



# Community Food Consultation Falkirk Council Area

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## Report

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## Falkirk Community Food Consultation - Key Messages and Recommendations

Public involvement, local needs assessment and increased awareness of the views and experiences of people in communities served by Falkirk Council and NHS Forth Valley are seen as important indicators of success in creating responsive health care. They are also a key part of community planning, delivering services in partnership based on local needs and involving local people.

This study seeks:

- to assess people's understanding of a healthy diet and healthy foods
- to assess the impact of community food and healthy eating initiatives in the area covered by the Falkirk Community Planning Partnership
- to identify key issues and opportunities for the future
- to place in the context of current policy programmes which encourage eating for health to enable a better quality of life

The study does not focus on key dietary targets rather the issues and concerns and understanding which people have of healthy eating and circumstances, which contribute to that.

From the study the following key messages and recommendations are made:

### Falkirk Area

- Local action and community based food initiatives are making a significant contribution to achieving food and health targets
- Targets should include changing diet through the promotion and provision of healthy food and eating practices, improving nutrition training and food hygiene, expanding work with disadvantaged and vulnerable groups and providing good, easily understood advice and information.
- A role for local community initiatives in this was clearly identified including the need for more development workers in community health.
- In areas of disadvantage community food initiatives aimed at encouraging low cost, healthy food choices and eating opportunities should have a higher priority. Similarly access to purchase such food should be an important part of the work.
- While programmes and projects take a whole population approach within that there has been a particular interest in developing specific initiatives in schools, community centres, workplaces and homes. In addition concentrations of excluded communities where inequalities are greatest have formed an increasing focus for practice.
- Skills development around engaging with communities to enhance healthy food choices requires training and networking opportunities across a number of professions and disciplines to support and enhance joint working.
- An accurate understanding/ knowledge of the main dietary messages and priorities is also required.

- A mixture of information provision and direct engagement with people around dietary and lifestyle choices appear to be effective in creating opportunities for change. This indicates the importance of continuing to develop community based activities that can develop action in a local context in terms of food.
- Interventions must be targeted towards specific issues identified within individual local communities. This may mean a different focus and emphasis within the various regeneration areas.
- There needs to be a greater awareness of the sources of funds, other resources and a sharing of experience to maximise the delivery of community food initiatives in the area.
- Community involvement brings additional benefits in tapping into local resources and experience that can support action and change in local communities. Understanding the processes involved in effective intervention needs to be embedded in developing action with communities as part of the community planning process.
- Community Planning as a process aims to deliver 'joined up' services on the basis of local needs. The current integration of social inclusion into Community Planning means that social justice priorities will be prioritised at strategic level and provide the focus for future work.
- The Falkirk Community Plan includes health as a theme in its own right and other themes, which impact on healthy lifestyles. The initial priorities for action around diet can be identified through the deprivation statistics.

**The following key messages and recommendations from national policies are in addition to the above local recommendations from the Falkirk area.**

- The importance of locally based initiatives to target particular groups of people is central to developing action based on need.
- More steps should be taken to discourage unhealthy eating through education, information and awareness.
- Poverty and disadvantage contribute significantly to health inequalities and while overall the UK indicators of deprivation have improved this improvement is less evident in Scotland.
- Scotland's eating habits are the second major cause of ill health after smoking.
- Raising awareness of healthy food choices is an important element of improving diet, however consideration of access and affordability are equally important.
- Labelling of food and awareness messages need to be clear, accurate and understandable.
- The role of community planning in integrating strategic planning across public sector agencies and priorities enables joint planning and development to inform local action. In moving towards integrated provision it is important to establish direct links between health and social justice priorities in improving dietary choices.
- Community planning creates an important opportunity for integrating thinking on current service priorities and supporting upstream intervention for longer-term

change. Sustained activity around diet and lifestyle choices is a priority for the longer-term health of people living in Scotland.

- National policies, local strategies and the resultant programmes have had success in changing the eating habits and culture of Scotland's people. Community food initiatives have formed an important part of these developments.

# Falkirk Community Food Consultation Report


## 1 Introduction

### 1.1 Background

NHS Forth Valley Community Dietitians commissioned Linked Work and Training Trust to undertake a study to identify the current position with respect to food projects and activities, the availability of facilities to develop work and to identify any relevant issues and opportunities for future consideration. The focus of the study was on the regeneration areas identified by the Falkirk Community Planning Partnership but the findings are intended to have a wider significance across the Falkirk Council area.

### 1.2 Methodology

The study included desk research, exploring literature related to policy, deprivation, health, diet and community food activities and projects. This information was used to design a questionnaire survey, which aimed to identify and gain a better understanding of the part that community food initiatives play in the work of a variety of agencies and organisations in the Falkirk area. The survey was undertaken between March and June 2005 and 128 questionnaires were distributed, with 65 responses received.

