSS to identify international recalls and access information allowing the FSA/FSS to action incidents more efficiently and consistently as information is kept up to date.

Focus group participants discussed the following hypothetical scenario:

During Covid-19 a home baker decided to start selling home-cooked products. The baker started selling an array of sweet goods and opted to sell them through Facebook Marketplace. You or someone you live with have a severe nut allergy. After purchasing from the baker on Facebook Marketplace, you found out that the product has no allergy labelling on it.

A large number of focus group participants (particularly female participants) had had previous experience of purchasing food products online (such as cupcakes and birthday cakes). There was also a significant number of participants who expressed apprehensions about purchasing food products online.

Overall, the consensus amongst focus group participants was that the onus was on the consumer themselves to alert the seller of any allergies, as opposed to the seller notifying consumers; *"it's a person's responsibility to check for labels if they have allergies".*

Since focus group participants regarded online sales as commercial transaction between the seller and the consumer, they suggested that they would first contact the seller in the case of an allergy incident, followed by the online sales platform (e.g. Facebook). A small proportion of participants mentioned going to their local authority for advice, and only one would raise the issue with the FSA.

Some suggestions for updating the current system included:

- mandatory allergy labelling for online sales; and
- a scores on the doors style system for online retailers, indicating that a business had been registered with environmental health.

10.3 Considerations for the future

The hypothetical scenarios highlighted the strengths and weaknesses in the current system to address new challenges, including:

- **Online food product recalls**: Feedback suggested that online FBOs are more likely to have their consumers' contact details to notify them of a recall, and could also place the recall notice online (which had less chance of being over-looked than an in store notice). However, there was limited resource within local authorities to identify unregistered FBOs selling food products online, and currently an over-reliance on the public to alert enforcement officers.
- **Counterfeit food recalls:** Feedback suggested that current guidance could be used to initiate this type of recall, however the challenge would be to determine if this was a food recall or a food crime concern, and therefore who was best placed within the regulator to address this issue.
- **International food product recalls:** Feedback suggested that, once the product was identified, then this type of incident would be able to be processed using current legislation, guidance and tools. However, there is less awareness of different international authorities' responsibilities in terms of communication with FBOs, and international food recall information is received more slowly through the current database.

Learning points from these scenarios to strengthen the system for the future include:

- **Creating specific guidance documents for enforcement officers and FBOs regarding online recalls, international recalls and counterfeit goods:** These would clarify the roles and responsibilities of each partner in the process, and how best to alert consumers of a recall in these situations
- **A series of webinars for local authorities on new and emerging trends:** These could cover topics such as how best to identify online FBOs, various roles and responsibilities in food crime cases, and how best to receive information from international regulators.

- **Informing current small online FBOs about their requirement to register as an FBO:** articles in local authority newsletters or a YouTube video could be good ways of raising awareness amongst those wishing to sell food products on the internet.
- **Having a single point of contact within the FSA/FSS as key sources of information on new and emerging trends:** consider signposting local authorities to individuals with the FSA/FSS to provide additional support/advice on issues such as how to alert consumers to a counterfeit goods recall, to supplement current knowledge and awareness.
- **Annual conferences with international regulator counterparts:** this would ensure that the current system reflects best practice internationally, as well as reviewing relevant international legislation and scope of powers to take action in the event of international legislation.
- **Periodic review of current guidance:** consider undertaking an annual review of current guidance to ensure that it continues to address any new and emerging trends

11 Conclusions

The table below maps the evaluation findings against the original evaluation questions, based on evidence from the data collection, various interviews and focus groups.

Table 10: Evaluation findings

	Evaluation question	Evaluation findings
Objective 1	To what extent has the project delivered its objectives?	• ESRG members were broadly positive that the planned outcomes had been met, both in the design of the new system and its outputs. • ESRG members observed that the guidance is clear, with the roles and responsibilities of participants clearly described. However, ESRG members from industry expressed concerns that smaller FBOs may have fewer resources to implement the new processes, as well as understand the legalities underpinning them. • The adjustments to the format and information included on the website and in the point of sale notices were highlighted as a positive step. However, as the regulators do not control where recall notices are placed within store, ensuring consistency is an ongoing challenge. • Raising consumer awareness is an iterative process. The delivery of the system redesign's anticipated consumer awareness campaign was impacted due to other pressures (eg EU exit and Covid-19). • The development of RCA guidance and the e-learning course were viewed positively. However ESRG members and enforcement officers suggested low numbers of FBOs undertaking the e-learning course, and that RCA findings were not always shared consistently.
	To what extent has the project met expectations?	• Overall, ESRG members considered the system redesign to have met expectations. • They acknowledged the inadequacy of recall and withdrawal systems prior to the system redesign, including inconsistencies and lack of awareness of roles and responsibilities. • The comprehensiveness of the process of building the evidence base was noted by several ESRG members (eg live case study reviews, qualitative international benchmarking and consumer workshops). This meant that best practice was directly used to create the four planned outcomes.

	Has the governance/ management of the process been adequate to ensure that the process was well run and supported?	Overall, ESRG members regarded the governance and management structures as robust and effective as: • the programme was a corporate priority for FSA/FSS, so it was assigned significant resource and support; • having the four workstreams was beneficial, as delivery was divided into manageable sections and aligned with clear and distinct objectives; • decision making was quick but thorough; and • there was good representation of all the relevant stakeholders within workstreams, including consumer and industry input.
	What went well?	• ESRG members were positive about the co-design element, including inputs from industry and consumers (eg during the drafting of point of sale notices). • There was a high level of trust between stakeholders, which encouraged open and honest discussions at ESRG meetings. • Due to the extensive engagement and co-development with a range of stakeholders, there was no requirement to pilot the outputs of the project.
	What could FSA/FSS have done differently?	ESRG members provided the following suggestions on how the process could have been improved: • more time to produce the guidance and templates, as these were delivered within tight timeframes; • more guidance offered to the industry-led workstream around requirements; and • more regular updates, as it felt as though several activities had progressed before an update was provided.
	Were the inputs (people, time, money, resources) to process enough to deliver the project's objectives?	• As the programme was a corporate priority for FSA/FSS, all ESRG members considered the system redesign to be well-resourced and funded. • As smaller FBOs can find implementing recalls processes more challenging than larger FBOs due to resource, there could have been additional engagement with this group during the design process. • The impact of EU Exit and Covid-19 were highlighted as limiting factors in the prioritisation of this work and industry's capacity to implement outputs.

Objective 2	Regulators awareness and understanding of the package, including perception of industry awareness, understanding and use	• All local authority enforcement officers were aware of the package, and often referred to the guidance during a recall incident, as this was considered comprehensive and straightforward. • Some enforcement officers questioned whether the guidance could be simplified or shortened to encourage implementation in practice. • On the whole, FBOs, ESRG members, and enforcement officers agreed that there was a clear understanding of roles and responsibilities. • Point of sale templates were helpful for providing consistency (particularly for smaller FBOs and FBOs who had never previously experienced a recall). • Enforcement officers suggested that many small FBOs were unaware that guidance was available, and that local authorities were required to signpost them to the FSA/FSS website.
	Industry awareness and understanding of the new guidance, including preparedness in the event of a recall	• The new guidance was regarded by FBOs as comprehensive, however, many were unaware of its existence prior to their own recall experience. • Findings from the FBO Tracker Wave 3 endorse this, as only 37% of FBOs were aware of guidance being available. • Contrary to many micro FBOs' expectations, the process was less daunting than expected, due to the responsiveness of the regulators to FBO queries, in addition to support and guidance received from local authorities. • Smaller FBOs interviewed suggested that their recall preparation was limited, while larger FBOs were more likely to have some form of internal policy in place in the event of a recall. • All agreed that post-recall experience, their internal policies were strengthened and were clear on the actions required
	Industry use of the new guidance and template in response to a	• Some ESRG members shared that the new guidance worked for larger FBOs but raised concerns about smaller FBOs having understanding of the processes.

	recall, including any changes in the time taken to issue a recall notice	• Some enforcement officers suggested that the point of sale template was more widely used by smaller FBOs, who had less experience of a recall, and welcomed the structure provided by the template. • No feedback on changes to timeliness was provided, however both enforcement officers and FBOs highlighted that the recall was a fast-paced process, suggesting that recall notices were issued in a prompt manner.
	Industry use of the RCA, whether it has been successful in finding a cause and whether findings have been shared more widely	• Enforcement officers suggested that RCAs were being routinely conducted by larger FBOs, but there was still some further work required to ensure that smaller FBOs also took part in this process • FBOs considered the completion of RCAs as beneficial for their individual businesses, as it helped to identify the root cause of the incident and enabled them to put specific measures in place to avoid future recall incidents. • However, the programme has not as effective in ensuring that the learnings from the RCA are being used to help other businesses avoid the same problems. There is currently no process to share the learnings more widely, nor a process to capture near-miss incidents • There appears to be limited awareness of the e-learning course amongst FBOs, with ESRG members reporting limited completion
	Has the learning from RCA been used to help other businesses avoid the same problems? How does that process work? How could it work better?	• Overall, learnings from RCAs do not appear to be shared in a consistent manner, meaning that there are no opportunities for cross-industry learning • There was some uncertainty expressed around who was responsible for sharing these RCA findings • ESRG members and enforcement officers suggested that the system has been less effective in ensuring industry-wide

		learning, as there is currently no formal process in place to share the RCA learnings.
	Consumer awareness of recalls and actions they should take in response to a recall	• Perceptions of consumer awareness differed between enforcement officers, FBOs and ESRG members, and consumers themselves. • Consumer focus groups suggested that those who had experienced a recall were cognisant of the process. However, the majority of participants had experienced a recent high-profile chocolate recall, during which steps were outlined in the media, which may have increased their knowledge. • Those who had not experienced a recall were less aware of the actions they should take, and many suggested they would rather dispose of the product than return it to the store. • However, data suggests that where consumers are aware of food recalls, they are increasingly returning food items: in 2021/22, 22% of consumers returned items to the store, compared to only 2% in 2018/19 (Public Attitudes Tracker & Food and You 2). This suggests increasing public awareness of required actions.
	To understand how and why the overall package has made a difference (if any)? What was the process by which the package led or contributed to outcomes?	• On the whole, the consistency of information for consumers has improved, but there are still some areas for future consideration • The guidance document sets out clear roles and responsibilities – previously there was no one resource that provided all necessary information • Continuous stakeholder engagement (from industry, consumer and local authority perspectives) and a commitment to the system redesign contributed to the attainment of outcomes.
	To identify what are the most useful elements of the package and why?	• The guidance was regarded as comprehensive and well-developed by FBOs and enforcement officers.

		• In particular, the flow charts were considered as accessible and easy to follow. • All FBOs praised their local authorities and/or FSA/FSS for being responsive and supportive during the recalls process.

Based on these key findings, the table below provides some **considerations for the future for the FSA/FSS**:

Table 11: Future considerations

1	**Process:** For any future FSA/FSS project requiring partnership working, consider adopting a similar approach to that used in the system redesign (eg clearly defined workstreams and engaging regularly with all key stakeholders).
2	**Guidance:** Continue to raise awareness of the recalls guidance on the FSA/FSS websites amongst FBOs, as FBOs and enforcement officers suggested that current awareness was limited. Once aware that the guidance was easily accessible, it was well regarded by FBOs. Raising awareness could be done via trade organisations, Linkedin posts or during local authority inspections. Consider also designing separate guidance documents on new and emerging trends, to ensure that the guidance remains current and responsive to new challenges within the industry (eg in the event of an online recall).
3	**Point of sale notices:** Consider making the point of sale notice template mandatory for FBOs to improve consistency of the information provided to consumers. As more consumers shop online, consider producing guidance on where these notices should be displayed online. The point of sales notice template could also include a QR code, as suggested by consumer focus groups.
4	**Consumer awareness:** Continue to raise consumer awareness of the steps to take during a food recall (eg at FSA/FSS stands at food shows or advertisement campaigns), as data suggests that awareness is still lower than expected. Consider further promoting the current FSA/FSS text alert service, as focus group participants were responsive to this idea (as long as the alerts received were tailored to their food consumption habits).
5	**SME support:** Consider providing more tailored support for smaller FBOs to raise awareness of their role within the recall and withdrawals process, as SMEs were less likely than larger FBOs to have internal processes or resources in place in the event of a recall. This could include a series of webinars, paid advertisements on social media platforms or additional posts designed for smaller FBOs on the FSA/FSS website. There may also be

	merit in producing simplified or shortened guidance to encourage smaller FBOs to complete RCAs.
6	**Communicating with consumers:** Going forwards, ensure that a combination of communication channels are being used by FBOs to notify consumers during a recall, to reflect consumer preferences and shopping habits. As part of this, the FSA/FSS could create a communicating best practice guide, outlining the various methods that could be used, and local authorities should encourage FBOs to use a combination in-store notices, online notices and social media posts.
7	**Greater sharing of Root Cause Analysis findings:** More clarity is required regarding who is responsible (FSA/FSS, local authorities or FBOs) for sharing RCA findings, and for confirming the types of forums these findings could be shared in. This would ensure continuous improvement within the system. Consider also developing a national database of RCAs, accessible by all local authorities, and consider developing a database of 'near-miss' incidents. This would be useful in monitoring any current recall trends, as well as noting any emerging trends.
8	**Further promotion of the e-learning course:** To increase uptake of the RCA e-learning course, consider requesting local authorities share the RCA e-learning course with FBOs as part of the recalls process. Consider monitoring course completion rates, to explore if uptake increases post-promotion.
9	**Data collection:** consider standardised the FSA and FSS data collection categories, so data can be directly compared going forward to monitor recall trends.

12 Appendix A: Workstream objectives

Table 1: Objectives for the Working Group of Workstream 1: Roles and Responsibilities

Objective 1	Agree the areas to be included in the guidance, taking into account existing guidance by FSA/FSS and others.
Objective 2	Identify measures of success against which the work can be evaluated.
Objective 3	Utilise expertise with the group to develop and shape the guidance in accordance with agreed timelines.
Objective 4	Where possible, represent the position as seen in the various UK nations, highlighting variances where known.
Objective 5	Take account of interdependencies between Working Group 1 and the other project working groups: • Working Group 2 – accessible and consistent consumer information; • Working Group 3 – improved trade to trade notifications; • Working Group 4 – feedback loops and incident prevention; and • Working Group 5 – increased consumer awareness.
Objective 6	Consult on the guidance and review comments from the consultation.
Objective 7	Consider how the guidance and its implementation should be evaluated.

Table 2: Objectives for the Working Group Workstream 2: Accessible and consistent consumer information

Objective 1	The Working Group will oversee further evidence gathering with the food industry to better understand: • how industry currently communicates food recall information to consumers and to identify best practice; • what is possible in relation to consumer engagement on food recalls; • any barriers that exist to develop best practice.
Objective 2	The Working Group will commission behavioural insight work with consumers to identify best practice (from the consumers perspective): • for consumer recall notifications in both content and style; • in relation to where these notifications should be placed in-store and online; • in relation to the relevant channels for active communication of the notifications.
Objective 3	The Working Group will develop best practice guidance that includes: • a template for consumer notifications • guidance on where notifications should be displayed (both in-store and digitally), and • guidance on active consumer communications, taking into account new technologies/potential solutions. This will be underpinned by better understanding existing good practice in industry and where necessary piloting approaches to assess their effectiveness. The Working Group will work with members of Workstream 1 as this guidance will form a section/sections of the overall Competent Authority guidance being developed through Workstream 1.
Objective 4	The Working Group will consult on the guidance and review comments from the consultation before final publication of the guidance.

Objective 5	The Working Group will consider how the guidance and its implementation should be evaluated.
Objective 6	The Working Group will review FSA and FSS food alerts templates to ensure they align with the key principles from the consumer insight, making recommendations for any change and considering best approaches for how these food alerts can be actively communicated to consumers.
Objective 7	The Working Group will identify measures of success against which the work can be evaluated.

Table 4: Objectives for the Working Group Workstream 3: Improved trade to trade notifications

Objective 1	The Working Group will commission insight work to identify best practice: • for B2B recall notifications in both content and style; • in relation to the preferred channels for active communication of the notifications.
Objective 2	The Working Group will develop best practice guidance that includes: • a template for B2B notifications • guidance on active B2B communications, taking account of new technologies/potential solutions.
Objective 3	The Working Group will consult on the guidance and review comments from the consultation before final publication of the guidance.
Objective 4	The Working Group will consider how the guidance and its implementation should be evaluated.
Objective 5	The Working Group will identify measures of success against which the work can be evaluated.

Table 5: Objectives for the Working Group Workstream 4: Feedback loops and incident prevention

Objective 1	The Working Group will develop methodology for RCA and agree the feedback mechanisms required whilst considering how the processes should be best implemented.
Objective 2	The Working Group will update and consult on an entry for RCA and feedback loops in the Food Law Code of Practice and consider the redevelopment of the existing RCA e-Learning course.
Objective 3	The Working Group will embed RCA with CAs and the food industry looking to work with the FSA Regulating our Future and FSS Regulatory Strategy programmes.
Objective 4	The Working Group will consider how the implementation of RCA and feedback loops should be evaluated in addition to identifying measures of success against which the work can be evaluated.
Objective 5	A programme will be established to consider the RCA information fed back to FSA/FSS, to better understand what causes incidents, to share best practice, and to feed into incident prevention work.