<p>Community Food Consultation</p>	 <b>Focus Group Programme 2005</b>	<p>The desk research was also used to design a focus group programme and seven focus groups, involving 58 people, were undertaken in community regeneration areas of the Falkirk Council area (Table 1).</p> <p>The final component of the study involved 12 interviews with people responsible for policy and/or practice in relation to community food or regeneration activities. Feedback from participants at all stages was positive</p>
<b>Programme</b>		
<p>1</p>	<p><b>Welcome and Introduction</b> Background to the consultation. Introductions to team</p>	
<p>2</p>	<p><b>What did you have for breakfast?</b> In pairs participants are asked to tell each other what they had for breakfast, note it on a post it and on a second post it note where it was bought and why. They then decide whether it is healthy, unhealthy, or don't know. Participants then put the post its on the appropriately headed flipchart sheet on the wall (Healthy/ Unhealthy/ Don't know/ Where).</p>	
<p>3</p>	<p><b>The area in the future – visioning exercise</b> Participants split into smaller groups (4 – 6). Each group is asked to discuss what their ideal community would be in terms of what they eat, where they buy, what they know about diet and health. Each group will record 3 to 5 bullet points by way of description.</p>	
<p>4</p>	<p><b>Reality</b> Smaller groups discuss what the current situation is recording as bullet points what exists – 3 to 5 bullet points and what has changed from the past – 3 to 5 bullet points.</p>	
<p>5</p>	<p><b>Plenary</b> Full participant discussion on the current gaps and needs, how to progress from the reality to the vision. Facilitated and recorded by team.</p>	
<p>6</p>	<p><b>What next</b> Input on the next stages of the consultation, the feedback event and sources of further information</p>	

<p><b>Focus Group Events - Feedback</b></p> <ul style="list-style-type: none"> <li>• Really enjoyable (7)</li> <li>• It is good we are getting feedback (2)</li> <li>• I am looking forward to the next meeting (4)</li> <li>• I met people I have not met before and can work together with (3)</li> </ul>	<ul style="list-style-type: none"> <li>• Can we come to the next one (2)</li> <li>• I felt that was useful and that my comments were listened to (1)</li> <li>• Discussion was really good (5)</li> </ul>
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**Table 1 Focus Group Attendance**

Areas Covered	Attendance
Grangemouth	7
Camelon, Thornhill Road, Maddiston	11
Denny	11
Stenhousemuir	5
Bo'ness	7
Westquarter, Hallglen, Falkirk High Flats	6
Dawson	11
Totals	58

The target age ranges were represented at the focus groups (15 – 24 years old 14%, 25 – 49 years old 62% and 50 years old plus 24%). There was also a wide range of interests from health professionals, other health interests, food interests, education and learning and other topics like sport and leisure, families, and the environment.

Of the respondents to the questionnaire survey more than half were managers, 26% provided support, information and advice, 17% were tasked with developing services and 2% direct training. There was almost an equal split between those employed in the public sector and in the voluntary sector with 1 private sector respondent.

## 2 Focus on the Falkirk Council Area

### 2.1 Background

The Falkirk Community Planning Partnership has established five theme groups, covering Economic Development and Tourism; Community Regeneration; Health; Environment and Transport; and, Community Safety. The role of the Community Plan, particularly in relation to health and community regeneration, is therefore an essential element of improving access to health lifestyle choices. The links between community infrastructure and the ability of people to make healthier lifestyle choices also plays a role, touching on other priorities such as transport, environment, employment and community safety. While diet may not be seen as underpinning these thematic dimensions, they can be judged as integral to successfully supporting action that will improve health and well-being across the area as a whole.

There is an ever-increasing body of evidence on the importance of local action in support of healthy eating. A recent report on research into the experiences of 25 food projects within city and small town estates as well as in villages found a range of activities, including co-operatives, community cafes, opportunities to come together at community level to undertake ‘cook and eat’ sessions, and education opportunities on nutrition for mothers to be and new parents (McGlone, Dobson, Dowler & Nelson, 1999). All of the projects studied worked with people on low incomes. Research into Breakfast Clubs in 2002 (NHS Health Scotland, 2002) identified 378 breakfast services across Scotland. Nearly half of these who provided information for the research and 62% did, were based in primary schools, with a further 19% in out of school care provision and 17% in secondary schools. A focus on health and healthy lifestyles was part of the focus for over two thirds, with the majority (90%) involved in healthy eating initiatives. Also highlighted during focus group discussions was a need for Councils to exercise their responsibility for planning and development in ways that supported community health initiatives and controlled and created more effective shopping patterns.

It is clear that initiatives focused on or incorporating healthy eating activities are increasingly recognised as central to engaging with people to raise awareness of and create opportunities around healthy eating. It is also extremely important to base activities on the needs and interests of those that projects wish to involve.

Understanding what works, and how it has worked, is central to these developments. But it is also essential to understand what may or may not be transferable. Sometimes success in an area may be due to aspects of the local community or the profile and approach of key workers (Duffy & McNeish, 2002).

## 2.2 Main Findings

There are eleven areas identified in Falkirk as the most significant areas of deprivation, covering a population of 22,856 people, ranging from 4,376 in Camelon to 949 in Westquarter. The aspects of deprivation that Falkirk has considered in relation to these areas include unemployment (A), low economic activity (B), limiting long term illness (C), poor health (D), single parents (E), no qualifications (F) and overcrowding (G). This has allowed Falkirk to prioritise three areas that were not identified as in the worst 15% of Scottish households, but are considered to be significant at local level. These are Bo'ness, Hallglen and Stenhousemuir (Falkirk Community Planning Partnership, 2004: adapted from Tables 1 and 2).

**Table 2 Most Significant Aspects of Deprivation**

Priority Areas	Population	A	B	C	D	E	F	G	SIMD 2004 Worst 15%
Camelon	3,876		X	X	X		X		X
Dawson	3,503	X	X	X	X		X	X	X
Bo'ness	4,376		X		X		X	X	
Denny	1,563	X X	X			X	X	X	X
Grangemouth	1,000	X X			X				X
Hallglen	1,359	X				X X		X	
High Flats	1,668	X	X X	X X	X		X		X
Maddiston	1,389	X	X	X	X	X			X
Stenhousemuir	949	X	X			X X			
Thornhill Road	1,755							X X	X
Westquarter	1,418		X X	X	X	X X	X X	X	X

Double X shows significantly above average level of deprivation on this measure.