13 Appendix B: Secondary data analysis

Table 1 - The largest incident categories for FSA and FSS pre and post system review project

FSA		FSS	
April 2018 – March 2019	**April 2019 – December 2019**	**April 2018 – March 2019**	**April 2021 – March 2022**
Pathogenic Microorganisms (16%)	Pathogenic Microorganisms (36%)	Allergens (19%)	Allergens (17%)
Allergens (13%)	Allergens (43%)	Regulatory Breaches (16%)	Regulatory Breaches (12%)
Clandestine Detection (9%)	Foreign Body (19%)	Microbiological (15%)	Microbiological (25%)
Poor or Insufficient Controls (8%)	Not Determined / Other (0.4%)	Chemical (8%)	Chemical (20%)

Figure 7 - FSA and FSS product types, 2021 – 2022

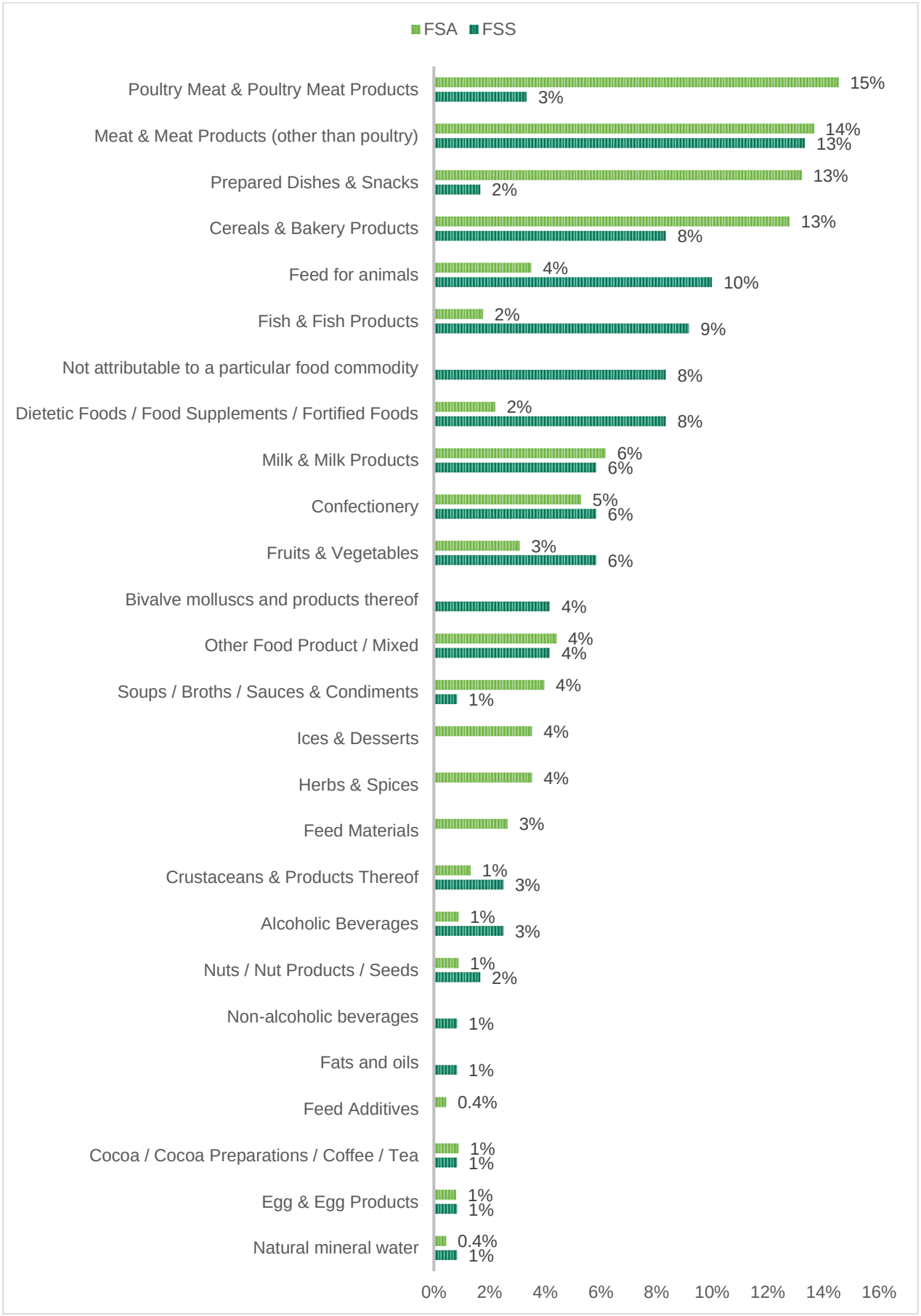
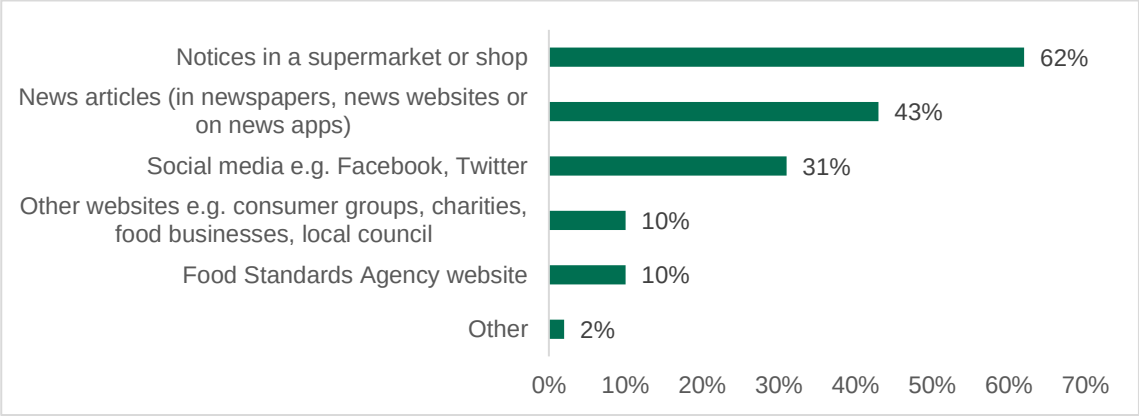


Figure 2: Where consumers find out about the food recalls



Source: Food and You Wave 3 (2021), n=1,446

Social media data

The FSA and FSS post product withdrawals and recalls information on their dedicated website, Facebook and Twitter pages. Examples of these posts are shown in figures below.

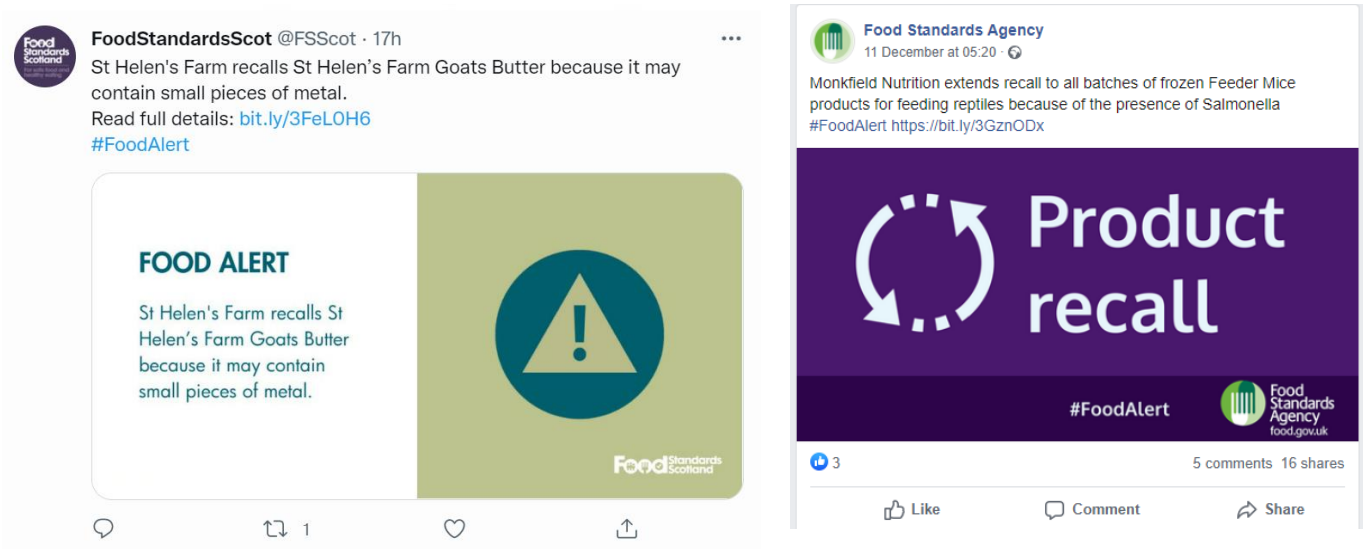


Figure 3 - Examples of FSA and FSS Social Media posts

In 2018/19, the FSA posted approximately 184 posts on their Facebook page, covering topics such as food recalls, food hygiene and food intolerances. In 2021/22, there were approximately 159 posts about food recalls. Table 2 illustrates the number of:

- Reach - total number of unique users who viewed posts;

- Impressions - how many times content was displayed on a screen; and
- Engagement - any action someone takes on the Facebook Page or one of the posts (including likes, shares and comments).

Examples of non-recall posts included food safety for students and Christmas food storage. The majority of the recall-related lifetime post impressions were viewed by people who have previously liked the FSA page, indicating that they have an existing interest in food recalls. It can be seen that the reach for recalls posts was relatively low in 2018/19, especially if compared with the non-recall posts. However, in 2021, the reach for both recalls and non-recalls post was significantly higher indicating better reach of posts to the audience.