In relation to diet and lifestyle choices this breakdown provides a useful indicator of what might be the highest priority issues in the areas. For instance the high number of single parents in six of the areas, particularly in Westquarter might indicate that breastfeeding, maternal and baby diets might usefully be targeted, while the high number of people dealing with illness or poor health in some areas might prioritise action around access to nutritious food, including public transport developments. High unemployment in Denny and Grangemouth in particular might make cost of good quality food a priority.

### Key Messages

**The importance of locally based initiatives to target particular groups of people is central to developing action based on need**

This focus on areas of disadvantage in developing community food initiatives demonstrates an understanding of the importance of integrating a whole population approach to improving diet with a focus on identifying and dealing with additional barriers that may face people in deprived areas. Priorities in disadvantaged areas highlighted by survey respondents were difficulty in accessing healthy food at a reasonable cost and conversely the ease of access to unhealthy food. Focus group participants identified

cost as a factor across the areas, but there was also a particular stress on access to both supermarkets and local provision of healthy food choices in the Grangemouth area, discussion and concern expressed about limited choice in terms of shopping in the Westquarter, Hallglen, and Falkirk High Flats areas. The Denny participants stressed the attraction of a local takeaway, which they believed was cheaper for chips and cheese in a cup than school meals. They felt that this gave out the wrong message and that it reinforced bad eating habits.

Targeting approaches by using a mixture of statistical information about the area and local knowledge and concerns in the community involved makes it possible to test assumptions about needs and vary approaches around different priority targets within local communities before implementing best practice across the Falkirk area.

The priorities identified in the survey focused on access and affordability, with education, information and awareness given middle rank and skills in preparation and cooking coming last. The current community food initiatives identified did not include examples of activities around cost or access although interviewees did cite examples of food co-operatives and delivery services. These were thought to have met with limited success mainly on the grounds of not being able to compete on cost.

A variety of different approaches to different target groups were identified as important in the focus group discussions.

Participants believed that it was important to understand how different age groups thought about food as a way of identifying how best to inform them about healthy eating and to engage with them around their eating and lifestyle habits. All groups identified broad generation differences summarised here.

**Older people** – thought to be less likely to eat food from other countries preferring traditional fare. They were believed to be more likely to have good cooking skills and knowledge, particularly women in this age group. They were thought less likely to waste food, having lived through 'rationing' and to have less knowledge or interest in food labelling or awareness of health food issues.

**Middle aged people** – were thought to be more likely to have experience of and eat food from a variety of different countries and more prepared to try new foods. They were also felt to be more likely to aspire to healthy eating and be aware of food issues. Participants believed this group were more likely to have less time for cooking and to resort to convenience food.

**Young people** – were believed to prefer 'snacks and graze' than eat meals at set times and to prefer fast food. They were thought to have less experience of different foods, to be more influenced by advertising, media and their peers, to be less knowledgeable of healthy eating and food issues and to have few food preparation and cooking skills.

The Regeneration objectives identified by the Community Planning Partnership also link local policies directly to targets to be met. Thus the Joint Health Improvement Plan 2005-2008, the Forth Valley Health Plan and the Forth Valley Mental Health Strategy are identified as strategies directly linked to meeting the objective of addressing health inequalities. In meeting this target other strategies identified include the Community Learning and Development Strategy, the Children's Service Plan and the Sustainability Strategy.

The benefits of targeting on an area basis, within a broader policy context, highlight the importance of ensuring that diet and lifestyle implications are considered within the context of work in and around areas of deprivation. Participants in two of the focus groups felt that there was a need for more development workers on community health, with a focus on disadvantaged areas but a Falkirk wide interest in development. The tasks they felt were key to delivery were to establish local initiatives to increase healthy

eating and to support and encourage networking. In this way participants felt that diet and healthy eating activities could be developed both as “standalone” initiatives and integrated into activities that were not primarily about healthy eating.

The Community Learning and Development Strategy is also linked to a number of objectives: ensuring all children have the best possible opportunities regardless of life circumstances; promoting personal and community development; increasing jobs, income and enterprise for all citizens; and, actively engaging people in agency business. This indicates a professional role in working with communities to consider in developing dietary action in support of health and well-being in areas of deprivation. Community learning and development also has a key role in Community Planning.

### **Ministerial Foreword (Scottish Executive & Communities Scotland 2003)**

*'We have placed our approach to Community Learning and Development at the heart of our work on community planning. This means that for the first time community learning and development is being taken out of the margins and placed at the centre of the decision-making process within our communities. We want CLD to become a central feature of the way in which planning authorities and service providers engage with the communities and citizens we are all here to serve.'*

**Margaret Curran Minister for Communities**

**Andy Kerr, Minister for Finance and Public Services**

**Peter Peacock, Minister for Education and Young People**

**Jim Wallace, Deputy First Minister and Minister for Lifelong Learning**

This is not to say that responsibility lies solely with those who deliver community learning and development in Falkirk but that there is a support function within communities that needs to be considered in relation to engaging with people in the most deprived areas to encourage interest in healthy food choices as well as the need to support action that will enhance their ability to make such choices.