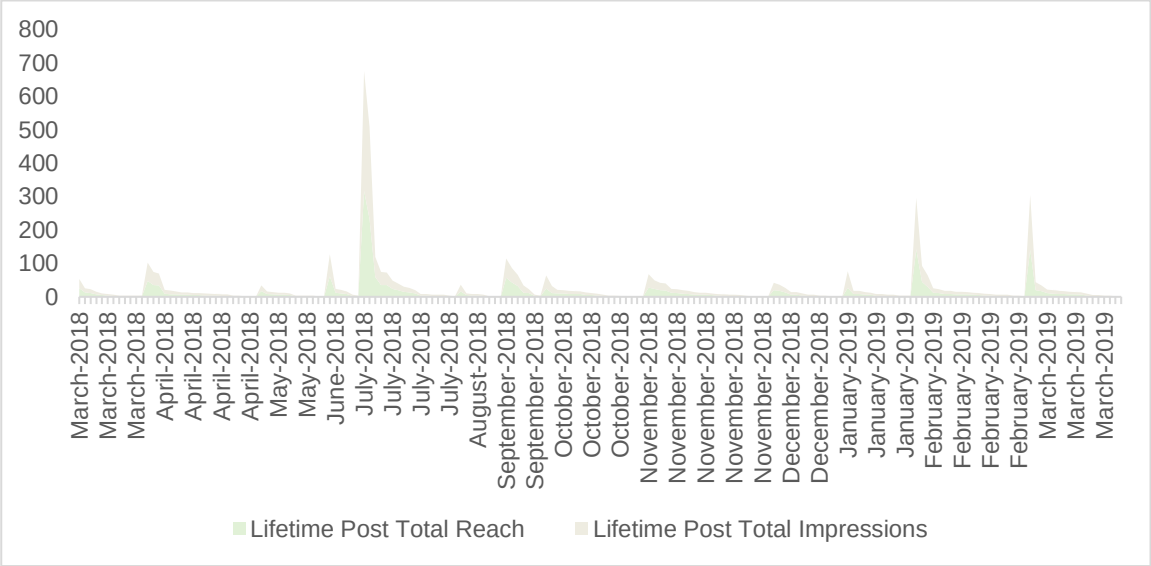
The data collected for 2018/19 and 2021/22 varies and it is impossible to compare post impressions and engagements between 2018/19 and 2021/22.

Table 2 – FSA statistics on Facebook

	Time period	Post reach	Post impressions	Post engagement
Overall average - recalls	**2018/19**	13	15	-
	2021/22	9,719	-	332
Overall average - non-recalls	**2018/19**	946	1,377	-
	2021/22	10,277	-	458

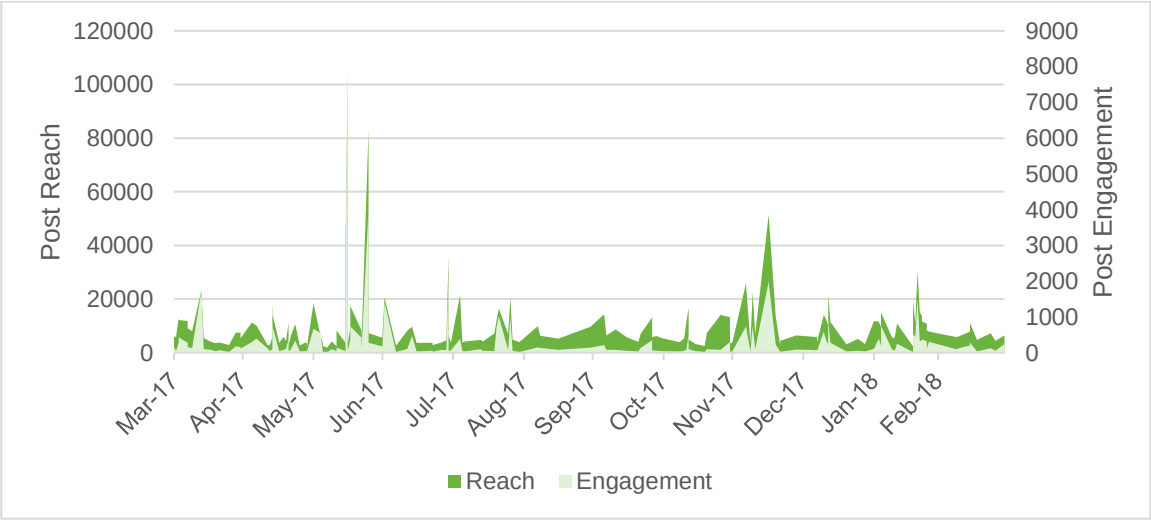
Source: FSA Facebook data analytics

Figure 4 - Facebook lifetime post total reach and impressions (2018/19)



Source: FSA Facebook data analytics

Figure 5 - Facebook lifetime post total reach and engagements (2018/19)



Source: FSA Facebook data analytics

During 2018/19, the FSA created 193 tweets about food recalls. Like with Facebook posts, Twitter users were less engaged with non-recall tweets than recall-related tweets. For example, non-recalls tweets had an average engagement level of 2.59% (i.e. users liking, replying, retweeting etc. these tweets) compared to an average of 0.79% for non-recalls tweets. According to social media management tools, an engagement level of

0.02% to 0.5% is classified as *'good'*.[33] However, when analysed by URL clicks, Twitter users were more likely to explore and click the URL with recalls posts than non-recall posts, indicating that these tweets were engaging or interesting for users.

During 2021/22 period, the FSA posted approximately 182 tweets about food recalls. Although the number of tweets remained similar, overall engagement had improved significantly. Average engagement rate was 0.026% which is considered 'good'. The engagement was up by ten times and the number of URL clicks was up by more nearly 14 times. Overall, these results indicated an improved reach of the FSA tweets.

Table 3 - FSA Twitter reach 2018/19 vs 2021/22

	Time period	Impressions	Engagement	Engagement rate	URL clicks
Overall average - recalls	**2018/19**	6,647	56	0.79%	15
	2021/22	7,754	541	0.026%	206
Overall average - non-recalls	**2018/19**	3,813	47	2.59%	8
	2021/22	2,704	42	0.027%	10

Web analytics

Overall, during 2018/19, there were 1,492,318 unique page views of the 153 alerts on the FSA withdrawals and recalls website. The average time spent on the webpage was around half a minute per user. Although the number of alerts dropped to 68 in 2021/22 with 367,853 unique page views, the average user was spending round 2 minutes on a webpage indicating a significant increase in content engagement.

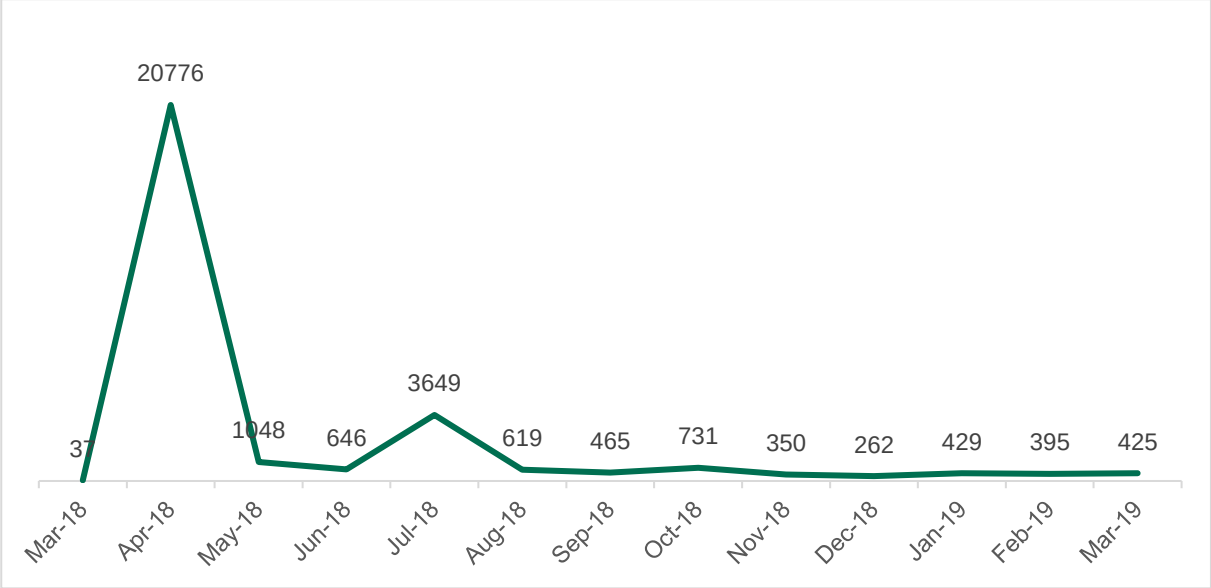
[33] Thomas RL, Alabraba V, Barnard S, et al. Use of Social Media as a Platform for Education and Support for People With Diabetes During a Global Pandemic. *Journal of Diabetes Science and Technology*. November 2021.

For the FSS, the website received 46,861 unique page views, with the average user spending 1 minute 12 second on the website in 2018/19. Unfortunately, there was no available data to do the comparison with 2021/22 stats for the FSS.

We also explored the bounce rate, which is the proportion of people that come to a website and leave without clicking to any other pages besides the one they first landed on. On average, the bounce rate for both the FSA and FSS was 68%, suggesting that the information consumers were looking for was easily accessible from a singular page. In 2021/22, the bounce rate for the FSA was down to 63% indicating a slight improvement in the website navigation between pages. Unfortunately, there was no available data to do the comparison with 2021/22 stats for the FSS.

A total of 367 people have subscribed to the FSS email alerts, and 51 to the text alert system. We currently do not have any demographic information on subscribers. Figure 4 below shows new subscriptions (by email and SMS) to the FSA alerts on a monthly basis. A total of 32,963 people subscribed to the FSA alerts from April 2018 to March 2019. Figure 4 below shows a big spike in subscriptions in April 2018 which coincides with the launch of the new system for the alerts.

Figure 6 – New monthly subscriptions to the FSA alerts (2018/19)



Source: FSA monthly subscriber data analytics

Since 2018/19 period, the overall number of platform users continued to grow reaching over 40K in 2021/22. At the end of March 2022, there were 41,571 users subscribed to food alerts and 30,867 – to allergy alerts.

14 Appendix C: Evaluation framework

Overview

The evaluation framework presents the evaluation questions mapped against potential sources of data/ information. The evaluation framework forms the basis for all evaluation activities and directly informs the development of research tools (such as interview guides). The following sources of evidence are to be used:

- Desk review of documentation (provided by the FSA);
- Secondary data (provided by the FSA, FSS and any partners eg. Local enforcement agencies);
- Interviews with ESRG members;
- Interviews with enforcement officers and wider stakeholders (eg. Industry body);
- Interviews with FBOs (sampled to represent companies who have/ have not experienced a product recall or withdrawal under the new system);
- Focus group with consumers; and
- Case studies with FBOs and enforcement agencies.

Evaluation framework

The evaluation framework below was discussed with the steering group at the evaluation workshop.

Table 12: Evaluation framework

Evaluation question/theme	Research questions or metrics	Data source/method
Objective 1: Efficacy of the internal programme process		
1. How effective was the system redesign?	**A) Strength of evidence base/how did it inform system re-design?** i) Evidence base and problem statement (e.g. consumer insights). Was the evidence sound, what were the recommendations and was best practice relevant to UK? ii) How were insights and pilot approaches with industry, used to inform design/implementation?	• Desk review of documentation • Interviews with ESRG members
	B) Governance/management structures for the programme of work: were they effective in system re-design? i) Were the governance/management structures/partnership approach fit for purpose? What worked well/less well?	• Desk review of documentation • Interviews with ESRG members • Interviews with enforcement officers and stakeholders

Evaluation question/theme	Research questions or metrics	Data source/method
	C) What were the objectives for reform (4 ESRG workstreams)? i) Discuss objectives for the 4 workstreams and overarching aims. ii) What was the purpose/intention of each workstream?	• Desk review of documentation • Interviews with ESRG members
2. How effective is the system delivery?	**A) Delivery progress of internal programme process and partnership approach** i) What worked well/less well? ii) Were approaches piloted to assess effectiveness before rolling out? iii) How were tools, guidance and processes decided on? iv) Were industry/enforcement authorities/consumer groups consulted/engaged with effectively? v) Could any improvements have been made?	• Desk review of documentation • Interviews with ESRG members • Interviews with enforcement officers and stakeholders

Evaluation question/theme	Research questions or metrics	Data source/method
	B) Have reform objectives been met in the design of the new system and the 'package' for FBOs/LAs? (Nb. This question is focused on design not implementation). i) A withdrawal and recall system founded on a clear and distinct set of roles and responsibilities, agreed, and commonly understood by all participants ii) Information to consumers is consistent and accessible, based on proven best practice and underpinned by cross industry sharing of approaches and impact iii) The public are aware of the recall process and what actions they should take iv) Feedback loops and a philosophy of continuous improvement amongst all stakeholders underpins the withdrawal and recall system	• Desk review of documentation • Interviews with ESRG members • Case studies with FBOs • Interviews with enforcement officers and stakeholders • Secondary data analysis
Objective 2: Efficacy of the new system		
1. Are roles/responsibilities in the new system clear and distinct?	**A) Regulators/industry awareness and understanding of 'the package'** i) Describe the relevant incident and processes followed in	• Case studies with FBOs • Interviews with enforcement officers and

Evaluation question/theme	Research questions or metrics	Data source/method
	providing support and reporting Root Cause Analysis ii) Did you use the package and what actions were advised? iii) Do you agree that the current withdrawal and recall system is founded on a clear and distinct set of roles and responsibilities, agreed, and commonly understood by all participants?	stakeholders (e.g. Industry bodies of relevance)
2. Is information provided to consumers, and cross-industry, sharing of approaches and impact, consistent and accessible?	**A) Industry use of 'the package'** i) What are the most useful elements of the package and why? ii) What are your views on the new guidance and materials for recalls and withdrawals available to FBOs, on the FSA/FSS website? iii) Do you know where to access these and are using the package regularly to support FBOs? iv) Do you think that industry is making good use of the new guidance and package of tools/support?	• Secondary data analysis • Case studies with FBOs • Interviews with enforcement officers and stakeholders
	B) Industry use of root cause analysis (RCA) and success in cause identification. i) Is RCA being routinely conducted?	• Secondary data analysis • Case studies with FBOs • Interviews with enforcement

Evaluation question/theme	Research questions or metrics	Data source/method
	ii) How successful is RCA in finding a cause and are findings shared with industry bodies? iii) Are any further improvements needed? iv) Has your organisation completed RCA e-learning training? If yes, was it useful? If no, why?	officers and stakeholders
	C) Sharing RCA learning with wider industry and impacts i) Have any RCA reports resulted in learning that has helped other businesses avoid the same problems? How has this worked in practice? ii) If learning has not been shared, why not? iii) What more could be done to share learning in industry?	• Secondary data analysis • Case studies with FBOs • Interviews with enforcement officers and stakeholders • Focus groups with consumers
	D) Impacts attributed to new system i) What difference has 'the package' made to timeliness of notices, consistency of information, targeting of consumers, under what circumstances and why? ii) What was the process/mechanism by which the whole package and individual	• Secondary data analysis • Case studies with FBOs • Interviews with enforcement officers and stakeholder

Evaluation question/theme	Research questions or metrics	Data source/method
	elements led to or contributed to outcomes (process tracing approach)? iii) Have some elements of the package been more impactful than others? iv) How did the package (or elements of it) lead to positive outcomes?	
3. Has public awareness of food recalls and actions they need to take been increased?	**A) Increased awareness of food recalls and actions required** **For consumers:** i) How aware were you of product recall procedures prior to the incident? ii) What are your preferred channels of information for food recalls (news sources, in store notices, social media, email, letter)? iii) How might technology be used to inform you about a product recall in future? **For FBOs:** i) Do you agree that the public are more aware of the recall process and what actions they should take? ii) Have you seen increased numbers of returns after incidents?	• Secondary data analysis • Case studies with FBOs • Interviews with enforcement officers and stakeholders • Focus groups with consumers

Evaluation question/theme	Research questions or metrics	Data source/method
4. Is there commitment to continuous system improvement?	**A) Commitment to improve delivery through continuous learning by delivery agencies** i) Which agencies did you engage with, what were their roles/responsibilities, and were they aware of these? ii) How well did the agencies carry these roles/responsibilities?	• Interviews with ESRG members • Interviews with enforcement officers and stakeholders • Case studies with FBOs
	B) Data collected/monitored and by which agencies. i) What data is collected and analysed? What are the indicators for success? ii) How is it used for system improvements?	• Secondary data analysis • Interviews with ESRG members
5. Other impacts and learning	**A) Have there been any unintended outcomes arising from system change?** i) Have there been any positive unintended effects? ii) Have there been any negative unintended effects? What is needed to address these?	• Secondary data analysis • Case studies with FBOs • Interviews with enforcement officers and stakeholders • Focus groups with consumers

15 Appendix D: ESRG interview topic guide

Introduction

RSM UK Consulting LLP (RSM) has been jointly commissioned by the Food Standards Agency and Food Standards Scotland to undertake an independent evaluation of the food recalls and withdrawals system. Specifically, the evaluation will look at how effective the processes involved in developing the new system have been, and the efficacy of the package developed, as well as the effectiveness of its implementation.

My name is [Name of interviewer], and I am an evaluator from the RSM research team. Thank you for agreeing to participate in this interview. Is now still a good time to complete the interview? [*Proceed if yes, reschedule if no*]

As part of this evaluation, we are hoping to interview ESRG members and FSA/ FSS stakeholders involved in developing the reforms and support package. The purpose of these interviews is to explore:

- The **rationale for system change** (including the policy context and problem statement) and the development of objectives to address needs.
- The **process for developing the new system and package**. How effective was the system redesign?
- Whether **stakeholder engagement** was sufficient and effective.
- How **effective is the system redesign** in meeting objectives?
- **Programme management** by the FSA and FSS and **governance** arrangements.
- Recommendations for **case studies**.
- Any further points you would like to raise.