### **Key Messages**

**The Falkirk Community Plan includes health as a theme in its own right and other themes, which impact on healthy lifestyles. The initial priorities for action around diet can be identified through the deprivation statistics.**

**Local action and community based food initiatives can make a significant contribution to achieving targets; the priority needs highlighted in the regeneration target areas in a number of policies and strategies can be combined to identify effective intervention around diet and lifestyle changes.**

**In areas of disadvantage community food initiatives aimed at encouraging low cost, healthy food and eating should have a higher priority. Similarly access to purchase such food should be an important part of the work.**

**More steps should be taken to discourage unhealthy eating through education, information and awareness**

## **3 The Context**

### **3.1 Scotland**

Scotland's health record is one of the worst in the developed world. Although life expectancy has increased by around 25 years since 1910 and infant mortality has significantly declined, Scotland has the highest death rates from heart disease and cancer in Western Europe. The bulk of the problems relate to heart disease, stroke and cancer. The links between diet and these diseases have been identified as key areas for intervention in supporting health and health improvement.

Dietary surveys across the Scottish population point to poor diet being established from an early age (Scottish Office 1996a). Scotland's eating habits are the second major cause of ill health (after smoking). The 1998 Scottish Health Survey (Shaw, McMunn & Field 2000) showed that around half of Scotland's population took sugar in tea and ate chocolates, crisps or biscuits daily. Despite nearly half of men and over half of women eating fresh fruit daily, Scots were found to have one of the lowest vegetable and fruit intakes in Western Europe. The implications touch on all parts of the population, and physical activity and awareness of dietary choices and their implications are seen as a priority in supporting health and well-being. While the statistics are improving they are improving at a slower rate than most other European countries.

Health inequalities, where a higher proportion of risk appears to be linked to socio economic status, have been identified as important factors, with deprivation seeming to have an impact in about 40% of the excess deaths. Diet was also identified as an influencing factor, with social classes 1 and 2 eating healthy food regularly compared to those in classes 4 and 5.

Links between poverty and health inequalities can be seen at all ages (Philip, James, Nelson, Ralph & Leather, 1997). Lower socio economic groups have higher chances of premature and lower birth weight babies, and of heart disease, stroke and some cancers in adults. The risk factors identified include a lack of breastfeeding, smoking, physical inactivity, obesity and poor diet. Diet in these groups has been identified as providing cheap energy from food like full cream milk, meat products, fats, sugars, potatoes and cereals, but with little in the way of vegetables, fruit and whole wheat bread. Therefore policy developments in relation to health and well being also link to action taken to combat poverty.

Low income, which would appear to have a direct impact on dietary choices, is a particular risk for those who are disconnected from the employment market. Single parents, older people who are suffering from long term illness or disability or those who are involved in caring roles and those whose income is solely based on their state pension are particularly vulnerable.

Although recently (for the first time) overall the number of indicators of deprivation which improved in the UK was greater than those which got worse (Rahman, Palmer & Kenway, 2001), there was a mixed picture of success in tackling poverty and social exclusion in Scotland (Kenway, Fuller, Rahman, Street & Palmer, 2002). The proportion of people living in poorer households rose slightly from 21.5% to 23.5%. There was an increase in the working poor households, with 40% of households below the poverty threshold including a working adult and 40% 'economically inactive'; only 20% were designated as unemployed. Around 1,300 babies born in 2001 were underweight, which is an indicator associated with higher risk of health problems later in life (Both of these studies defined poverty as households with less than 60% of median income).

### **Key Messages**

**In Scotland we have an ageing population, the highest death rates from heart and lung disease in Western Europe.**

**Scotland's eating habits are the second major cause of ill health after smoking. Poverty and disadvantage contribute significantly to health inequalities and while overall the UK indicators of deprivation have improved this improvement is less evident in Scotland.**

### 3.2 Policy Aspirations and the Views of Participants

Policies and projects have been developed over the last ten years that have specific dietary improvement aims (Scottish Office, 1999), such as encouraging good nutrition before and during pregnancy and through breastfeeding, promoting eating for health through the 'Heart of Scotland' demonstration project. These can be seen as building on the 'Scottish Dietary Action Plan' through a proactive and broad policy aspiration.

#### ' Scottish Dietary Action Plan' recommendations:

- Stimulate consumer demand for fruit and vegetables through developmental initiatives and marketing
- Breed leaner livestock for human consumption
- Develop new low fat meat products
- Stimulate consumer demand for oil rich fish
- Produce weaning and infant foods low or free from extrinsic sugars
- Nutritional training for the food industry
- Produce more foods low in fat, salt and sugar
- Present labelling in ways people understand their meaning
- Local community initiatives must be taken tapping into community energy and expertise
- Expand work with the disadvantaged
- Target pregnancy, pre-school children and school students
- Caterers should provide a variety of vegetables as part of a main meal
- Fast food sector should broaden the range of nutritionally beneficial foods

The Scottish Dietary Action Plan outlined a framework for action over 10 years by all sectors and agencies. This identified the need to influence from an early age and to improve access to affordable healthy food, provide information so that consumers could make informed choices and to ensure that people recognised the need to alter their diet (Scottish Office, 1996b). Towards a Healthier Scotland (Scottish Office, 1999) also recognised diet and lifestyle issues as national health priorities, with powerful effects on health, linking to social class and life circumstances. This was reinforced the following year in 'Our National Health Plan' (Scottish Executive, 2000), which stressed that people wanted better information about a healthy diet and better access to good quality food. It also highlighted the importance of high quality food in pregnancy and as part of helping people to prevent cancer, which was followed with action for change around cancer (Scottish Executive, 2001) and a strategic approach to dealing with heart disease (Scottish Executive, 2002a), both of which highlighted lifestyle and dietary change.