This discussion should take 45-60 minutes via MS Teams. Your comments will be completely anonymous and confidential, will be stored securely by RSM, and will not be attributed to you in our final report. [INFORMED CONSENT TAKEN – check participant understands how their data will be processes and check if they have any questions. Gain explicit consent for audio recording of interview. Confirm confidentiality – eg. no individual names used in reports or outputs].

Background questions

1. Please can you describe your role and responsibilities and how this relates to the programme of activity?
2. What is your understanding of the overarching aims of the new system and package of support?

[Next, I'm going to ask you about your reflections on efficacy of the internal programme process.]

Rationale for system change

[In this section, we want to understand the strength of the evidence base and how it informed system re-design.]

3. Please describe from your recollection the evidence base which informed development of the four workstreams and the rationale for each workstream ie. what were the problem statements the ESRG was seeking to develop solutions for? **Nb. Stakeholders may only be able to answer for the workstreams they were involved with.**
4. Linked to the question above, can you recall the objectives for reform across the 4 ESRG workstreams)? **Nb. Stakeholders may only be able to answer for the workstreams they were involved with.**
5. In your view were you happy that the evidence was sound and can you recall the recommendations? Were any best practices identified relevant to the UK context (or were there challenges translating these to the UK context)?
6. How were insights and pilot approaches with industry, used to inform design/ implementation?

Programme delivery and partnership approach

[Please answer the following questions for the period 2016 up to launch in 2019.]

7. In Your view do you think the governance structures were effective? Were governance and management structures for the programme of work effective in system re-design? Any thoughts on what worked well or less well?
8. How do you think the partnership approach worked? Any thoughts on what worked well/ less well?
9. Which workstreams were you involved in?

a. What was the purpose/ intention of each workstream? Ie. What were the aims and objectives?

b. What planned outcomes did you hope to achieve?

c. What activities did you undertake?

d. How were tools, guidance and processes decided on?

e. What outputs/ outcomes did you achieve?

f. Were approaches piloted (ie. to assess effectiveness) before rolling out?

10. In your view, could more have been done to engage stakeholders? Were industry/ enforcement authorities/ consumer groups consulted/ engaged with effectively? Why do you say that?

11. Can you think of any improvements that could have been made during the design and consultation period?

Efficacy of the system redesign and package

[Please answer the following questions for the system and package launched in 2019.]

12. In your view, does the new system and package meet needs expressed in the problem statements for each workstream (ie. have reform objectives been met)? *(nb. This question is focused on design, not implementation).*

13. Is the withdrawal and recall system launched in 2019 founded on a clear and distinct set of roles and responsibilities, agreed, and commonly understood by all participants? Why do you say that?

14. Is it more likely that information provided to consumers is consistent and accessible, based on proven best practice and underpinned by cross industry sharing of approaches and impact? Why do you say that?

15. Are the public more likely to be aware of the recall process and what actions they should take? Why do you say that?

16. Do feedback loops and a commitment to continuous improvement amongst stakeholders underpin the withdrawal and recall system? Why do you say that?

Suggestions for potential case studies

The evaluation team will be undertaking case studies of FBOs, to gather evidence of system effectiveness. We are looking for 8-10 case studies of post 2019 food incidents and 2-4 hypothetical case studies of industries which are at risk of highly impactful recalls/ withdrawals.

17. Are you aware of any local enforcement teams or industries doing particularly good work in helping to implement the reforms?
18. Are you aware of any recent incidents, which benefited from the new package and could be a case study?
19. Are you aware of any major challenges / risks facing particular industries in the food and drinks sector, that might form the basis of a hypothetical case study?

Thinking to the future

20. Going forwards, should the programme continue to be delivered as it is, or are further improvements required? Why do you say that?
21. Is there anything else you would like to raise in our discussion today?

Thank interviewee for their time

16 Appendix E: Hypothetical scenarios

Introduction

RSM UK Consulting LLP (RSM) has been jointly commissioned by the Food Standards Agency and Food Standards Scotland to undertake an independent evaluation of the food recalls and withdrawals system. To date, the evaluation has looked at how effective the processes have been in developing the new system, as well as the effectiveness of its implementation in delivering the planned outcomes.

We are here today to think more about the future and the glean learning on how you think the recalls and withdrawals system may respond to new and emerging food trends. We have three hypothetical scenarios to discuss with you that cover:

- Online sales
- Counterfeit candy and
- International recalls.

In doing so, we are interested in your opinion on the strengths and weaknesses that the system may have in responding to these scenarios. And of course, any wider learning or considerations that you think would need to be taken for the recalls and withdrawals system to effectively respond in each scenario.

My name is [Name of interviewer], and I am an evaluator from the RSM research team. Thank you for agreeing to participate in this interview. Is now still a good time to complete the interview? [Proceed if yes, reschedule if no].

This discussion should take around 60 minutes. Your comments will be completely anonymous and confidential, will be stored securely by RSM, and will not be attributed to you in our final report. [INFORMED CONSENT TAKEN – check participant understands how their data will be processes and check if they have any questions. Gain explicit consent for audio recording of interview. Confirm confidentiality – eg. no individual names used in reports or outputs].

Background and introduction

Please can you describe a little more about your role, and how you became involved with the recalls and withdrawals project?

Hypothetical scenarios

We'll now go on to introduce each of the three scenarios, one at a time.

Scenario 1 theme: Online sales

Whilst on furlough during the Covid-19 pandemic, a keen home baker decided to use the opportunity to raise additional funds by selling home-cooked products. The baker produced an array of sweet goods and opted to sell them through Facebook Marketplace. The distributer was not registered with the Local Authority. After distributing food products for 18 weeks, it came to light that goods were being sold without allergy labels.

1. How well do you think the system would respond to addressing recalls or withdrawals of online sales?
2. Where do you see the strengths and weaknesses of the systems in responding to online sales?
3. What, if any, additional steps, resources or considerations would need to be taken to address recalls/withdrawals of online sales?

Scenario 2 theme: Counterfeit candy

Recently, a criminal gang has been repackaging candy drops and selling them in American food stores across the UK as a well-known brand.

1. How well do you think the system would respond to addressing recalls or withdrawals of counterfeit candy?
2. Where do you see the strengths and weaknesses of the systems in responding to counterfeit candy?
3. What, if any, additional steps, resources or considerations would need to be taken to address recalls/withdrawals of counterfeit candy?

Scenario 3 theme: International Recall

A batch of Canadian maple syrup has been subject to an international recall due to concerns about the potential presence of small pieces of glass. No distribution to the UK is recorded, however, the Receipt and Management (RAM) Team identifies various

outlets and wholesalers where the batch of maple syrup looks to be available to purchase. The Local Authorities are investigating if, and to what extent, the affected products are being sold in the UK.

1. How well do you think the system would respond to addressing recalls or withdrawals of international recalls?
2. Where do you see the strengths and weaknesses of the systems in responding to international recalls?
3. What, if any, additional steps, resources or considerations would need to be taken to address recalls/withdrawals of international recalls?

General reflections on the current system for the future

With the hypothetical scenarios in mind, we'd like to gauge your reflections more generally about how well equipped you believe the recalls and withdrawals system to be in dealing with evolving challenges for the future.

1. What challenges do you see that the recalls and withdrawals system may face in the future?
2. What new or emerging challenges can you foresee, or think may arise in the coming years?
3. How well do you think the system will respond to new and emerging trends in the food sector?
4. Where do you see the strengths and weaknesses of the system in responding to new and future needs?
5. What, if anything, do you think needs to happen next to allow the recalls and withdrawals system to respond to future needs?
6. Knowing what you know now, is there anything that you would change about the recalls and withdrawals system or how it was designed/implemented?

Thank interviewee for their time

17 Appendix F: FBO topic guide

FBO interview topic guide – final

RSM UK Consulting LLP (RSM) has been commissioned by the Food Standards Agency (FSA) and Food Standards Scotland (FSS) to undertake an independent evaluation of the food recalls and withdrawals system. Specifically, the evaluation will look at how effective the processes involved in developing the current system have been, and the efficacy of the package developed, as well as the effectiveness of its implementation.

My name is [Name of interviewer], and I am an evaluator from the RSM research team. Thank you for agreeing to participate in this interview.

As part of this evaluation, we are interviewing food businesses with recent experience of recalls/withdrawals to share their experiences for case studies. The interview will cover:

- Your **recent experience**
- Your feedback on the **current system and package**
- **Communications with consumers**
- **Future planning**
- **Any other recommendations** you might have

This discussion should take 45-60 minutes via MS Teams.*[INFORMED CONSENT TAKEN – check participant understands how their data will be processed and check if they have any questions. Gain explicit consent for audio recording of interview. Confirm confidentiality – eg. Are they happy for their company name to be used in a case study].*

Introduction

1. Please can you describe your business, and your role within this business? *(prompt: products manufactured, number of employees, location)*

Experience of the recent product recall/withdrawal

2. Please can you describe what happened during the (INSERT NAME) incident?
    - How did you notify consumers?
3. Did you undertake a Root Cause Analysis?
    - Do you think you were successful in finding a cause?

- Did you get any feedback or input from the LA or the FSA on any Root cause carried out?
- Did you share these findings with anyone else including the FSA (eg with your sector representative body?)

4. During this incident, which agencies did you engage with? (eg FSA/FSS, local authority, port authority, industry representatives)
    - What role did they play?
    - Did the FSA/FSS or enforcement agencies share best practice examples for completing processes and paperwork for recalls and withdrawals? Was this helpful?
    - How well did they carry these out responsibilities?
    - To what extent did you feel supported by the FSA/FSS during this period?
    - Looking back, is there anything that they could have done differently?
5. Was the guidance/ advice issued to you clear/ appropriate about where and how the notifications should be displayed (in store and online) or other actions that needed to be taken?
6. To what extent did you feel that all parties involved (eg yourselves, FSA/FSS, local authority) were clear on their responsibilities during the recall/withdrawal?
    - Is there anything else that could be done to make these responsibilities clearer?

Feedback on the current product recall and withdrawal system

7. Did you use the FSA/FSS guidance and materials for recalls and withdrawals during the incident? *This includes guidance documents, example contact templates for notifying consumers and other businesses and root cause analysis documents.*
    - Was this easy to access?
    - How useful did you find these during your incident?
    - Were there any parts that were particularly useful, and why?
    - (if used templates) did these meet your needs? *(eg were they comprehensive/ too complicated/ easy or difficult to complete/ missing sections for collating key information)?*
    - (if used RCA e-learning training) If yes, was it useful? If no, why*?*
    - What impacts did this guidance and materials have?

8. To what extent (on a scale of one to ten) has the guidance and materials improved:
    - timeliness of notices
    - consistency of information
    - targeting of consumers
9. Were you aware that these materials were available prior to the incident?
    - If not, how could the FSA/FSS increase awareness of these within your industry?
10. Was the content and style of communications and guidance/ tools appropriate?
11. If the guidance and materials hadn't been available, would you have handled the recall in a different manner? Would you use the guidance and materials if you ever had another recalls incident in future?
12. What benefits do you think the recalls and withdrawals system will have for your wider industry? (*prompt, sharing of good practice, continuous improvement)*
13. Based on your experience, are there any improvements you could suggest for the current product recall system?
14. Were there are any unintended outcomes of this process?

Consumers and communications

15. To what extent do you think consumers are aware of what to do during the recalls process?
    - Has this awareness increased following the introduction of the current system?
    - Is information about recalls accessible to the public?
    - did you have any returns of your product following the recall?
16. What do you think is the best way to alert consumers about product recalls (eg social media, notices in stores, newspaper advertisements, FSA text alerts to subscribers, FSA website)?
    - Why do you say that?
    - Does the current FSA/FSS guidance and templates take into account social media?
17. In your mind, what does best practice look like in terms of alerting consumers to food recalls?

- What could be done to ensure that best practice is shared within the industry?

Experience of the previous product recall system

18. Before the current system was introduced in 2019, have you ever had a previous recall or withdraw a product?
19. How does the current system compare with the previous recall system? (eg clarity of roles, support provided, speed of issuing a recall notice etc)
    - To what extent would you say that the current system is an improvement?

Planning for food safety incidents

20. Did the incident lead to any changes in your processes, risk management or compliance?
21. Have you used any of the guidance and template/ tools available on the FSA/ FSS websites to support you in planning for managing food safety incidents?
22. Did you have any concerns following the food safety incident and did the FSA/FSS or enforcement agencies help address these at all? If so, how?

Any other comments

23. Do you have any other comments that you would like to share?

Thank and close (plus check if email address best way to send e-voucher)

18 Appendix G: Consumer topic guide

RSM UK Consulting LLP (RSM) has been jointly commissioned by the Food Standards Agency and Food Standards Scotland to undertake an independent evaluation of the food withdrawals and recalls system. As part of this, we are interested in how aware consumers (like yourselves) are of the recalls system.

My name is *[Emma Sutton / Katy Field/ Sofia Reva]*, and I am an evaluator from the RSM team. Thank you for agreeing to participate in this focus group.

The purpose of today's discussion is to understand your views on the food recalls process. Areas which we will explore in our focus group discussion will include:

- Exploring awareness of food recalls
- Identifying any existing experience of the food recall process
- Ideas for how it could be improved.

It should take around one hour for our discussion. Your comments will be treated confidentially and reported anonymously. Data will be stored securely by RSM in a GDPR compliant format and will not be attributed to you in the evaluation report or debriefs to the Food Standards Agency and Food Standards Scotland. During our conversation, we would like to video record the focus group on MS Teams to capture the key themes emerging, are you happy for us to do so?

- *[If yes]* Thank you – I will hit record
- *[If no]* Thank you – we will not make any video recordings from our conversation but will take detailed notes during our discussion. All information provided by you will be treated confidentially and securely. When information is no longer required, official RSM procedures will be followed to dispose of your information.

Introductions

1. To start, please could you briefly summarise:

- Your name
- Your age
- (18-24) (25-29) (30-34) (35-39) (40- 44) (45-49) (50-54) (55-59) (60-64) (65-69) (70-74) (75-79) (80-84) (85+)
- Whether you have children/dependents living at home?

2. If you were having a dinner party for your favourite celebrity, what would be on the menu?
3. Do either you or someone you know in your immediate family have any food hypersensitivities including allergies and intolerances?
    a. If so, could you please tell us what they are?
4. Can you tell me whether you have heard of the Food Standards Agency or Food Standards Scotland?
    a. If so, what is your understanding of their role?
    b. How well informed do you feel about their work?
    - How confident do you feel that FSA/FSS ensure that food is safe and what it says it is?
5. Can you tell me whether you use social media, if so, please can you tell me which social media sites you use?
    - Facebook
    - LinkedIn
    - Twitter
    - Instagram
    - Snapchat
    - Tiktok
    - Other
        a. Can you please give me a rough idea of how often you access these sites?

Shopping habits

6. Can you please tell me how you usually do your food shopping?
    - Online
    - Weekly instore shop (Big retailers i.e. Tesco Extra or Asda)
    - Corner shops
    - Express shops (mini stores i.e. Tesco Express)
    - Or a combination of the above
7. Can you please tell me whether you are part of any supermarket loyalty schemes, if so, which ones?

Only ask if they indicate they use social media platforms

8. Have you previously bought/purchased food products from Facebook or Instagram? *Such as birthday cakes, cookies, or takeaways.*
    a. If yes - Could you, please tell me about your experience?
    b. If no – Would you consider purchasing food products from either Facebook or Instagram in the future?

Product recall process

9. Have you experienced a product recall for a product purchased through a retailer/ supermarket, i.e. have you ever had to return or destroy (N.B. Suggestion) a food product?

If so, could you please tell us about your experience?

    a. If yes – How did you first find out about the product recall? *(Prompt: Instore, via social media, printed media)* Was the information clear? How did it make you feel?
    b. If yes (instore) – Did you see a product recall notice in store? Where was the notice displayed and was it prominent enough? Did it contain sufficient information?
    c. If yes – would there have been any additional support that you would have liked (N.B. Suggestion) during this process?
    d. If yes – Has your trust in the UK food system changed because of your experience? (Prompt: changes to shopping habits)
    e. If yes – Could you, please explain why?
    f. If yes - Are there any improvements you could suggest, based on your experience?

10. Have you ever seen a product recall in a store, but not personally been affected? Could you tell me about them? What are your thoughts/feelings when you have seen such notices?
11. We would like to show you some examples of previous and current product recall notices. Of these two examples:
    - Which one contains the most relevant information?
    - Which one would you be more likely to read?
    - Is there any information missing on the notices?

Allergy Alert

Allergen – NUTS (Pecan)

EVERFRESH
SPROUTED STEM GINGER CAKE

We are recalling a batch of Everfresh Sprouted Stem Ginger Cake due to the possibility that it may contain NUTS (pecan) which are not mentioned on the label. This means that it is a possible health risk for anyone with an allergy to nuts.

EVERFRESH SPROUTED STEM GINGER CAKE

Pack sizes, batch codes and best before dates affected:

Pack size: 350g

Batch code: 2833

Best before date: 17/10/22

The batch code and best before date can be found on a white panel on the rear of the wrap around label above the barcode.

What you should do

If you have bought EVERFRESH SPROUTED STEM GINGER CAKE as detailed above, and you have an allergy to NUTS do not eat it.

Instead:

- Check if you have bought the affected batch code and best before date of the EVERFRESH SPROUTED STEM GINGER CAKE
- You can do this by taking a picture of this notice or writing down the batch code best before date for reference at home.
- Return the product(s) to the store for a full refund (with or without a receipt).

Want more information?

For more information contact us on bakery@everfreshnaturalfoods.com or 01452 687088

Date: 21/04/2022

BARR
SOFT DRINKS

IMPORTANT SAFETY NOTICE

As a precautionary measure A.G. Barr is recalling certain 750ml IRN-BRU Regular and IRN-BRU 1901 glass bottles from the market because of an issue with caps which may cause them to pop off unexpectedly. We believe this to be an infrequent, intermittent fault in some of our bottles. The liquid in the bottle is good and tastes as you would expect.