The case for improving the Scottish diet is now well established through the Scottish Diet Action Plan and these other policy developments. Implementation of this is a key action identified in 'Improving Health in Scotland – The Challenge' (Scottish Executive, 2003a). In particular, the need to '*narrow the opportunity gap and improve the health of our most disadvantaged communities at a faster rate*'. At a strategic level the way forward is set out in 'Eating for Health - Meeting the Challenge' (Scottish Executive 2004):

*In order to ensure continued co-ordinated action and commitment towards food policy and health and to strengthen the work of the Scottish Food and Health Co-ordinator, the Scottish Executive intends to:*

- engage widely on a **strategic framework** which will develop further food and health policy to guide national and local food and health action plans. The framework should inform and co-ordinate work between partner agencies, local government and communities;
- establish a **Scottish Food and Health Council** with a Ministerial lead focused on formulating, delivering and reporting on an annual action plan. The Food Champions group will merge with the Council. This will be a publicly appointed body of key stakeholders and experts together with heads of relevant Scottish Executive departments and the Food Standards Agency Scotland (FSA Scotland);

- *join with FSA Scotland to establish a national **Healthyliving Food and Health Alliance**, to ensure strong and effective engagement and interactive communication with all key sectors, including food retailers and manufacturers, stakeholders and networks, facilitating information sharing, consultation, evidence gathering and partnership development; and*
- *deliver a cross cutting **annual Food and Health action plan** in support of this strategic approach;*

At local level within Falkirk topics were highlighted as part of the survey undertaken as part of the study. Survey respondents were asked to rank a list of 12 food topics on a scale of 1-10 (with one being the highest priority) (Table 3).

**Table 3 Priorities for Action**

<b>Topic</b>	<b>High est</b>	<b>Low est</b>	<b>Aver age</b>
Cost of good quality food	1	9	1
Availability of unhealthy food (e.g. fish and chips)	12	1	2
Access to good quality food	2=	2=	3
Confidence in expert opinions	11	2=	4
Education about food	3=	9=	5
Confusion from reporting on what foods are good or bad for people	10	6=	6
Belief in the importance of dietary food	7=	6=	7
Access to information on food choices	5=	12	8
Taste	7=	2=	10
Understanding of dietary information	9	5	11
Awareness of the health implication of not eating healthy food	3=	6	9
Skills in food preparation	5=	9=	12

Cost, the availability of unhealthy food and access to good quality food came out as the top three priorities followed by confidence in expert opinions, education and confusion about what might be good or bad for people. It should be noted that this does not mean that respondents did not think that those issues with the lowest priorities were unimportant, a point that was reinforced during the focus group discussions where awareness of the health implications around healthy food and food preparation skills were identified as important as were cost and the availability of healthy and unhealthy food choices.

There was a general view expressed during focus group discussions that awareness of healthy eating was improving but that labelling and sometimes contradictory advice was also confusing. Increased awareness was thought to result from things like health advice during illness, community food projects, health promotion campaigns and media reporting, advertising and documentaries and cookery programmes. The most frequently made comment in the focus groups concerned the need for clear, simple labelling. Some participants also expressed concern about advertising and the media, particularly in relation to promoting unhealthy food and reporting confusing health scares.

**Key Messages**

**Targets therefore have included changing diet through the promotion and provision of healthy food and eating practices, improving nutritional training and hygiene, expanding work with disadvantaged and vulnerable groups and providing good, easily understood advice and information**

**A role for local community initiatives in this was also identified.**

**Raising awareness of healthy food choices is an important element of improving diet, however consideration of access and affordability are equally important.**

**Labelling of food and awareness messages need to be clear, accurate and understandable.**

### 3.3 Changing Focus

The concept of well being has become one of the important drivers for health change. This does not mean that illness and dealing with illness have not remained the primary targets of health policy but it has added some important dimensions of prevention or minimisation of ill-health to a range of policy developments. Health and well being are seen as part of the social fabric rather than a narrower definition focusing on disease management has become a key focus for the way forward. Social Justice commitments in Scotland have been an important move in the direction of integrating thinking across sectors and responsibilities in tackling inequality and life cycle vulnerabilities. By acknowledging the importance of inclusive life course and community activities as part of the health and well-being agenda the social justice framework broadened the scope for the discussion of and integration of services.

*'Many of the policies that have the greatest potential impact on health have traditionally been outside the influence of the health sector (e.g. pensions, housing, and transport). These policies have been introduced primarily for other reasons and this has consequently meant that their health and particularly their health inequalities impact have rarely been fully evaluated'*  
**Blamey & Murie, 2002**

As part of 'Our National Health Plan' (Scottish Executive, 2000) the Scottish Executive explicitly saw a social role in the development of a healthy Scotland. *'The drive for better health must extend into the school, the community centre, the workplace and the home'*. This has helped to establish a number of issues to take into consideration when working to improve dietary choices.

Drivers of change (Table 4) were highlighted during the focus groups as including

**Table 4 Shopping Comments**

Topic	Comment	Frequency
Low income families	• Less purchasing power, less choice	4 groups
	• Needs careful planning and management to eat healthy food	1 group
	• Further to travel to supermarkets, travel by taxi (expensive) or bus (timely) if not car owner	2 groups
Specialist shops	• Would use butchers, baker, greengrocer if close to home or supermarket	2 groups
	• Fewer specialist food retailers around	1 groups
Fridges and freezers	• Have changed shopping patterns as you can buy in bulk and/ or store longer	3 groups
Single and elderly people	• Difficult to buy food in supermarkets in quantities suitable for 1 person	3 groups
	• More expensive to buy small quantities/ packages	3 groups
Local producers	• We should support good local producers	3 groups
Social responsibility	• Supermarkets should demonstrate some commitment to local communities and social responsibility	1 group
	- Grant aiding community food projects - Promoting healthy eating through store magazines	
International influences	• The availability of food from other countries at competitive prices has affected home producers	1 group
	• Experience of food and meals from other countries has impacted on food buying	1 group

technical developments, such as the impact of fridges and freezers on shopping patterns, difficulties facing people because of poverty and access issues and the ability to buy nutritional food.

### 3.4 Changing Culture

Dealing with reducing poor health, statistics about fresh fruit intake and interventions to reduce inequalities in health can be directed at structural or regulatory level, at local level and with individuals and families, all of which need to be considered in relation to diet (McIntyre, 2001). At individual level this has prompted action aimed at encouraging people to think about and understand the dietary benefits of increased fruit and vegetable intake and cutting back on things like sugar and processed foods. The cultural assumptions that are being targeted through these processes need to be considered.

Focus group participants highlighted a change in culture in that cooking was done less often than in the past. Time and convenience were highlighted as the main reasons people did less cooking, followed by 'can't cook'. Three groups believed that mothers with babies fed branded baby food jars believing them 'best for baby' when often liquidised adult food was less expensive and, depending on the ingredients, more healthy. Two groups also thought that young people should be taught about nutrition and healthy food as early as possible. Developing awareness of the cultural barriers, assumptions and aspirations that influence how people think about food and nutrition are important elements of promoting change.

The Scottish Executive has used advertising in support of smoking cessation and improved diet to begin to deal with some of the cultural norms that are thought to block improvements. In addition the Executive has moved towards a ban on smoking in public places as a way to cut the numbers of those smoking and they have given women a legal right to breast feed in public places. If we see policy development as a mixture of sermon (changing the way that people understand the implications of what they are doing), carrots (offering improvement for individuals) and sticks (making some actions more difficult and open to punishment), it is possible to see all three approaches at work in the developments of activities around diet and lifestyles.

### 3.5 Inequalities

Income inequality, poverty and the need to integrate policy development and implementation have been increasingly identified as important elements of initiating and supporting changes in lifestyle and stimulating health supporting action. Social and economic conditions have a direct impact on the quality of diet, with poorer people generally eating less fruit and vegetables and more cheap, high fat, high sugar foods. *Access to affordable healthy food has more of an impact on diet than health education.* The poorest 10% of households spend 29% of their income on food, compared to 18% in the richest. People living in deprived areas are less likely to eat fresh fruit or green vegetables daily. The Scottish diet is unhealthy, high in fat, salt and sugar and low in fruit and vegetables. As deprivation increases the percentage of adults eating fresh fruit decreases, therefore improving diet, particularly in deprived communities and with children, is a high priority for the Scottish Executive.

The dietary targets for 2005 set out in the 'Eating for Health' include doubling consumption of fruit and vegetables, reducing total consumption of fat and doubling the consumption of oily fish (Scottish Executive, 2004).

**Eating for Health**

**Dietary Targets for Scotland for the Year 2005**

Fruit and vegetables Average intake to double to more than 400 grams per day.

Bread Intake to increase by 45% from present daily intake of 106 grams, mainly using wholemeal and brown breads.

Breakfast and cereals Average intake to double from the present intake of 17 grams per day.

Fats Average intake of total fat to reduce from 40.7% to no more than 35% of food energy. Average intake of saturated fatty acids to reduce from 16.6% to no more than 11 % of food energy.

Salt Average intake to reduce from 163 mmol per day to 100 mmol per day.

Sugar Average intake of NME sugars in adults not to increase.

Average intake of NME sugars in children to reduce by half, that is to less than 100% of total energy.

Breastfeeding The proportion of mothers breastfeeding their babies for the first 5 weeks of life should increase to more than 50% from the present incidence of around 30%.

Total complex carbohydrates Increase average non-sugar carbohydrates intake by 25% from 124 grams per day through increased consumption of fruit and vegetables, bread, breakfast cereals, rice and pasta and through an increase of 25% in potato consumption.

Fish White fish consumption to be maintained at current levels. Oily fish consumption to double from 44 grams per week to 88 grams per week

Although changes since 1995 indicate that the percentage of the population eating fresh fruit has increased, it has increased least in the most deprived areas (Bain 2001). The proportion of people aware of the recommended daily consumption of five portions of fruit and vegetables has risen from 19% in 1996 to 59% in 2003 (Health Education Population Survey).

The need to target disadvantaged communities was emphasised at two of the focus group discussion. It was felt that in these areas the need for awareness and education was greatest, with more people on low incomes and less local shopping opportunities for healthy food.

**3.6 Effective Intervention**

Improved diet, exercise, access to good quality, nutritious food and cutting back on unhealthy activities have all been priority aims in the fight against ill-health and high morbidity rates in Scotland (Scottish Executive 2002b). The relationship between diet and diseases such as cancer and coronary heart disease means that these are priority areas in the targets that both link to issues like smoking cessation (a direct change in behaviour known to have links to both) and diet (choices that are seen to encourage life enhancing activities). This puts dietary considerations into a broader community based approach, aimed at increasing awareness and understanding of some of the issues, enhancing access to information and support and the ability to make informed choices for people in the most deprived areas and encouraging changes in behaviour across the population. This has supported intervention in relation to diet in schools through a range of initiatives including the national 'Hungry for Success' scheme funded by the Scottish Executive. This has prompted creative practice around

**Food Boxes**

A local farmer currently delivers 25-39 food boxes per week in the Falkirk area. A vegetable box with 12-13 items costs £7 and a fruit bag £5.

The **Meals on Wheels** service delivers meals across the Falkirk area. Falkirk Council funds the service. The food is prepared on the day and delivered under strict hygiene conditions in insulated packaging to ensure it remains hot.