The recall affects only 750ml glass bottles with codes shown below. You'll find the code stamped onto the neck of the bottle.

The flavours and batches affected are:

IRN-BRU Regular
MAR 2023, C2 2083
MAR 2023, C2 2084

IRN-BRU 1901
MAR 2023, C2 2082
MAR 2023, C2 2087
MAR 2023, C2 2088

No other Barr Soft Drinks pack sizes are affected.

As a precautionary measure we are asking consumers who have the affected batches of IRN-BRU Regular and IRN-BRU 1901 in 750ml glass, to open the bottles with care to release the pressure. The bottle should be handled carefully, pointed away from the body at arm's length.

If you have any questions please email consumercare@agbarr.co.uk.

At A.G. Barr p.l.c we take great care to ensure that our products reach our consumers and customers in perfect condition and are sorry that on this occasion a limited quantity of our products has failed to meet expectations.

29th April 2022

If no - We'll now go on to introduce each of the two scenarios, one at a time.

Scenario 1: A batch of sliced bread has been recalled due to concerns about the potential presence of small pieces of glass. You purchased a loaf of the sliced bread from your local supermarket and have now found out the product has been recalled.

a. How do you think you would find out that the product has been recalled?
b. What do you think you would do during this product recall? Do you have any friends or family who have experienced a recall?
c. Where do you think you would go for guidance during this incident?
d. If you were to experience an in-store product recall in the future would your trust in the UK food system change because of your experience?

Scenario 2: During Covid-19 a home baker decided to start selling home-cooked products. The baker started selling an array of sweet goods and opted to sell them through Facebook Marketplace. You or someone you live with have a severe nut allergy. After purchasing from the baker on Facebook Marketplace, you found out that the product has no allergy labelling on it.

a. What action would you take?
b. Who would you report the incident to?
c. Where do you think you would go for guidance during this incident?
d. How do you think you would find out that the product has been recalled?
e. Have you ever seen a product recall notice online? Could you tell me about them? What are your thoughts/ feelings when you have seen such notices?
f. What do you think you would do during this incident? Do you have any friends or family who have experienced a recall?
g. If you were to experience this online product recall in the future would your trust in the UK food system change because of your experience?

Future

12. If you were to purchase a product that was then recalled, in what format would you most like to receive this information? (prompt: news sources, in store notices, social media, email, letter)
    a. Do you have any other ideas about the best way to let you know you needed to return a product? (Prompt: pop-up boxes on shopping sites, features of online platforms)
13. How might social media be used to inform you about a product recall in future?
14. Are you registered to receive text alerts from the Food Standards Agency or Food Standards Scotland about either allergens or food product recalls?
        a. If yes – Which updates are you signed up to receive? How helpful do you find these alerts?
        a. If no – Would this service be something you would be interested in? Why do you say that?

Final comments and close

15. Is there anything else you would like to add? (prompt: other improvements that could be made, or how to notify customers of a product recall)

If you have any further questions, want to sign up for text alerts, or have concerns about the food recall process, please visit either https://www.food.gov.uk/news-alerts/signin, https://www.foodstandards.gov.scot/subscribe *or* socialscience@food.gov.uk

19 Appendix H: Enforcement officer topic guide

Enforcement officers interview topic guide – final

RSM UK Consulting LLP (RSM) has been commissioned by the FSA and FSS to undertake an independent evaluation of the current food traceability, withdrawals and recalls system following changes made between 2017 – 2019 to improve the effectiveness of alerts in protecting consumers. The evaluation will look at the effectiveness of changes to processes, the package of guidance and materials introduced, as well as the efficiency of their implementation. We will refer to the post 2019 recalls/ system as 'the new system' and pre 2019 as 'the old system'.

My name is [Name of interviewer], and I am an evaluator from the RSM research team. Thank you for agreeing to participate in this interview.

As part of this evaluation, we are interviewing food businesses with recent experience of recalls/withdrawals to share their experiences for case studies. The interview will cover:

- Your **recent experience**
- Your **awareness and feedback on the improved system** and package
- **Communications with consumers**
- **Future planning**
- **Any other thoughts or recommendations** you might have

This discussion should take 45-60 minutes via MS Teams.*[INFORMED CONSENT TAKEN – check participant understands how their data will be processed and check if they have any questions. Gain explicit consent for audio recording of interview. Confirm confidentiality – eg. Are they happy for their company name to be used in a case study].*

Introduction

1. Please can you describe your role within this recall/withdrawal incident?

Experience of the recent product recall/withdrawal

2. Please can you describe what happened during the (INSERT NAME) incident?
    - How did the FBO notify consumers?
3. Did the FBO undertake a Root Cause Analysis? (Where they aware of it?)

- If so, were you successful in finding a cause?
- Did the FBO share these findings with anyone else (eg with your sector representative body? The FSA?)

4. Is RCA being routinely conducted?
    - If not, why do you think this is the case?
    - From your experience, how successful is RCA in finding a cause and are there any specific barriers to establishing the root cause?
    - Are these learnings shared more widely within the industry? Are you aware of any learning sharing being carried out by industry??
    - Do you think that any RCA reports from your business would have helped other businesses avoid the same problems?
    - What would you like to see the FSA do in terms of sharing these RCA learnings? [Would you like to be involved in helping the FSA develop this?
5. To what extent did you feel that all parties involved (eg yourselves, FSA/FSS, local authority) were clear on their responsibilities during the recall/withdrawal?
    - Is there anything else that could be done to make these responsibilities clearer?
    - [If this is LAs can we ask perhaps?] Are you aware of the reference to RCA in the Food Law Code of Practice and Practice guidance?

Feedback on the new product recall and withdrawal system

6. To what extent (on a scale of one to ten) has the guidance and materials improved:
    - timeliness of notices
    - consistency of information
    - targeting of consumers
7. Was the content and style of communications and guidance/ tools appropriate?
8. What benefits do you think the changes to the recalls and withdrawals system will have for your wider industry? (*prompt, sharing of good practice, continuous improvement)*
9. Based on your experience, are there any improvements you could suggest for further improving the product recall system?
10. Were there are any unintended outcomes of this process?

11. Do you think that industry and enforcement authorities are making good use of the new guidance and package of tools/ support?
12. Is the revised system compatible for all businesses i.e. smaller and medium-sized companies, as well as larger organisations?

Consumers and communications

13. To what extent do you think consumers are aware of what to do during the recalls process?
    - Has this awareness increased following the introduction of the new system?
    - Is information about recalls accessible to the public?
    - Have you experienced an increased number of returns of product to businesses after incidents?
14. What do you think is the best way to alert consumers about product recalls (eg social media, notices in stores, newspaper advertisements, FSA/FSS websites)?
    - Why do you say that?
    - Does the current FSA/FSS guidance and templates take into account social media?
15. In your mind, what does best practice look like in terms of alerting consumers to food recalls?
    - What could be done to ensure that best practice is shared within the industry?

Experience of the previous product recall system

16. How does the new system compare with the previous recall system? (eg clarity of roles, support provided, speed of issuing a recall notice etc)
    - To what extent would you say that the new system is an improvement?

Continuous system improvement

17. What recall data is collected and analysed?
    - What are the indicators for success?

How is this data used for system improvements?

Any other comments

18. Do you have any other comments that you would like to share?

The matters raised in this report are only those which came to our attention during the course of our review and are not necessarily a comprehensive statement of all the weaknesses that exist or all improvements that might be made.

Recommendations for improvements should be assessed by you for their full impact before they are implemented. This report, or our work, should not be taken as a substitute for management's responsibilities for the application of sound commercial practices. We emphasise that the responsibility for a sound system of internal controls rests with management and our work should not be relied upon to identify all strengths and weaknesses that may exist. Neither should our work be relied upon to identify all circumstances of fraud and irregularity should there be any.

This report is supplied on the understanding that it is solely for the use of the persons to whom it is addressed and for the purposes set out herein. Our work has been undertaken solely to prepare this report and state those matters that we have agreed to state to them. This report should not therefore be regarded as suitable to be used or relied on by any other party wishing to acquire any rights from RSM UK Consulting LLP for any purpose or in any context. Any party other than the Board which obtains access to this report or a copy and chooses to rely on this report (or any part of it) will do so at its own risk. To the fullest extent permitted by law, RSM UK Consulting LLP will accept no responsibility or liability in respect of this report to any other party and shall not be liable for any loss, damage or expense of whatsoever nature which is caused by any person's reliance on representations in this report.

This report is released to our Client on the basis that it shall not be copied, referred to or disclosed, in whole or in part (save as otherwise permitted by agreed written terms), without our prior written consent.

We have no responsibility to update this report for events and circumstances occurring after the date of this report. RSM UK Consulting LLP is a limited liability partnership registered in England and Wales no.OC397475 at 6th floor, 25 Farringdon Street, London EC4A 4AB

For enquiries about this publication, contact the Food Standards Agency.

Project reference: FS430836

Follow us on Twitter: @foodgov

Find us on Facebook: facebook.com/FoodStandardsAgency