**Berry Days**

*The 'Hungry for Success' teams have been supporting annual 'berry days' where local primary school children get the opportunity to follow the berry from grower to plate and sample a variety of local berries.*

food growing, understanding what is good and bad for health in diets and positive understanding of food as well as improving nutritional standards in school meals and increasing uptake. Respondents to the survey identified work with schools (37%) and community groups (37%) as the most common approaches they were aware of in engaging with people around community food activities. This was followed by information dissemination

through newsletters (30%), leaflets (27%), public meetings and consultation documents (16% each), use of the Internet (16%) and surveys (13%). The recent Jamie Oliver television documentary working in primary schools in a London borough to provide healthy food and encourage healthy eating was the most frequently quoted high profile example. Most were aware of the changes in Scotland's primary schools as a result of intervention through the 'Hungry for Success' and other initiatives.

**'Hit Squad'**

*The 'Hit Squad' based in the Dawson regeneration area received a Queen's Jubilee award in 2002 in recognition of their work on healthy food and environmental initiatives. The Squad are a group of young volunteers.*

*In Denny the 'Food Dudes' Project has been running for young people in youth clubs. Young people got the opportunity to try new fruit and vegetables. It was a pilot, successful from the feedback from the young people but was never followed up.*

*The Dundas Centre provides services to the physically disabled. A range of activities is available, including a training kitchen adapted for physically disabled. The kitchen is in the process of being renovated with surfaces and appliances being made suitable for wheelchair*

**Table 5 Future Plans**

Category	Yes	No
Children and parents/guardians	46%	22%
Young People	43%	27%
Community groups	37%	24%
Carers	32%	22%
Older people	29%	32%
Staff	27%	24%
People with disabilities	25%	10%
People from ethnic minority groups	24%	32%
Pupils and staff in schools	19%	21%
Patients	17%	29%
Other	5%	5%

Survey respondents in the Falkirk area identified their main target groups in relation to future plans to engage sections of the community around food issues as children and parents/guardians, with almost half having such plans (Table 5). The second highest priority was young people, followed closely by community groups, carers and older people.

Focus group participants also felt that there was a need for Councils to exercise their responsibilities in planning and development in ways which support community health initiatives and control and create more effective shopping patterns.

The importance of where people live to what they might choose to eat has been a stimulus for community-based work with people in some of the most deprived areas in Scotland. The real challenge appears to be how these might be integrated and embedded in broader approaches to supporting health and well-being in communities, despite low incomes, multiple needs and cultural assumptions or preferences that might undermine health.

**Key Messages**

**The policy and resultant programmes have had success in changing the eating habits and culture of Scotland's people. Community food initiatives have formed an important part of these developments.**

**Current challenges in reshaping delivery include integrating approaches to bring together different professional priorities to meet individual and community needs and embedding approaches to working with communities based on understanding people's social and economic context, including the cultural assumptions and preferences at work that might undermine health.**

**While programmes and projects take a whole population approach within that there has been a particular interest in developing specific initiatives in schools, community centres, workplaces and homes. In addition concentrations of excluded communities where inequalities are greatest have formed an increasing focus for practice.**

**A mixture of information provision and direct engagement with people around dietary and lifestyle choices appear to be effective in creating opportunities for change. This indicates the importance of continuing to develop community based activities that can develop action in a local context in terms of food.**

**3.7 Community Planning**

With the Local Government in Scotland Act 2003 community planning, the overarching process to provide services based on needs and the regeneration of communities, became a statutory responsibility for local authorities to initiate and lead the process and for certain other agencies to participate. National priorities that need to be taken into consideration as part of the community planning process include health and other policy priorities that are part of or inform the healthy eating agenda such as social justice, sustainable development, equalities, education and community regeneration.

The Scottish Executive's commitment to 'Closing the Opportunity Gap', reinforces people's health in Scotland should not depend on where they live or on their socio-economic status (Scottish Executive, 2003b), aiming to tackle causes of ill-health including diet, and addressing inequalities in health that are linked to poverty and deprivation. Objectives announced in July 2004 included (Scottish Executive, 2005) increasing the rate of improvement of the health status of people living in the most deprived communities. To help achieve these objectives the community planning process is linking specific investment of Executive funding through Regeneration Outcome Agreements focused on data zones identifying areas of deprivation in each local authority.

The health priorities of diet and nutrition would appear to be reflected by survey respondents' priority listings of policies (Table 6) that they thought were most important for the agenda, with nearly all of the health policies receiving higher prioritisation than community planning or educational, involvement or social justice policies. The community plan and social justice were given medium rankings in terms of priorities, which may reflect that respondents were less familiar with both policies since other information supplied within the survey highlighted their interest in activities around excluded and vulnerable groups and regeneration processes.

Table 6 Priority Policies

Policy	High priority	Medium priority	Low priority	Don't know
Falkirk Health Improvement Plan	73%	19%	2%	2%
Eating for health – Diet action plan for Scotland	68%	17%	0%	3%
Local Health Plan	68%	22%	0%	2%
Community Health Partnerships	65%	25%	2%	2%
Towards a healthier Scotland	62%	25%	2%	2%
Cancer in Scotland	60%	29%	0%	29%
Our National Health	56%	29%	3%	2%
Oral Health Strategy	49%	38%	2%	5%
Community planning	48%	38%	2%	2%
Best value	44%	27%	3%	3%
Patient focus & public involvement	43%	38%	3%	5%
Community Learning Strategy	40%	49%	2%	5%
Integrated Learning Communities	37%	38%	5%	3%
Further Education	24%	51%	5%	5%
Social justice	22%	56%	5%	6%
Higher Education	21%	57%	2%	5%

### Key Messages

The role of community planning in integrating strategic planning across public sector agencies and priorities enables joint planning and development to inform local action. In moving towards integrated provision it is important to establish direct links between health and social justice priorities in improving dietary choices.

Community Planning as a process aims to deliver ‘joined up’ services on the basis of local needs. The current integration of social inclusion into Community Planning means that social justice priorities will be prioritised at strategic level and provide the focus for future work.

Community planning creates an important opportunity for integrating thinking on current service priorities and supporting upstream intervention for longer-term change. Sustained activity around diet and lifestyle choices is a priority for the longer-term health of people living in Scotland.

### 3.8 Resourcing Community Food Initiatives

The resources available to support health improvement, dietary change and cultural developments can be found across a range of disciplines, in compulsory education, in health promotion, in health service delivery and in community learning and development. Integrated thinking at this level is increasingly taking place, raising awareness among professionals of the long term benefits of diet and life style choices has also been an important gain from the 10 year focus on dietary action. The priorities for the next 10 years require an understanding of how integrated implementation might be best supported, through existing resources as well as with funding streams that can stimulate pilot activities and test new and innovative approaches. Sustained activity around diet and lifestyle choices is a priority for the longer-term health of people living in Scotland.

More locally the Forth Valley Food Links small grants scheme has supported a variety of projects which aim to increase the supply of fresh food in the Falkirk area. Food Links exists to establish links between individuals, communities and producers to increase access to fresh local food products providing social, environmental, economic and health benefits.

In developing policy and practice to help to

change Scottish people's choices around diet and lifestyle choices there has been some success across the population as a whole. Funding streams from the Scottish Community Diet Project have supported much activity across a range of organisations. The Scottish Community Diet Project specifically works with low-income communities to improve diet. Part of the Project's work involves a small grant scheme, which supports the establishment and development of Community Food Initiatives. During 2001, funding for this grant scheme was increased to allow it to help at least 50% more projects from 2001-2.

One of the issues raised in Falkirk in this connection and with resourcing projects generally was a lack of awareness of these and other schemes which potentially could fund community food initiatives.

Additional resources are also clearly available in communities (CHEX 2004), through volunteering in support to health, from individual experience of ill-health and dietary changes needed to support health, and from the activities stimulated and supported to enhance understanding of health and lifestyle choices. Many of these activities are found in community organisations where the primary focus is not on health, but on social inclusion, on working with different groups within communities and on family learning developments. Tapping into these resources and working with people to support inclusion through health and well-being developments is a primary source of effective planning and delivery.

When asked whether their organisation was involved in community food initiatives 94% of survey respondents answered the question, with 48% saying they were involved and 46% saying that they were not. Respondents identified 25 examples of initiatives. Broadly 6 of these were of an educational nature, 8 were based on acquiring skills in preparing healthy meals and food, 8 were related to providing healthy food for consumption. 2 were on food hygiene and 1 on diet and health. Activities included increased availability, for instance fruit and vegetable resource boxes and training in encouraging healthy eating for childminders; training in food preparation and cookery; involvement in Hungry for Success; healthy eating workshops and discussions; and, a healthy tuck shop in a community centre.

Only 22% of respondents' felt that the resources allocated to community food initiatives were adequate, with 40% feeling that they were less than adequate and 27% that they were significantly less than adequate.

An equal number of survey respondents felt that key skills for staff included engaging with communities (25%) and knowledge of food and health (25%). Good communication skills were also felt to be important (20%). Less than 10% of respondents' identified skills in supporting joint working; creating and sustaining partnerships; a good knowledge and awareness of resources; funds and how to use them; and, leadership. There was an equal division between respondents who thought that current skills were adequate (43%) and those who felt they were either less than adequate (33%) or significantly less than adequate (10%); 16% of respondents did not answer this question. Focus group participants highlighted how important they felt it was to encourage networking around community food initiatives, feeling that this supported information exchange and sharing experiences, better joint working and more effective training and helping people to keep up to date with policies, programmes and funding developments that might support activities.

Awareness of the availability of training for staff working on community food activities was relative low, with just over a quarter of survey respondents saying that there was no training available (28%), 21.5% did not know, and 21.5% were aware of training (although 2 of these said that they were unsure of what it was) and 29% did not answer

the question. The kind of training identified was mainly in food hygiene (10 respondents identified this), others mentioned were healthy eating for the pre 5s and health issues in the community.

**Key Messages**

**Skills development around engaging with communities to enhance dietary choices requires training and networking opportunities across a number of professions and disciplines to support and enhance joint working.**

**Also required is understanding/ knowledge of the main dietary messages and priorities.**

**Community involvement brings additional benefits in tapping into local resources and experience that can support action and change in local communities. Understanding the processes involved in effective intervention needs to be embedded in developing action with communities as part of the community planning process.**

**There needs to be a greater awareness of the sources of funds, other resources and a sharing of experience to maximise the delivery of community food initiatives in the area.**

**4 The Next Steps**

It is intended that the study will help to inform the future work in developing community food and healthy eating initiatives in the Falkirk area. The key messages and recommendations are being considered by the Falkirk Food Group and it is hoped that agencies and organisations in the public, private, voluntary and community sectors who have an interest and involvement in promoting and supporting work on healthy food, on service delivery which impacts of healthy eating and lifestyles and on community regeneration will give consideration to how best to contribute to the developing agenda.

A newsletter summarising the findings of the study has been produced as has more detailed reports of the focus groups, the questionnaire survey and the policy and literature review. For further information on these, contact:

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The views expressed in this Report are those of the participants in the study as recorded by Linked Work and Training Trust who undertook the analysis and prepared the study reports. They are not those of NHS Forth Valley.

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